

**“A POSITION OF GREAT TRUST AND RESPONSIBILITY”:
A SOCIAL HISTORY OF THE GRAHAMSTOWN ASYLUM, 1875 – c. 1905**

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Kylie van Zyl

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Co-supervisors:

Professor Gary Baines and Dr Carla Tsampiras

ABSTRACT

Much has been written about the inequalities inherent in the psychiatric care provided to mentally ill individuals in the Cape Colony, but to date few works have been produced that describe in detail the processes and care regimes at particular institutions. This thesis examines the history of care and custody provided by the Grahamstown Asylum in the Cape between the years of 1875 and 1905. The intention is to determine the means and methods by which the Asylum's authorities developed, almost unchallenged, a system of unequal treatment and favouritism within that facility, and what this meant for the men and women committed to the Asylum's custody. To this end, contemporaneous official reports from Asylum staff and Colonial authorities were consulted, in conjunction with the Asylum's internal records such as registers and individual patient files.

This thesis concludes that the evolution of the Colony's psychiatric community's beliefs around mental illness, philosophies of protective custody and moral treatment within the psychiatric community at the time, the region's laws governing psychiatric institutionalisation, and the larger context of the Cape's socio-political environment at the time converged to create an institution that practiced discrimination on both a macro- and micro-level. This discriminatory framework affected who was admitted, the diagnosis that each person received, the asylum facilities to which they had access, and further, to the odds against their recovery. The implications of this study are relevant in the present day, as the modern South African system of psychiatric institutionalisation, though embedded within a socio-political context of equality and non-discrimination nevertheless appears to suffer from a similarly undemocratic framework of operation.

CONTENTS

	PAGE
INTRODUCTION	1
Approaching the Asylum: Sources and Challenges	1
The Choice of 1875 – c. 1905 as a Time Periodisation	2
Primary Sources: Patient Case Files, Patient Registers, and Government Documents	3
Putting the Asylum in Context	10
Literature Review	11
Thesis Goals and Structure	25
Notes on Terminology	28
Pseudonyms	29
 CHAPTER ONE: The Evolution of Grahamstown Asylum	 30
The Cape Colonial Context, 1812 – 1905	30
The Selection of Grahamstown as the Site of an Asylum	38
The Design and Location of the Grahamstown Asylum	44
Two Very Different Medical Superintendents: Robert Hullah (1875-1890) and T Duncan Greenlees (1890 – 1909)	49
The Origins of Internal Segregation: The Robert Hullah Era, 1875 – 1890	51
The Entrenchment of Favouritism: The Superintendence of T Duncan Greenlees, 1890 – 1905	61
 CHAPTER TWO: Total Institutions, Moral Therapy and the Cape Asylums	 75
Privilege, Oppression and Power in Institutions: A Brief Theoretical Overview	77
Moral Treatment, Asylums, and Total Institutions: An Uneasy Co-existence	84
Moral Treatment and the Design of Asylums	89
Staffing the Grahamstown Asylum	97
Asylum working conditions and staffing challenges	103
Rules and Regulations for Staff in the Asylum	112
Hints and Allegations: Nurse Hickey vs the Asylum	122
 CHAPTER THREE: Understanding Mental Illness in the Nineteenth-Century Cape Colony: Causes and Categories	 126
Universalism and Essentialism in Colonial Psychiatry	128
Causes of Insanity: Gender and Race in the Aetiology of Insanity	130
Preconceptions and Repercussions: Trends in Diagnosis in the Grahamstown Asylum	138
Diagnostic Patterns in the Grahamstown Asylum, 1875 – 1905	144
Mania	145
Dementia and dementia praecox	146
Melancholia	148
Diagnoses within the Grahamstown Asylum	148
 CHAPTER FOUR: The Cape Colony's Lunacy Acts and Institutional Committal	 162
Unacceptable Behaviour and the Appearance of Insanity	166
The 1879 Lunacy Act	179
The 1891 and 1897 Lunacy Acts	180
Implementing the Acts: Safety and Detainment under the 1891 and 1897 Lunacy Acts	203

CHAPTER FIVE: Demographic Trends and Discriminatory Patterns in the Grahamstown Asylum	208
The Asylum Population: An Overview	208
Age and Marriage	210
Age profiles in the Grahamstown Asylum	210
Marriage profiles in the Grahamstown Asylum	212
Place of Origin: Immigration and Migrancy	216
Committal, Recovery and Death in the Grahamstown Asylum, 1875 – 1905	218
 CHAPTER SIX: Conditions Inside the Grahamstown Asylum	 233
Idle Hands: Work and Therapy in the Grahamstown Asylum	235
“This Entire Change from the Monotony”: Entertainment and Recreational Activities in the Grahamstown Asylum	247
“Suited to Their Requirements and Habits”: Food in the Grahamstown Asylum	257
 CONCLUSION	 273
 BIBLIOGRAPHY	 279

LIST OF FIGURES AND ILLUSTRATIONS

	PAGE
Figure 1: the Eastern Frontier region of the Cape Colony, c. 1820 - c. 1880	30
Figure 2: Chain of command from Governor to Medical Superintendent.	99
Figure 3: Chain of Command, Superintendent of Asylum to Nurses and Ward Attendants.	99
Figure 4: Exciting Causes of Insanity among Grahamstown Asylum Patients, 1875 - 1905, by percentage.	136
Figure 5: Example of a “Medical Certificate That A Person is a Lunatic”	183
Figure 6: Example of a “Medical Certificate That A Person is a Lunatic”	184
Figure 7: Example of a “Summary Reception Order”	185
Figure 8: Admissions by Section of 1897 Lunacy Act, 1898 - 1905	192
Figure 9: paying patients, by Section of 1897 Lunacy Act under which admitted	193
Figure 10: White Men, Sections of 1897 Lunacy Act under which admitted.	194
Figure 11: White women, Sections of 1897 Lunacy Act under which admitted	195
Figure 12: Black men, Sections of 1897 Lunacy Act under which admitted	196
Figure 13: Black women, Sections of 1897 Act under which admitted	197

LIST OF MAPS

Map 1: Grahamstown, 1824	47
Map 2: Grahamstown, 1832	48
Map 3: Aerial view of the Fort England Hospital, as of 2018	49

PREFACE

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Introduction

Approaching the Asylum: Sources and Challenges

Researching the history of a physical place – somewhere it is still possible to walk to, look at, and see its past made visible to the eye, as is possible with the Grahamstown Asylum, now known as Fort England Hospital – is quite different to researching the history of an event, organisation, or person. In fact it is more like researching the history of a certain process than anything else, and an incomplete process at that. Places change over time; they begin to exist some time before they become physically tangible, and the external and internal influences that shape their natures are both intangible and tangible in nature. Public institutions feel the influence of the social and economic context of the society around them and the region in which they are situated, both of which experience flux. They are influenced by the political climates in which they are immersed, and which are themselves tied quite strongly to place. Important individual people bring their own ideas, preconceptions and philosophies to bear on institutions, and these individuals in their turn are guided – or, indeed, misguided – by the norms and values of the societies in which they live. The sentiments and actions of less important people also accrete around public institutions. The Grahamstown Asylum was a very particular kind of place; one might say, the species of institution to which it belonged – the colonial mental hospital – no longer exists, and that is just as well. It is not possible to divorce the nature of the Grahamstown Asylum across the period 1875 to 1905 from the nature of the society it grew from, the community in which it was situated, and the philosophies of the people who governed it; it is almost impossible to separate out these three things from one another.

The Grahamstown Asylum, though renamed several times to fit in with the values of the time, and reconfigured to fit in with changing psychiatric and therapeutic practice, still exists. Even today it is a cluster of distinctive red roofs on the outskirts of Grahamstown, in what is now the central region of the Eastern Cape Province of the Republic of South Africa. The Republic is no longer a British possession; the Cape Colony has long since been subdivided and recombined several times. The British metropole no longer holds any particular sway over the region, and the British Empire is almost entirely dismantled. The men and women mentioned in the following pages are long dead; even their immediate descendants may be dead. Nevertheless, there are still a number of

similarities between the Grahamstown Asylum of the latter 1800s and the present-day psychiatric hospital to render a study of the former institution relevant. While I do not compare the modern Fort England Hospital with the Grahamstown Asylum, the two institutions are dogged by many of the same issues.

The Choice of 1875 – c. 1905 as a Time Periodisation

This thesis does not cover the whole period of the Grahamstown Asylum's existence. As the institution, now known as Fort England Hospital, is one of the oldest psychiatric institutions in a territory with a turbulent socio-political history, encompassing its 143 years of history would be a mammoth and sprawling task. Instead, I have focussed on the Asylum's first thirty years, beginning in 1875, the year of its establishment, including the entire Superintendence of Dr Robert Hullah, and ending in roughly 1905 but continuing, patchily, to 1907, the year in which Dr T Duncan Greenlees' returned to the United Kingdom to take up a post there.

The decision to end this thesis in roughly 1905 results from the end of Greenlees' tenure in 1907. As will be seen in later chapters, despite this there is no clean break, and even events subsequent to 1907 are sometimes mentioned. The Asylum continued when Greenlees left, and it is more accurate to speak of a transition period between Greenlees and his successor than the end of one superintendence and the beginning of another.

The period 1875 to 1907 saw the formation of what would become the Cape Colony's asylum network; as will be discussed, the closing quarter of the 19th century was a time of considerable change and development in the field of European and colonial psychiatry and psychiatric institutionalisation, and saw the spread of asylums throughout the Cape Colony. Moreover, this period was also a time when British Colonial settler society attempted to entrench its cultural and social norms in the newly- annexed eastern regions of the Cape Colony. The Grahamstown Asylum was well and truly embedded in both of these fields of change, and thus this thesis examines the ways in which they influenced the shape and nature of the Asylum.

Primary Sources: Patient Case Files, Patient Registers, and Government Documents

Primary sources are the most fertile source of information on the variables that come to govern any institutions' nature, and for this reason I was both determined and fortunate enough to make extensive use of primary sources in this thesis. I should at this point indicate that prior to the start of my research for this thesis, two of the four main sets of primary records I used in my research were not in fact in an archive. Instead, they were being stored in a conference room in the main administration building of Fort England Hospital, the present incarnation of the Asylum. They had been discovered in a locked cabinet in this room during initial clearing-out prior to the commencement of some minor renovations in the building.

Dr Mohammed Nagdee, then the acting-CEO of Fort England Hospital, immediately realised that these records were immensely valuable as a historical resource, and needed to be preserved. To that end, he contacted Dr Carla Tsampiras, then of the Rhodes University Department of History, who contacted this researcher as well as Dr Jeff Peires, then Director of the Cory Library for Historical Research at Rhodes University, and Ms Vathiswa Nhanha, the Cory Library's cataloguing librarian. Dr Tsampiras and I conducted an initial survey and inventory of the materials Dr Nagdee had preserved for us, and discovered a number of patient registers, case files and case books covering the period between the establishment of the Grahamstown Asylum in 1875 and the mid-1970s (by which point it had been renamed Fort England Hospital). These were duly taken into the custody of the Cory Library on an indefinite loan, catalogued and cleaned by two student volunteers, and placed on restricted access in the Cory's storage vaults.

The records take the shape of various hard-cover canvas-bound pre-printed admissions registers with handwritten entries, as well as various A4-sized cardboard folders housing, in some cases, older cardboard folders, in which are stored the various items of paperwork that make up the personal files of white male patients admitted between the 1880s and the early 1900s. These are the two categories of file used in the research for this thesis, as they all fall within the remit of the bracketing dates 1875 to 1905. Also included in the collection currently housed at the Cory Library are several books of hand-written notes on patients, dating from the earlier 1910s to the 1960s.

The history of the Grahamstown Asylum is best approached through an examination of these primary sources. Secondary sources are of course useful, but do not generally provide a satisfactory amount of 'marrow'. This thesis makes use of three main categories of primary source: patient files, patient registers, and annual reports. All of these were created by Asylum authorities, which means, at the very least, that they need to be treated with some caution: very few bureaucrats would be in favour of the sort of complete transparency that the historian prefers, and there is a great deal of selective editing involved in the construction of any form of public record. Furthermore it should also be always kept in mind that the purpose of these records were not constructed as source material for an academic study of the Asylum. In the case of files and registers, the main purpose was the internal keeping of records for the use of the Asylum authorities and staff.

The annual reports were more widely circulated, and published on an annual basis in government Blue Books, which were compiled by the Cape Colony's government to enable easy access to any particular year's set of government gazettes, reports and committee records. Although these reports were more widely available than private communications from Asylum authorities, or the Asylum's internal records, would have been, they were not exactly public property. (In fact, in all honesty, then as now it is hard to imagine any government report ever becoming chosen leisure-time reading for anyone who did not absolutely *have* to read it.).

The patient files available at the Cory Library at Rhodes University are all those of white men, but despite this limitation they are nonetheless revealing. They contain, at minimum, the documentation that accompanied the particular asylum patient's certification as a lunatic – the Magistrate's report, two medical certificates, and a Summary Reception Order. Often the files also contain a patient's periodical reports, on their recovery or lack thereof, admission documentation, and case notes made on a monthly or bi-monthly basis by Asylum staff. As such they are a goldmine of specific information – they tell of a patient's history, their life before certification as a lunatic, and sometimes his family or social situation. They note his behaviour inside the Asylum, his general demeanour, his approach to work and recreation, and his interactions with staff and other patients. Often the files contain peripheral documents such as Asylum correspondence with concerned parties on the outside. Using these files it is possible to reconstruct elements of the lives of specific patients, and in doing so provide living colour to academic study. However, these files have a major drawback: they do not include any files belonging to any female or black patients. There is a lacuna, a void in the archive.

The effect of this void is, firstly, to raise the eternal historian's question of "What happened?" These files may merely be archived elsewhere; they may have been destroyed, and indeed this is certainly the fate of some of them. But if they were moved, why were they moved? Who moved them? More pertinently, I must ask, why were only certain files preserved here? Why has nobody come looking for them, to move them in with the remainder of the collection, assuming it is housed elsewhere? The fate of these records is interesting in itself, and suggests that the maintenance of a historically comprehensive archive is not a priority for a working hospital. Indeed it points to a larger trend towards ahistoricity throughout Western society, where all too often an awareness of the history of something that is still in process is considered to be interesting but beside the point when compared to current challenges and events. It should also be noted that accident may play a role in the survival and preservation of historical documents and artefacts: the records used here may simply have slipped through the cracks, been forgotten, packed away for later retrieval and never retrieved, or arbitrarily kept for reasons we cannot reconstruct now.

Secondly, and more pertinently for the purposes of my research as outlined here, the abovementioned lacuna meant that I did not have the full array of patient records available to me. I could not flesh out the lives of the black men, white women or black women whom I know for a fact lived in the Grahamstown Asylum. The Asylum inmates for whom I have constructed a full-colour, live-action mental image are all white men. This is upsetting on several levels, not least because it is a truism that white men tend rather to hog the historical limelight. This one-sidedness does not render my conclusions as to the nature of life in the asylum invalid. White men, as pointed out in more detail elsewhere in this thesis, were and in fact still are the socially, economically and culturally dominant group in most Western-style societies of the 19th, 20th and 21st centuries. They were certainly the most powerful, privileged group in the 19th-century Cape. Therefore, by examining these records of white men, it is possible to see exactly how this privilege translated into the Asylum setting, and from there deduce the various diminishing levels of intra-Asylum privilege for those groups situated lower down the Cape's social ladder. Fortunately, the information contained in the patient registers, while basic and lacking in anecdotal information, *is* relatively complete: these are my primary source of information on black and female patients.

The earliest of these registers, titled the *General Register of Admissions*, began in 1875 and ended in 1896. At that point, another register book was used; in this volume, entries continue until 1908. These registers contain the multitude of basic biographical information used in the qualitative analyses included in this thesis and used to derive many of the conclusions herein. Both of these registers record the date upon which a patient entered the Asylum, their age at the time, their marital status, place of origin, language and nationality, religion and diagnosis. The post-1890 entries record whether a patient was paying fees for his or her sojourn in the Asylum, and if so, the amount which they paid. Also in the post-1890 entries is noted the section of the Lunacy Acts under which the inmate had been certified as insane and committed to the Asylum. From these registers, one can reconstruct the age, 'race' and 'sex' profile of the Asylum population between 1875 and 1905, as well as trace exactly who was admitted with which diagnosis, payment status, a record of violence or suicide risk.

These registers did not remain the same in form or content over the entire period 1875 – 1905. Changes were minor, but present. The earliest register, the one which ran from 1875 to 1896, is not segregated at all, but rather sequential: each patient was entered into the register in the order in which he or she was admitted. The register does not contain separate sections for black, white, male and female patients, as would become the norm in the late 19th century and in fact the rule from the early 1900s onward. Each patient's marital status is indicated by the entry of "married", "single", "widowed" or, rarely, "divorced" in the appropriate column, and then their age, diagnosis, religious affiliation, place of origin, place of residence, and nationality. The date upon which they entered the Asylum is also recorded, as is their evident biological sex. The shifting distinctions between place of origin, place of residence and nationality will be more comprehensively discussed in Chapter Five, so suffice it so say here that although this register was not segregated, the ethnic grouping of patients was nevertheless very much a concern. In later registers, particularly that beginning in 1889 and running to 1908, the layout of the columns changed slightly, with marital status and evident biological sex now being indicated as a tick or cross entered in the relevant box, rather than the whole word being written out. The effect of this may have been negligible, except to save space in the printed items; it is however arguably easier to make a mistake when ticking a column than it when one is required to slow down and copy out an entire word. This register adds columns to indicate the inmate's physical condition at the time of admission, the section of the Lunacy Act they were admitted under, and whether they were fee-paying. This register, in the later 1890s, also included columns indicating into whose care the patient had been discharged, and where that person lived. Both registers contained columns for listing the inmate's diagnosis, whether they had

previously been committed to an asylum, and whether the cause of their affliction was known, as well as whether they were known to be violent, suicidal or epileptic. The right-hand page recorded the date at which they left the Asylum, whether they had died or been discharged, and if discharged, what state they had been discharged in. Obviously these latter items of information were not entered at the same time as the initial biographical information.

This information was entered by hand, in ink, with later amendments and annotations added in different ink, or pencil. Fortunately the clerk in charge of keeping the registers during this period, and his successors, were blessed with clear handwriting. Nevertheless, their need to fit all relevant information into pre-printed blocks led to some instances of tiny, cramped handwriting, with the inevitable effect of lessened legibility. I should also add that the passage of a century does not add to the brightness of the ink used, and nor has my upbringing in a culture adjusted to screens and printed text improved my ability to decipher 19th-century copperplate. Nevertheless I am fairly confident that I made a minimum of errors when reading these registers.

At this point, a word on the naming of black patients in this thesis and the historical records from which it derived should be made. Black patients are often misnamed in the registers, and this may indicate that Asylum authorities did not create an accurate record of the names of black patients. Some of these mistakes may have resulted from the practice among white Colonial authorities of refusing to use a black individual's name and instead dubbing him or her with a European-style name that they found easier to pronounce or remember; the re-naming of someone who already *has* a name is also an act of subjugation. This would account for the number of black patient's names in the Asylum registers enclosed in quotes, and an equally high number of 'generic' European names attached to black patients. In some cases, these aliases may have been assigned by Asylum staff or, earlier in the committal process, by physicians or gaolers as a result of the individual refusing to give his or her actual name. The Asylum's admissions registers certainly bear plentiful evidence of problems that Asylum staff had in accurately rendering, for example, isiXhosa names, with many entries being inexact phonetic versions of what the incoming inmate had actually pronounced. All in all, the plethora of errors made when transcribing the names of black patients into the Asylum's registers indicates a somewhat unconcerned attitude towards correctly recording their details, and this in turn may bespeak a relative lack of concern among Asylum staff for the welfare of black patients. However, this will be discussed in much more detail elsewhere in this thesis.

None of these above problems apply to the Medical Superintendents Annual Reports and the Inspector of Asylums Annual Reports that were published in each year's Government Blue-Books between 1875 and 1905. The annual reports contained in the Government Blue-Books are of two major types: those written by Hullah and Greenlees, the Medical Superintendents of the Grahamstown Asylum, and those written by William Dodds, the Inspector of Asylums, from 1889 onward. These were public reports that had both a broader audience and a more subjective cast than the abovementioned registers and patient files. The annual reports written by the Medical Superintendents often employ euphemism and oblique statements to convey their concern or disapproval of certain events or situations without openly complaining. I have kept the potential unreliability of these documents in mind while dealing with them. Aside from the prejudices and preconceptions that informed the Medical Superintendents' understandings of their patients, there was undoubtedly also a reluctance to admit to fault or failure that would have resulted in opprobrium, reprimand, retrenchment or reduction in resources by the Colonial government. Therefore the information in these annual reports cannot be considered completely innocent or wholly accurate. It is not likely that readers in the government service would have been naïve enough to assume that these reports were completely guileless, but as they did form part of the official record, we can assume that readers, politely, regarded them as the official version of the truth about matters concerning the Asylum.

In this thesis I have used the Medical Superintendents' Reports more often than I have the Inspector of Asylums reports. The latter date from only the late 1880s and, because the Inspector of Asylums was charged with managing all of the Cape Colony's asylums, as well as assisting in the improvement and refinement of the Lunacy Acts and various policy decisions, only part of each year's report deals with the Grahamstown Asylum. Although at times I consulted other asylum's entries in these reports, for the most part I concentrated on the general introductory section and the Grahamstown Asylum section of each report. These reports provided both anecdotal evidence and statistical evidence of changes and trends within the Colonial asylum system.

The Medical Superintendents' reports were published annually, usually in the same Blue Book volume as the Inspector's reports, and were intended to give the reader a comprehensive picture of the Asylum's activities, challenges and statistical profile during the year. Accidents, patient-related

problems, and escapes were dutifully listed and described, along with improvements that the Superintendents had made, reports on facilities and activities, asylum income, and the Asylum's requirements and wished-for improvements. They were the primary forum for Superintendents to express what would today no doubt be labelled a "mission statement", as well as the best way for them to convey whatever discontentment they felt towards the government and the Colony's asylum system. For this reason, they were an invaluable source of both factual information on the Asylum's changes, but also on its ethos and philosophical premises.

Both the official Annual Reports and the patient registers provide broader views of the Asylum, but the wealth of ephemeral detail about the daily experiences of patients in the Asylum comes from the patient case files I mentioned briefly above. I have outlined the difficulties that the limited nature of these case files poses to creating a balanced historical picture of life inside the Asylum, but it remains true that they *do* contain a wealth of anecdotal information. Each of these files contains the inmates' committal documentation, including physicians' reports, affidavits from members of the public testifying to the inmate's insanity, and a cover-page summarising the results of the inmates' physical assessment at intake, salient details from the physicians' reports, and basic biographical information. Most of the files also contain some pages from the notes made by the Medical Superintendent at the time of his periodic interviews with the patient. These notes contain information on the patient's demeanour, any improvements or deteriorations of his condition, and whatever other events or attributes the examining doctor felt it necessary to record. They are by far some of the most densely-packed sources of information that I have used in this thesis. Many files also contain correspondence from relatives, legal documents regarding the appointment of guardians and estate curators, and, in the cases of inmates who arrived from other asylums, copies of their intake sheets from that asylum, and transfer documents.

These documents provide not only factual, quantitative evidence about the nature of the Asylum, but provide an overarching image of the ways in which the Asylum operated within the larger context of the Cape Colony's mainstream civil society, as well as how it fit into the Colony's psychiatric fraternity. From them I gleaned both the 'nuts and bolts' information – what was bought, sold, and what things cost, what furnishings were installed, what food served, how many people were admitted and discharged and what was provided for them to occupy themselves with in between those events, where they came from, and why they had been sent from there – as well as the *why* that underlay many of the decisions and actions implied above.

This thesis is not intended to be an examination of whether it was wrong or right to admit these people to the Asylum, and certainly does not undertake to question whether they were genuinely mad in the first place. It is not intended to provide an argument that the Grahamstown Asylum was a microcosm of the entire Colonial asylum system. Instead, this thesis seeks to examine the Grahamstown Asylum's *particular* and *unique* interior logic and world, set *within* the Colonial asylum system: not an interchangeable part of it, but rather a very particular set of circumstances operating in a very particular context and location. Although it was of course an integral part of the Cape Colonial asylum system, it had a peculiarity of community, context and function that were not replicated elsewhere exactly. This study of the Grahamstown Asylum is therefore both a study that uncovers the development and entrenchment of inequality in the Cape Colonial psychiatric sphere, and examines the particular inner workings of that inequality in a particular asylum.

Putting the Asylum in Context

No person entering the Asylum left their past entirely behind them. This thesis will examine the ways in which their status in the Colonial social system impacted on even the minutest details of their life inside the Asylum. By examining the most prosaic details of the asylum's environments: its physical shape, its means of occupying its residents, and its provision of the basic necessities of life, it is possible to tease out the essential effects of these larger structures of discrimination and favouritism on Asylum patients. Moreover, in this thesis, examination of the means by which that same set of privilege and subordination pushed people towards the Asylum will determine whether the systems of privilege outside that extended into life inside.

The Grahamstown Asylum was, at least in the period between 1875 and 1905, a place where a patient's insanity was perhaps less important than their 'race', gender, and wealth in determining how they weathered and experienced their time of committal. No person entering the Asylum left their past entirely behind them. Instead, it echoed forward and dictated the quality of life, and the day-to-day pattern of their lives. A person's wealth, poverty, sex and racial classification, their violence or gentleness, sadness, madness or badness, their place in a family or their estrangement from it, and their status in the Colonial social system all impacted on even the most minute details of their life inside the Asylum, from whether they would be cured to whether they got sugar in their tea at breakfast.

Literature Review

As a subspecialty, the history of psychiatric institutions and institutionalisation developed from the 1950s onwards, catalysed by the work of Kathleen Jones¹ and Michel Foucault.² Foucault has, of course, remained a cornerstone of almost all subsequent writing on psychiatry, to the point where his influence might be compared to that of the carbon molecule – ever-present, if not always specifically acknowledged. Because of this, although very little direct reference to Foucault has been made in this thesis, it would be incorrect to say that he has been left out or that he had no influence. Indeed, his conception of ‘The Great Confinement’ – or at least a rejection of that concept as it applied to Africa, as devised by Megan Vaughan – informs this thesis.

The field was later enriched by the contribution of Roy Porter and Andrew Scull,³ William F Bynum,⁴ and, more recently, David Wright. Wright, Catharine Coleborne, Gail Hornstein, and Leonard Smith⁵ stress that ‘the asylum’ can be understood in a number of ways, one of which is as a method of control – used by families as a way to deal with mentally ill relatives, but also a way for society to sequester problematic, mentally ill, individuals. In this vein, this thesis explores the means by which individuals came to be certified as insane and committed to the Asylum, and the subsequent ways in which privilege and discrimination intersected with individual patients’ experience. The conceptual framework of this thesis is indebted in many ways to Roy Porter’s view that the physician-centred view of medicine is distorted by the relative positions of physicians and those they treat. In terms of

¹ Jones, Kathleen, *Lunacy, Law and Conscience 1744 – 1845: The Social History of the Care of the Insane* (London, 1955).

² Foucault, Michel, *Madness and Civilisation: A History of Madness in the Age of Reason* (London, 1971).

³ Scull, Andrew, *The most solitary of afflictions : madness and society in Britain, 1700-1900* (New Haven, 1993); “A Convenient Place to Get Rid of Inconvenient People: the Victorian Lunatic Asylum”, in Anthony D. King (ed.), *Buildings and Society: Essays on the Social Development of the Built Environment* (London, 1980).

⁴ Bynum, WF, and Roy Porter and Michael Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry, volume one: People and Ideas* (Abingdon, 1985); Bynum, WF, and Roy Porter and Michael Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry, volume two: Institutions and Society* (Abingdon, 1985); Bynum, WF, and Roy Porter and Michael Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry, volume three: The Asylum and its Psychiatry* (Abingdon, 1988); Anne Hardy, Stephen Jacyna, Christopher Lawrence and E.M. Tansey, *The Western Medical Tradition 1800 to 2000* (Cambridge, 2006).

⁵ David Wright, “Getting Out of the Asylum: Understanding the Confinement of the Insane in the 19th Century”, *Social History of Medicine*, 10, 01, 1997; David Wright, James Moran and Sean Gouglas, “The Confinement of the Insane in Victorian Canada: the Hamilton and Toronto Asylum, c. 1861 – 1891”, in Roy Porter, and David Wright, *The Confinement of the Insane: International Perspectives, 1800 – 1965* (Cambridge, 2003); Coleborne, Catharine, “‘His Brain Was Wrong, His Mind Astray’: Families and the Language of Insanity in New South Wales, Queensland and New Zealand, 1880 – 1910”, *Journal of Family History*, 31, 45, 2006; Hornstein, Gail, *Agnes’s Jacket: a Psychologist’s Search for the Meanings of Madness* (New York, 2009); Smith, Leonard, “‘Your Very Thankful Inmate’: Discovering the Patients of an Early County Lunatic Asylum”, *Social Science of Medicine*, 21, 2, 2008.

African asylums, this is doubly true: the wholly inegalitarian division of socioeconomic status and cultural dominance in the colonies renders the African voice almost unheard in asylum history in the colonies and begs deep questions about the role of colonial medicine in the colonial project. Porter argues that patients, their families, and the communities in which they originated should be given more space in the history of medical encounters.⁶ Although this has not been possible to do to a great extent in this thesis, it has informed my approach throughout. Porter's paper "The Patient's View: Doing Medical History from Below", published in 1985 in *Theory and Society* nudged me in an important direction early on in the research process by pointing out that, in all the histories of illness included in the canon, very few originate with the sufferers themselves.⁷ Moreover, Porter discovered that those that do originate with sufferers are all too often anecdotal rather than data-based; most are written from the point-of-view of the physician, and this view of medicine may be, as Porter puts it, one of the major historical distortions.⁸ Further, in the abovementioned paper Porter emphasised the fact that sickness is not always an individual experience, or even a private one, but rather one in which families, friends, and community members and physicians each have a specific role.⁹

David Wright's work on the Toronto and Hamilton asylums in colonial Canada throws light on the demographic trends I observed in the Asylum population, derived from the examination of official Asylum records.¹⁰ Although Wright's work is based on asylums that were in a colonial context quite different to the one I deal with here, basic similarities between colonial Canada and the Cape Colony existed, in that both were British colonies, dominated by English-speaking populations of British origin, situated very far away from the metropole of the United Kingdom. Wright established that in colonial or frontier societies, there was often a gender imbalance, with more men in the region and consequently more men in the region's asylums.¹¹ He also discovered that most of the lunatics

⁶ Porter, Roy, "The Patient's View"; *A Social History of Madness: Stories of the Insane* (London, 1989); *Madness: a Short History*; Porter, Roy and David Wright, *The Confinement of the Insane: International Perspectives, 1800 – 1965* (Cambridge, 2003); and WF Bynum and Michael Shepherd, *The Anatomy of Madness: Essays in the History of Psychiatry* (London, 1985).

⁷ Porter, Roy, "The Patient's View: Doing Medical History from Below", *Theory and Society*, 14, 2, 1985; *A Social History of Madness: Stories of the Insane* (London, 1989); *Madness: a Short History*; and David Wright, *The Confinement of the Insane: International Perspectives, 1800 – 1965* (Cambridge, 2003); and WF Bynum and Michael Shepherd, *The Anatomy of Madness: Essays in the History of Psychiatry* (London, 1985).

⁸ Porter, "The Patient's View: Doing Medical History from Below", pg. 172, 182.

⁹ Porter, "The Patient's View", pg. 194.

¹⁰ Wright, David, "Getting Out of the Asylum: Understanding the Confinement of the Insane in the 19th Century", *Social History of Medicine*, 10, 01, 1997; Wright, David, James Moran and Sean Gouglas, "The Confinement of the Insane in Victorian Canada: the Hamilton and Toronto Asylum, c. 1861 – 1891", in Porter and Wright.

¹¹ Wright, Moran and Gouglas, "The Confinement of the Insane", pg. 112.

admitted to asylums in colonial Canada were usually engaged in work or following gainful employment, but were seldom professionals.¹² Both of these things are also true of the Grahamstown Asylum. Furthermore, Wright suggests that these trends may be the result of the fact that younger men and women tended to emigrate alone; in the case of men, many worked long hours and taxing jobs, and ended up suffering from social isolation and often low socioeconomic status. In the case of women, Wright says, the inbuilt social and economic vulnerability of unmarried, unattached women made them susceptible to committal to an asylum in the event that they developed a mental disorder or began to show uncontrollable symptoms of disorder. Both sexes may have become more vulnerable to committal if single, because of the absence of readily available family support structures or social networks.¹³

Another work of Wright's, entitled "Getting out of the Asylum: Understanding the Confinement of the Insane in the 19th Century", makes the important point that families and social networks, rather than physicians, may have been primarily responsible for the committal of insane individuals to asylums.¹⁴ He also identified the two main types of committal: those that occurred when lunatics were 'apprehended at large', perceived to be threats to themselves, their families or society at large, and duly locked up, and those that occurred when a lunatic's family or friends arranged the committal, sometimes even with the co-operation of the lunatic themselves.¹⁵ This work also provided valuable tactical pointers for my examination of the Grahamstown Asylum's primary record by raising several interesting points to consider when examining the processes that underlay a lunatic's committal to formalised residential care in an asylum. Namely, what changed to make the lunatic eligible, for want of a better word, for committal: was it their behaviour, the family situation, or the family's ability to care for them, or was it rather something more severe, such as estrangement or the involvement of individuals from outside the family?¹⁶

One of the major differences between the imperial metropole and the colonial periphery was the relative heterogeneity of the colonial setting. Discriminatory practices based on racial classification arose, particularly those imposed by socioeconomically if not numerically dominant colonial powers upon increasingly-disenfranchised indigenous populations. The reification of invented difference and

¹² Wright, Gouglas and Moran, "The Confinement of the Insane", pg. 119.

¹³ Wright, Gouglas and Moran, "The Confinement of the Insane", pg. 120.

¹⁴ Wright, "Getting Out", pg. 139.

¹⁵ Wright, "Getting Out", pg. 143.

¹⁶ Wright, "Getting Out," pg 152.

the creation and entrenchment of “otherness” based on racial classification are covered at length by Sander Gilman’s classic *Difference and Pathology*¹⁷ and the equally influential *Imperial Leather* by Anne McClintock,¹⁸ as well as Alexander Butchart’s *The Anatomy of Power*¹⁹ and Megan Vaughan’s *Curing Their Ills: Colonial Power and African Illness*. All three of these works also take into account the intersectionality of racial classification, health and disease, and sexuality; all of them deal with imperial and colonial attempts to regulate and/or control indigenous populations while – or indeed by – pathologising them. The relevance of these texts is unquestionable: the Asylum population was, regardless of race or gender, made up of individuals who were pathologised by mainstream opinion owing to the manifestation of their mental illness. It was the existing prejudices that mainstream Cape society held towards the region’s indigenous peoples that created the real problems here. McClintock, Gilman, Vaughan and Butchart’s works provide a framework for understanding the rationales behind the ways in which Cape psychiatrists understood their patients, as well as the Grahamstown Asylum’s treatment of those patients once they become Asylum inmates.

Megan Vaughan’s *Curing Their Ills: Colonial Power and African Illness*²⁰ is extremely pertinent in that it unpacks the structures of otherness as constructed by colonial medicine. First published in 1991, this text interrogates whether colonial medical power in Africa diverged from Foucault’s schema of ‘bio-power’.²¹ Foucault’s schema concerns post-Enlightenment Europe, particularly France, and Vaughan questions the relevance of this system, ultimately concluding that Foucault’s thesis does not fit comfortably when applied to the reality of colonial-era Africa. Foucault’s thesis held that power is produced by the identification and description of small differences between individuals. In other words, in modern European states, ‘the other’ was created incrementally and through means that were almost impossible to resist. In Africa, by contrast, Vaughan contends that othering occurs on a much less incremental scale.

Pathology and otherness were the cornerstones of the field of psychiatry as practiced in the Cape Colony during the late 19th century. The work of Saul Dubow is pioneering in this area, particularly his *Scientific Racism in Modern South Africa*,²² which is complemented by the work of Butchart. Shula

¹⁷ Gilman, Sander, *Difference and Pathology: Stereotypes of Sexuality, Race and Madness* (Ithaca, 1985).

¹⁸ McClintock, Anne, *Imperial Leather : Race, Gender and Sexuality in the Colonial Context* (London, 1995).

¹⁹ Butchart, Alexander, *The Anatomy of Power: European Constructions of the African Body* (New York, 1998).

²⁰ Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Cambridge, 1991), pg. 101.

²¹ Vaughan, *Curing Their Ills*, pg. 13.

²² Dubow, Saul, *Scientific Racism in Modern South Africa* (Johannesburg, 1995).

Marks,²³ Harriet Deacon,²⁴ and Sally Swartz.²⁵ While the work of Marks, Deacon and Schwartz work is not directly indebted to that of Dubow, they each examine the development of colonial psychiatry and psychiatric institutions using the lenses of difference-linked pathology that Dubow and Gilman use. Unlike Dubow, however, these historians concentrate specifically on the intersectionality of insanity and racially-based inequality. In terms of understanding the Grahamstown Asylum in particular, the work of Felicity Swanson²⁶ and Sally Swartz is invaluable. Swartz's excellent work on the construction of psychiatric knowledge at the Cape, particularly regarding that done in the late nineteenth and early twentieth centuries at Valkenberg Asylum in Cape Town,²⁷ has been both a starting point and a goal for this thesis. The same is true of the work of Julie Parle.²⁸ Although not focused on the Grahamstown Asylum in particular, or even the Cape Colony, her *States of Mind* is a ground-breaking study of methods of coping with mental illness in colonial Natal, both using the growing asylum system and alternative methods outside the realm of Western biomedicine. Both Julie Parle and Roy Porter place emphasis on the experience of patients rather than doctors connected with asylums. All historians of colonial psychiatry would do well to at least keep this approach in mind, even in cases where the available primary materials make producing a patient-centred narrative difficult or impossible to execute well. This approach will be analysed in the next section.

This thesis makes use of works in the areas of the history of psychiatry both generally and specifically in terms of the 19th-century Cape Colony, as well as the history of the eastern Colony and Grahamstown itself. Further, histories of the way colonial societies understood race and gender were consulted in order to contextualise the various discriminatory practices embedded in the structure and practices of the Grahamstown Asylum. Another important element of the literature consulted for this thesis were several works on the practice of moral therapy, such as that Niall

²³ Marks, Shula, "'Every Facility that Modern Science and Enlightened Humanity Have Devised': Race and Progress in a Colonial Hospital, Valkenberg Mental Asylum, Cape Colony, 1894 – 1910", in Joseph Melling and Bill Forsyth (eds.) *Insanity, Institutions and Society, 1800 – 1914: A Social History of Madness in Comparative Perspective* (London, 1999).

²⁴ Deacon, Harriet, "Racism and Medical Science in South Africa's Cape Colony in the Mid- to Late Nineteenth Century", *Osiris*, 2001, 15.

²⁵ Swartz, Sally, "The Black Insane in the Cape, 1891 – 1920", *Journal of Southern African Studies*, 21, 3, 1995.

²⁶ Swanson, Felicity, "'Of Unsound Mind': A History of Three Eastern Cape Mental Institutions, 1875 – 1910", Unpublished MA Thesis, University of Cape Town, 1994.

²⁷ Sally Swartz, "Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920", Unpublished PhD thesis, University of Cape Town, 1996.

²⁸ Parle, Julie, *States of Mind: Searching for Mental Health in Natal and Zululand, 1868 – 1918* (Scottsville, 2007).

McCrae²⁹, and Andrew Scull's work³⁰ on the effects of this trend on the design of psychiatric institutions. This, of course, linked back to the deeper, underlying role of control in the establishment and internal organisation of psychiatric institutions, a central concern in the work of Erving Goffman.³¹ Goffman's thesis of total institutions was crucial in developing my understanding of the nature of the Grahamstown Asylum. It provided a means of understanding the dual nature of the Asylum as a place that repeatedly called itself a place of care but was simultaneously a place of deeply entrenched and ever-intensifying inegalitarianism. Under Goffman's schema, the Janus-faced complexion of the Asylum is explained by the difference between the Asylum's public appearance and the reality of its internal function. Furthermore, Goffman's matrices of authority, bureaucracy and management inside the Asylum provide a framework with which to assess the internal logic and functions of the Asylum.

Within the field of the social history of medicine there are large bodies of work on the history of psychiatry and the history of psychiatric institutions as a class of medical and/or social institutions. Some of these works, for example, that of Foucault, Bynum, Scull and Porter, were distinctly Eurocentric in nature; Goffman, and more recently David Wright, concentrated on the North American asylum context. Swartz, Parle and Deacon all focus closely on psychiatry and psychiatric institutions in the region now known as the Republic of South Africa, during the colonial period; Parle's work focuses on the colonial territory of Natal (now KwaZulu-Natal), while Swartz and Deacon concentrate on the Cape Colony, with particular focus on the asylums of Valkenberg and Robben Island, respectively. This thesis makes much more use of Parle, Swartz and Deacon than it does of Foucault or Bynum, it should be said, although the work of Porter, Wright and in particular Goffman proved vital in my understanding of philosophies that underlay the Grahamstown Asylum's organisation and structure.

A significant part of the existing literature on psychiatric institutions tends to deal with particular aspects of individual hospitals – for example, the geographic origins of patients, treatment methods, staffing, and record-keeping practices, recreation and landscaping.³² These texts are useful in that

²⁹ McCrae, Niall, "The Beer Ration in Victorian Asylums", *History of Psychiatry*, 15, 2, 2004.

³⁰ Scull, "Inconvenient People".

³¹ Goffman, Erving, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York, 1961).

³² Andrews, Jonathan, "Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century," *Social History of Medicine*, 11, 2, 1998; Hickman, ; Claire, "The Picturesque at Brislington House, Bristol: The Role of Landscape in Relation to the Treatment of Mental Illness

they prove both that examining the minutiae of asylum populations and practices is both possible and illuminating, as well as providing detailed, informative snapshots of the various individual asylums with which they are concerned. Furthermore, this species of item-specific study provided a major inspiration for the type of research this thesis undertook and consequently profoundly influenced the form and focus of the research. However, it is this specificity and attention to minute detail that renders these works less than useful when it comes to applying their conclusions to other studies. It is possible to identify broad trends in patterns of asylum administration in the colonial periphery, however.

A prime example of the abovementioned close-range examination of an individual asylum is Jonathan Andrews' "Case Notes, Case Histories and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century", published in the journal *Social History of Medicine*, in 1998. In this paper, Andrews examines the development of British asylums' record-keeping practices, as powered by changes in British asylum legislation.³³ He identifies several major obstacles to reconstructing any one inmates' history, obstacles which I identified in my own examinations of the Grahamstown Asylum's records. Among these obstacles are the reality that lunatics' families or friends often omitted, lied about or were simply unaware of salient facts about the individual being committed, leading to case histories that were, at best, incomplete and, at worst, incorrect.³⁴ Another issue with the reliability of lunatics' asylum records was the fact that in most cases more than one person compiled the records.³⁵ David Wright's "The Confinement of the Insane", discussed above, and Lorraine Walsh's "'The Property of the Whole Community: Charity and Insanity in Urban Scotland: the Dundee Royal Lunatic Asylum, 1805 – 1850" are similar in this respect: very specific and therefore limited in their direct applicability, but nevertheless illuminating in terms of method, as well as useful in the development of an understanding of the *specificity* of each asylum.

in the Early Nineteenth-Century Asylum", *Garden History*, 33, 1, 2005; Prestwich, Patricia E. "Family Strategies and Medical Power: 'Voluntary' Committal in a Parisian Asylum, 1976 – 1914", in Roy Porter and David Wright (eds.), *The Confinement of the Insane: International Perspectives, 1800-1965*, (Cambridge, 2003); Cathy Smith, "Family, Community and the Victorian Asylum: a Case Study of the Northampton General Lunatic Asylum and its Pauper Lunatics", *Family and Community History*, 9, 2, 2006; Suzuki, Akihito, "Framing Psychiatric Subjectivity: Doctor, Patient and Record-Keeping at Bethlem in the Nineteenth Century", in Joseph Melling and Bill Forsythe (eds.), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London, 1999); Walsh, Oonagh, "'The Designs of Providence': Race, Religion and Irish Insanity", in Joseph Melling and Bill Forsythe (eds.), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London, 1999); Wright, David, "Getting Out of the Asylum"..

³³ Andrews, Jonathan, "Case Notes, Case Histories", pg. 257-8.

³⁴ Andrews, "Case Notes", pg. 263.

³⁵ *Ibid.*

There is also a growing body of work on colonial psychiatric institutions, of the Cape Colony and elsewhere, such as Wright's abovementioned work on Canadian asylums, Waltraud Ernst's body of work on asylums in British India, Catharine Coleborne's work on asylums in Australia and New Zealand, and, in the South African context, the work of Harriet Deacon³⁶ and Sally Swartz³⁷, as well as Julie Parle. The work of Ernst is particularly interesting in terms of my thesis, as it deals with asylums in British India. "The Raj" was much larger a colony, or set of colonies, than the Cape Colony, but which had – unlike the British metropole or the Antipodean colonies of New Zealand and Australia – a native population that was numerically dominant over the colonial interlopers but culturally subordinate to them, at least in terms of colonial life. Ernst, in "Idioms of Madness and Colonial Boundaries: the Case of the European and 'Native' Mentally Ill in Early Nineteenth-Century British India", published in *Comparative Studies in Society and History* in 1997, points out that Europeans in India could not rely on the presence of their families or extensive networks of friends for support in the event of developing a mental disorder.³⁸ Furthermore, in this paper, Ernst points out that was impossible to simply transplant British asylum practices into the Indian context, because the surrounding societal contexts were too different.³⁹ The difficulty of transplanting the psychiatric and institutional practices of one sociocultural space into another is a constant focus of Ernst's work, along with her examination of the development and entrenchment of gender and racial inequalities in situations where there has been an incomplete, unsuccessful attempt by an interloping culture at imposing these practices in foreign contexts. This certainly applied at the Grahamstown Asylum where, it will be shown later in this thesis, the Asylum authorities' attempts to create a place of egalitarian care for all the region's lunatics fell quickly by the wayside and were replaced by a system of inequality based, quite openly, on racial and socioeconomic prejudices.

³⁶ Deacon, Harriet, "Landscapes of Exile and Healing: Climate and Gardens on Robben Island", *The South African Archaeological Bulletin*, 55, 172, 2000; "Racism and Medical Science"; "Insanity, Institutions and Society: the Case of the Robben Island Lunatic Asylum, 1846 – 1910", in Roy Porter and David Wright (eds.), *The Confinement of the Insane: International Perspectives, 1800-1965*, (Cambridge, 2003).

³⁷ Swartz, "The Black Insane in the Cape"; Swartz, "Lost Lives: Gender, History and Mental Illness in the Cape, 1891-1910", *Feminism and Psychology*, 9, 152, 1999; Swartz, "The Regulation of British Colonial Lunatic Asylums and the Origins of Colonial Psychiatry, 1860-1864", *History of Psychology*, 13, 2, 2010; Swartz and Faldiela Ismail, "A Motley Crowd: the Emergence of Personality Disorder as a Diagnostic Category in Early Twentieth-Century South African Psychiatry", *History of Psychiatry*, 12, 157, 2001.

³⁸ Ernst, Waltraud, "Idioms of Madness and Colonial Boundaries: the Case of the European and 'Native' Mentally Ill in Early Nineteenth-Century British India", *Comparative Studies in Society and History*, 39, 1, 1997, pg. 153.

³⁹ Ernst, "Idioms of Madness", pg. 155.

Most colonial asylums were originally established and staffed by doctors from the colonial metropole, and originally followed metropolitan patterns. However, the Colonial sphere was, by definition, not the metropole; conditions on the ground were often quite altered and this led to colonial asylums being substantially different to their metropolitan counterparts. For the purposes of this thesis, the term *metropole*⁴⁰ designates the parent state of a colony; in the case of the Cape Colony, the metropole would have been the United Kingdom, as the Cape formed part of the British Empire. The term *colony* designates, according to the Oxford English Dictionary,

A settlement in a new country; a body of people who settle in a new locality, forming a community subject to or connected with their parent state; the community so formed, consisting of the original settlers and their descendants and successors, as long as the connection with the parent state is kept up.⁴¹

As such, the Cape Colony was connected to the United Kingdom throughout the period 1875 to 1905, and was firmly part of what I shall call the *colonial sphere*, which in the context of this thesis refers to the sphere of influence of the British Empire.

Although the broad legal context governing the committal of the insane and the running of colonial asylums often remained similar to those in practice in the metropole, their custodial and therapeutic traditions changed. This was inevitable, in order to accommodate, firstly, metropolitan-trained psychiatrists' developing ideas around the nature of the colonial patients they encountered; and, secondly, the different socioeconomic contexts of the colonial territories and the populations that inhabited them by dint of emigration, conquest and/or labour migration. Colonial asylums in the Cape presented a set of circumstances quite different to those found in the metropole. Among other things, they were often more linguistically diverse, owing to the intersection of high numbers of immigrants from Europe, Britain, other British colonies, and the African subcontinent. Asylums in the Cape were therefore more racially diverse than the relatively homogenous British asylum population, and had, moreover, higher rates of religious diversity among their inmates. Also present in Cape asylums were a large number of emigrants who had come to the Cape without families or friends, or had lost connection with these people. This, combined with the arguably alien setting of the Colony itself, made assessing new inmates in the Asylum far more challenging than might have been the case in a relatively monolingual, socially-embedded, culturally-homogenous British asylum. All of

⁴⁰ *The Shorter Oxford English Dictionary on Historical Principles, Fifth Edition, Volume 1: A – M* (Oxford, 2002), pg. 1764.

⁴¹ *The Shorter Oxford English Dictionary on Historical Principles, Fifth Edition, Volume 1: A – M* (Oxford, 2002), pg. 451.

these factors combined to provide colonial psychiatrists with a challenge quite different to that they encountered in the metropole.

Unfortunately, new geographic and sociocultural contexts for psychiatry led to the systems of disenfranchisement and inequality in colonial asylums, mirroring those that were developing on the outside, in broader colonial society. Some of those resultant complexities of Colonial psychiatric care and psychiatric institutions in the Cape Colony and, later, South Africa have already been highlighted by historians such as Shula Marks,⁴² Harriet Deacon, Sally Swartz, and Julie Parle. Marks, Deacon, Swartz and Parle all concentrated on the development of psychiatric practice and institutions in British colonies in what is now South Africa, with the former three focussing on the Cape Colony and particularly the asylums of the Cape Town region in the late 19th century. Harriet Deacon's body of work on the asylum at Robben Island is invaluable, in that it charts the earliest developments of the South African asylum system, identifying the Cape authorities' earliest attempts to address the problem of the confinement of the insane. Deacon's work also shows the embryonic roots of the racial inequality and prejudicial practices that would later find full bloom in the Grahamstown Asylum. Sally Swartz's body of work on the development of a form of colonial psychiatry in the Cape is likewise inestimably important in developing an understanding of the values, aims and preconceptions that informed the practices of the Cape's psychiatrists and the asylums these men established and managed. It is in Swartz's work that the disjuncture between the aims of colonial psychiatry and its practice in the Cape becomes clear and undeniable. Swartz also contributes to the field of the study of psychiatry and psychiatric institutionalisation in the Cape Colony by outlining the development of the committal and admissions process lunatics underwent to become asylum inmates. In this work she identifies the twin failures of the Cape government and colonial psychiatrists to, firstly, allow for cultural differences among inmates and, secondly, to adequately provide means of protection for them.

This thesis will contribute to the lines of enquiry these historians have already opened, locating the practices and nature of Grahamstown Asylum between 1875 and 1905 within the broader contexts of the Cape Colony's social sphere and its psychiatric practice. A major work focused solely on Grahamstown Asylum owes a considerable debt to the studies of Felicity Swanson.⁴³ Felicity Swanson's 1994 University of Cape Town Master of Arts thesis, *"Of Unsound Mind": A History of*

⁴² Marks, Shula, "Modern Science and Enlightened Humanity," pg. 283.

⁴³ See Swanson, *"Of Unsound Mind"*.

Three Eastern Cape Mental Institutions, 1875 – 1910” is an invaluable source of information on the eastern Cape Colony’s asylum system in the late 19th-century and, as such, was a major influence on this thesis. It is as yet unparalleled as a history of the development of the region’s three public asylums – Grahamstown, Fort Beaufort, and Port Alfred – as well as a good examination of the system of unequal provision of services that black inmates in these institutions experienced under the aegis of the Cape government’s asylum services. However, a major weakness of Swanson’s text is its focus on three separate institutions, which makes for a disparate work. Although her overarching thesis is undoubtedly sound, the relative brevity of the thesis hampers her attempts to examine each of these institutions in sufficient depth. It might have been better for Swanson, to borrow a quote from Erving Goffman, to “[have] different coats to clothe the children well than single splendid tent in which they all shiver.”⁴⁴ Hampering Swanson’s analysis, also, is a lack of attention to the prosaic human details of this unequal care. A concentration on broader legal and abstract issues is typical of most South African writing on asylums, and to my mind this leads to a wealth of detail, both fascinating and illuminating, being passed over.

To gain a better understanding of the methods of control and surveillance by which institutional authorities in asylums controlled the “inmates” in their care, I consulted several works on the design and development of asylum buildings, and also several specific studies of the aspects of asylum life I felt had not received adequate attention in the existing literature on Grahamstown Asylum, particularly the design of asylum buildings and grounds, and the roles played by asylum attendants. Much of the existing work on asylum design in colonial contexts focuses on specific institutions in New Zealand and Australia; the work of Elizabeth Malcolm⁴⁵ proved most useful. Malcolm’s 2009 article “Australian Asylum Architecture Through German Eyes: Kew, Melbourne, 1867” makes the point that most colonial asylums were designed by architects who were neither native to nor indeed even resident in the area where the asylum was to be built; they were, more often, residents of the metropole.⁴⁶ Moreover, according to Malcolm, the design of these asylums followed the growing British and American trend towards making the asylum building itself part of the therapeutic regime: they were designed to be places of order and symmetry in order to calm the disturbed minds within, and, incidentally, also made rigid gender-segregation possible.⁴⁷ This was *not* true of the physical plant of the Grahamstown Asylum, which was neither symmetrical nor particularly orderly, nor built

⁴⁴ Goffman, *Asylums*, pg. 11.

⁴⁵ Malcolm, Elizabeth, “Australian Asylum Architecture Through German Eyes: Kew, Melbourne, 1867”, *Health and History*, 11, 1, 2009.

⁴⁶ Malcolm, “Australian Asylum Architecture”, pg. 48.

⁴⁷ Malcolm, “Australian Asylum Architecture”, pg. 51-53.

from scratch, as will be shown in a later chapter. Nevertheless, Malcolm's article points to the goals of the asylum – the creation of a therapeutic environment by virtue of introducing moral therapy, which eschewed restraints and strict discipline in favour of kindness and a tranquil, therapeutic environment.⁴⁸ Malcolm also suggests the degree to which the piecemeal construction of the Grahamstown Asylum departed from this ideal.

On a more general scale, the work of Chris Philo, Andrew Scull, and Barry Edginton informed a great deal of this thesis' understanding of the role late 19th-century trends towards moral therapy played in effecting changes in the ways asylums were laid out and operated.⁴⁹ Andrew Scull's 1980 paper "A Convenient Place to Get Rid of Inconvenient People: the Victorian Lunatic Asylum" provided a guide to the philosophies that were followed by asylum designers and asylum authorities in the use of the constructed asylum space, and provided an important starting point for the examination of the growth of Grahamstown Asylum's physical establishment in this thesis. Chris Philo's "'Fit Localities for an Asylum': the Historical Geography of the Nineteenth-Century 'Mad-Business' in England as Viewed through the Pages of the *Asylum Journal*" was also formative, as was Parr, Philo *et al*'s 2004 *Transactions of the Institute of British Geographers* paper, "Social Geographies of Rural Mental Health: Experiencing Inclusions and Exclusions". Both of these papers examine the geographical situation of mental asylums: the location of a suitable site, the attitudes of residents in the immediate area, the possibilities inherent in each site, and the degree to which a series of preferred attributes – elevation, air quality, and water supply among them – dictated where new asylums were constructed, all with the eventual aim of creating a therapeutic, pleasant environment for lunatics to recover. Once again, these works were valuable largely by providing a guide for comparing the eventual physical reality of the Grahamstown Asylum to the ideal, and dissecting the role of the Asylum's actual requirements on the ground in changing the shape of its physical plant.

The Grahamstown Asylum did adhere at least broadly to the guidelines in play in the British asylum-guides in the broader British imperial asylum system. These can be summarised as being the

⁴⁸ Clare Hickman, "The Picturesque at Brislington House, Bristol: the Role of Landscape in Relation to the Treatment of Mental Illness in the Early Nineteenth-Century Asylum, *Garden History*, 33, 1, 2005, pg. 48.

⁴⁹ McCarthy, Angela, "Ethnicity, Migration and the Lunatic Asylum in Early Twentieth-Century New Zealand", *Social History of Medicine*, 21, 1, 2008; Edginton, Barry, "Moral Architecture: the Influence of the York Retreat on Asylum Design", *Health and Place*, 3, 2, 1997; Scull, Andrew, *The most solitary of afflictions*"; "Inconvenient People; Philo, Chris, "'Fit Localities for an Asylum': the Historical Geography of the Nineteenth-Century 'Mad-Business' in England as Viewed through the Pages of the *Asylum Journal*", *Journal of Historical Geography*, 13, 4, 1987; Parr, Hester, Chris Philo and Nicola Burns, "Social Geographies of Rural Mental Health: Experiencing Inclusions and Exclusions", *Transactions of the Institute of British Geographers*, 29, 4, 2004.

intention of providing an environment conducive to the lunatics' recovery; this provision included finding a suitable location at which to build the asylum, the preferred style in which to construct it, establishing a congenial environment, employing suitable staff, and providing suitable food, recreation and means of employment.

The works of Claire Hickman, Niall McCrae, LD Smith, Lee-Ann Monk, Jane Harmlett and Lesley Hoskins, and Harriet Deacon were consulted to complement the picture of the Grahamstown Asylum's workings.⁵⁰ Derived from primary evidence, these works proved useful by providing, firstly, examples of how these goals were achieved elsewhere, and, secondly, material against which to compare the Grahamstown Asylum's attempts to construct its own therapeutic (or custodial) environment. Smith and Monk examine the employment of asylum attendants, and the kind of work they were required to do, while Hickman examines the establishment of pleasant gardens around British asylums, McCrae the provision of small daily comforts, and Harmlett and Hoskins the supply of clothing and the ramifications for individual identity among asylum inmates. All of these works were British in focus but, nevertheless, were instructive in aiding my reconstruction of the Grahamstown Asylum's daily routines and provided a basis of comparison for, once again, determining the degree to which the Asylum's *de facto* operation diverged from the ideals espoused in the metropole.

Likewise, the work of Scull, Edginton, Philo et al., and King proved seminal, despite their focus on the asylums of the United Kingdom. Because the Colonial psychiatric fraternity was trained and educated in the British system, it is acceptable for the purposes of this study that these texts do not focus specifically on the Colonial context. Furthermore, it is quite possible to apply the theories put forward by King, Philo, Scull and Edginton to the Grahamstown Asylum. In the case of these works, it is the differences between the institutions and psychiatric protocols that they cover and the individual nature of the Grahamstown Asylum that render them valuable in this thesis: by examining the ways in which the Asylum differed from other asylums, we come to understand how it assumed its specific nature.

⁵⁰ Smith, LD, "Behind Closed Doors: Lunatic Asylum Keepers, 1800 – 1860", *Social History of Medicine*, 1988. Monk, Lee-Ann, "Working in the Asylum: Attendants to the Insane", *Health and History*, 11, 1, 2009. Harmlett, Jane and Lesley Hoskins, "Comfort in Small Things? Clothing, Control and Agency in County Lunatic Asylums in Nineteenth- and Early-Twentieth Century England," *Journal of Victorian Culture*, 18, 1, 2013; Deacon, Harriet, "Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town," *Journal of Southern African Studies*, 22, 2, 1996; and Deacon, "Racism and Medical Science."

Inevitably, no one work can contain all existing knowledge on any one subject, and so with this thesis. I did not have the skill or the resources to make full use of all available archival sources, and so it is fortunate that the work of Rory du Plessis⁵¹ interleaves with the ground covered in this thesis. His work as a semiotician informs his various articles analysing the visual artefacts manufactured by Grahamstown Asylum authorities. While much of the information that informs his work is also available elsewhere via other sources, this thesis nevertheless must acknowledge his publications, especially “Photographs from the Grahamstown Lunatic Asylum, South Africa, 1890–1907,” first published in the journal *Social Dynamics* in 2014, and “Beyond a clinical narrative: casebook photographs from the Grahamstown Lunatic Asylum, c. 1890s,” published in *Critical Arts* in 2015. These two articles provide useful analysis of the visual environment of the Asylum and the role it was made to play by Asylum authorities in the process of constructing the Asylum’s image as a well-equipped “resort” facility for the wealthy white insane. As this thesis did not make use of the visual archives, I must immediately refer all readers interested in such analyses to these two excellent articles. However, some of Du Plessis other work treads familiar ground and, though approaching it from a somewhat different theoretical background to that use in this thesis, did not reveal much that I had not already discovered for myself using primary sources.⁵²

The particularity of the Grahamstown Asylum’s situation is a result, generally, of its place in the Cape Colony’s development of a psychiatric community and also its development of a deeply unequal colonial society; indeed, these two evolutionary processes are interlinked, the former being dependent on the latter. Specifically, much of the nature of the Grahamstown Asylum arises from its situation in Grahamstown, in the eastern districts of the Cape, in the later 19th Century. The history of Grahamstown is well-documented, as is the region’s highly-contested and unstable early history. For the specific purposes of the thesis, I consulted a number of academic theses, finding them more direct and topic-specific. The histories of Grahamstown produced by Richard Marshall

⁵¹ Du Plessis, Rory, “Photographs from the Grahamstown Lunatic Asylum, South Africa, 1890–1907,” *Social Dynamics*, 40, 1, 2014, “Beyond a clinical narrative: casebook photographs from the Grahamstown Lunatic Asylum, c. 1890s,” *Critical Arts*, 29, 1, 2015, , “The principles and priorities of Dr T.D. Greenlees, medical superintendent of the Grahamstown Lunatic Asylum, 1890–1907,” *Historia*, 60, 1, 2015, and “Constructing patient–psychiatrist relations in psychiatric hospitals: the role of space and personal action,” *Social Semiotics*, 23, 3, 2013.

⁵² For example, Du Plessis, “The principles and priorities of Dr T.D. Greenlees, medical superintendent of the Grahamstown Lunatic Asylum, 1890–1907,” published in *Historia*, 60, 1, 2015 and to a lesser degree, “Constructing patient–psychiatrist relations in psychiatric hospitals: the role of space and personal action,” found in *Social Semiotics*, 23, 3, 2013, use similar sources but different theorists. His work and mine run alongside one another, and may in all likelihood profitably be read in parallel.

and Melanie Gibbens provided valuable context for the community in which the Asylum arose, while Jill Payne's excellent "Re-Creating Home" provided deeper context for the claims made by historians of Cape psychiatry that the Cape system and society strongly and deliberately tried to model itself on that of the Colonial metropole.⁵³

This thesis hopes to fill an existing gap in the literature of psychiatric institutionalisation in the eastern reaches of the Cape Colony by providing a detailed discussion of the physical premises of the region's largest and oldest asylum, and the philosophies and practices that shaped this premises, the treatment it claimed to provide for the region's insane, and the experience of inmates confined within it.

Thesis Goals and Structure

The overarching goal of this thesis is to compile a comprehensive picture of the nature of care/custody provided for individuals at Grahamstown Asylum between 1875 and 1905. The major question is, how did the Grahamstown Asylum come to develop and entrench a system of unequal treatment of patients, and what was the effect of this on the individuals in the Asylum's control? It aims to examine the role of class, race and gender in the institutionalisation and hospitalisation of individuals within the larger context of the institution itself.⁵⁴ A secondary consideration of this thesis is to determine whether the Asylum's authorities implemented practices of favouritism and deprivation, and, if this is indeed so, to determine how these impacted adversely on the lives of inmates. Overall, my aim is to determine what the Asylum's stated aims were in terms of its provision of care to various patients. Further, this thesis intends to discover whether there was any disjuncture between the Grahamstown Asylum's stated aims and its actual provision of care.

Chapter One examines, in roughly chronological order, the foundations of the civil environment in which the Grahamstown Asylum was situated. It further traces the physical development of the Grahamstown Asylum from its establishment in 1875 to the early 1900s. This chapter traces the

⁵³ Marshall, Richard G., "A Social and Cultural History of Grahamstown. 1812 To c1845", Unpublished MA Thesis, Rhodes University, 2008; Gibbens, Melanie, "Two decades in the life of a city : Grahamstown 1862-1882", Unpublished MA Thesis, Rhodes University, 1982; Payne, Jill, "Re-Creating Home: British colonialism, culture and the Zuurveld environment in the nineteenth century", Unpublished MA Thesis, Rhodes University, 1998.

⁵⁴ Please see Notes on Terminology.

development of the Asylum's wards and common facilities, paying particular attention to the emphasis Asylum Superintendents placed on providing space for paying patients and their accompanying reluctance to dedicate any space to black and/or poor patients that could conceivably be used for white patients

In Chapter Two, I examine the roots of the Asylum's physical form, paying particular attention to the influence of the idea of moral therapy on asylum design in general and on the development and nature of the Grahamstown Asylum in particular. Equality and kindness towards all inmates were the bywords of both the Grahamstown Asylum and moral therapy. I argue that the Asylum's therapeutic and custodial practices replicated the prejudices of the surrounding society, and that this had ramifications this had for the ways in which the Asylum implemented the system of moral therapy in its grounds and physical plant. Chapter Two also examines the experiences of staff who worked at the asylum and the framework in which they tried to care for, or at least control, the Asylum's inmates, I shall illustrate the impact of the Asylum's authority structures on the Asylum's employees. These men and women were tasked with enforcing a system of unfair treatment that they had not themselves devised, even if they might have agreed with it. Also in this section, I outline the Asylum's authority structures and the rules governing staff and the Asylum's daily routines, including visiting hours, bathing, and mail procedures. By looking into the rules and "mission statements" laid out in the Asylum's rule books, I hope to illustrate the disjuncture that existed between the Asylum's stated position on equality and moral therapy and the reality that existed on the ground. To further press home this point, in the last part of the chapter, I examine the case of nurse Mary Hickey, who clashed repeatedly with the Asylum's Superintendent on various matters pertaining to the Asylum's day-to-day operation, possibly because of what we would now term personality clashes, but also out of concern for the welfare of patients.

In the third chapter of this thesis, an attempt is made to locate and specifically understand the ways in which mainstream Cape society's concerns around lunacy, race and gender played out in the experiences of the Colony's lunatics. Chapter Two delves into the frameworks that shaped the Grahamstown Asylum's understanding of the individual men and women in its care, and subsequently its treatment of them. In this chapter I examine the supposed causes of insanity among the Asylum's population, as recorded in the patient registers and committal documents. With these two overarching structures of psychiatry and the law weighted against equal treatment, it is

not surprising that the world within the Asylum was well prepared to operate with the same set of prejudices and rules. The closing part of Chapter Three is devoted to a dissection of the diagnostic patterns among lunatics committed to the Grahamstown Asylum between 1875 and 1905, and in it I intend to demonstrate that the preconceptions surrounding gender and race came together to create very clear patterns.

In Chapter Four, I address the mechanisms by which men and women came to be committed to the custody of the Cape Colony's asylum system, paying particular attention to the role the various provisions of the 19th-century Cape's three Lunacy Acts played in determining which individuals should be committed to the asylum. In this Chapter, I look into the development of the period's three primary Lunacy Acts – those of 1879, 1891 and 1896. The examination of violent, unacceptable and just downright strange behaviour that I undertake in the middle part of this chapter is intended to shed some light on the ways in which inmates were distinguished from sane members of the society from which they came. I examine the role played by threatening or odd behaviour in influencing the decisions that examining physicians made in declaring a particular individual to be mad. This section illuminates the *difference* displayed by lunatics when compared to sane individuals, and, by examining the ways in which some insane individuals were believed to depart from normal behaviour, complements the preceding section's examination of the ways in which insane individuals were distinguished from the mainstream by their behaviour but nevertheless understood in terms of normative preconceptions.

The aim of Chapter Five is to create for the reader a sense of the Asylum's population – where they came from, what their lives were like outside, how long they were there for, and the effects this had on their links to the outside, as well as their deaths. I begin Chapter Five with an examination of who, precisely, made up the patient population of the Grahamstown Asylum. Further, I look into the patterns that existed in the discharge logs of the Asylum, the kinds of discharge that were available, and how they were deployed. In Chapter Six, I examine three of the Asylum's most basic daily functions – the occupations patients engaged in, their leisure and recreational activities, and the food they were fed. I have grouped work, recreation, and the Asylum's dietary practices together in this chapter, along with a discussion of the establishment and expansion of the Asylum's farm, because these topics all illustrate the depth and indeed also the prosaic nature of the Grahamstown Asylum's system of wealth- and race-based differentiation.

Notes on terminology

An examination of mental illness and its institutions often risks becoming something of a stew of jargon, technical terms and synonyms that, when left unexplained, obscure meaning. Therefore it is vital to define and differentiate at this point, before proceeding into the main body of the thesis.

In this thesis, the terms “Asylum” and “the Asylum”, when capitalised, refer to the Grahamstown Asylum, which is the name by which the current Fort England Hospital was known in the period 1875 – 1905. When not capitalised, “asylum”, “asylums” and “the asylum” refer more generally to the asylum system and the concept of asylums and their management. “Lunatic”, “patient”, “inmate” and “resident” have been used more or less interchangeably throughout this thesis. The term “lunatic” was widely used in the 19th century, but has been replaced by “patient” in formal use and most modern texts. However, given the Colonial asylum system’s attitude towards some of the people caught up in its mechanisms, I feel that “patient” alone does not adequately represent the reality of their situation, especially in the case of black and poorer patients. Therefore I have used the term “inmate” in some cases. On occasion, also, I have used the term “resident” to refer to all those resident on the Asylum grounds, staff and patients alike. Furthermore, here, “institutionalisation” refers to the ways and means by which a person came to be in the asylum, while “hospitalisation” refers to the experience of people within the asylum.

In the intervening century-and-a-half between the establishment of the Asylum and the present day, psychiatric terminology has changed apace, mirroring the vast changes in psychiatry as a medical field. As it is not the purpose of this thesis to retrospectively diagnose or re-diagnose any of the men and women admitted to the Grahamstown Asylum, and as I have no formal training in psychology, general medicine or psychiatry, I have not modified any of the diagnostic terms used in the primary sources I consulted for this thesis. Some, such as *dementia praecox* and *melancholia*, have been superseded by more accurate, newer diagnostic terms such as *schizophrenia* and *depression*. Others, such as *idiocy* and *imbecility* are no longer in current formal use at all.

Throughout this thesis I have used the term “sex” to refer to biological sex, i.e. either of the two main categories into which humans are divided on the basis of their reproductive functions. I have

used “gender” to refer to the sociocultural state of being a man or boy, woman or girl, which is usually strongly influenced by social and cultural mores and is changeable over time. The viewpoint of the Grahamstown Asylum’s authorities does not appear to have allowed for the possibility, now widely accepted, that sex and gender do not neatly coincide.

As will be elucidated at considerable length throughout the body of this thesis, the Grahamstown Asylum’s authorities were obsessed with classifying incoming men and women into racial groups, along which lines the Asylum population was then segregated. Throughout this thesis I have, in the interests of clarity, used “black” and “white” rather than “African” or “European”. The demographic makeup of the Colony’s white population included both individuals born in the Colony and more recent immigrants, some of whom referred to themselves as “European” or by a more specific national designation (such as “Welsh” or “German”) whether or not they had been born in Europe. At the same time, individuals born in the Colony also referred to themselves as European, but often also as “European Colonial”, “Colonial”, “Colonial English”, and so on. I am well aware that the terms “black” and “white” are narrow and elide nuance, especially in view of the fact that there were a number of inmates of the Grahamstown Asylum who were classified as “black” despite being Asian, Indian, Malaysian or Coloured. However, in a work of this length, terminological consistency is crucial, and so I have opted to keep terminology in the main text as straightforward as possible.

Pseudonyms

I have not used the real names of Grahamstown Asylum patients anywhere in this text. Asylum staff and Colonial authorities have been called by their names as recorded in the official documentation, but nowhere have I used the full, unabridged name of any man or woman admitted to the Asylum. Instead I have adopted a system of using the individual’s first name, followed by the initial letter of their surname. In cases where there were multiple individuals with the same first name and surname initial, I have usually opted to refer to them by a middle name (if available), or a randomly-designated surname initial. In this manner I hope to protect the identities of those individuals mentioned herein.

Chapter 1: The Evolution of Grahamstown Asylum

The Cape Colonial Context, 1812 – 1905

The Cape Colony's history can be described as an ongoing process of conquest, shifting from the literal physical annexation of land to the appropriation of livelihoods. Over the years preceding the Grahamstown Asylum's establishment, and those that followed, the Cape Colony's socio-political currents all flowed in the direction of the acquisition and consolidation of white control over all resources: animal, agricultural and mineral, as well as, in the shape of a large workforce, human. Nowhere was the determination to gain settler ascendancy more pronounced than in the eastern reaches of the Cape Colony, the Eastern Frontier.



Figure 1: the Eastern Frontier region of the Cape Colony, c. 1820 - c. 1880¹

¹ File from Wikimedia Commons, accessed at https://upload.wikimedia.org/wikipedia/commons/f/f9/Eastern_Frontier%2C_Cape_of_Good_Hope%2C_ca_1835.png, 26 May 2018.

Even before the arrival of British settlers in Albany in 1820, the amaXhosa, who had previously inhabited the region between Algoa Bay and what later became the Colony of Natal, had lost land to British imperial expansion.² Treaties signed between the British and certain amaXhosa chiefs after the end of the Fourth Xhosa War were considered, by the British, to hold all amaXhosa groups to the agreement that they would not venture west of the Great Fish River. The amaXhosa, however, did not follow the European concept of exclusive territorial boundaries; further, they believed that the treaty applied only to those chiefs who had signed the treaty.³ Among white settlers on the Eastern Frontier, opinions divided into two main camps: those who saw the amaXhosa as a threat to livelihood, safety and colonial supremacy, and a more humanitarian school who regarded the amaXhosa as fertile ground for missionary work and education.⁴ The latter group were based in Cape Town in the Colony's far western corner. The former mostly lived in territories closer to the artificial, shifting, contested border. This division, between settlers who saw the amaXhosa as enemies and humanitarians who did not, would persist for the next several decades.

In 1815, the Cape became a Crown Colony of the British Empire, and a permanent government replaced military command.⁵ The Cape fell under the purview of the Colonial Office, headquartered in London, and this office was required to manage British operations in the colonies without bankrupting the Crown. Keeping costs to a minimum involved making sure that colonial governmental and military bodies remained on an even keel.⁶ As a result, Permanent Under Secretaries spent a great deal of time trying to reign in rogue local administrators, who tended to become caught up in urgent local matters that did not seem quite as pressing or as clear-cut to the cooler heads that prevailed in London when they were made aware of them, thousands of miles away and many weeks later.⁷

² Alan Lester, "'Otherness' and the frontiers of empire: the Eastern Cape Colony, 1806-c.1850", *Journal of Historical Geography*, 24, 1, 1998, pg. 6.

³ Lester, "Otherness", pg. 6.

⁴ *Ibid.*

⁵ Timothy Keegan, *Colonial South Africa and the Origins of the Racial Order* (Cape Town, 1996), pg. 44

⁶ John W Cell, *British Colonial Administration in the Mid Nineteenth Century: the Policy-Making Process* (New Haven, 1970), pg. 7. Secretaries of State for the Colonies tended to stay in office for less than five years, and often as little as two.

⁷ Keegan, *Origins*, pg. 44.

Before Grahamstown⁸ was established, the amaXhosa of the borderlands between the Cape and independent eastern territories had lost land in four wars. As a result, groups formerly living west of the border had been thrown back onto groups living east of the border, resulting in overcrowding and retributational cross-border raids.⁹ Border disputes and cross-border raids led to the Fifth Xhosa War in 1815, which included a major amaXhosa defeat at the Battle of Grahamstown in 1819. Following the end of the war, Governor Charles Somerset expelled the amaXhosa to lands even further east, and creating a “buffer zone” between the Great Fish and Keiskamma Rivers. This territory was named Victoria; just west, beginning on the far bank of the Great Fish and extending west as far as Algoa Bay, was Albany.¹⁰ In 1820, 60 parties of British settlers, about 4000 people in total, were settled in Albany. Grahamstown, established around the military emplacement of Fort England in 1817, was to serve as their capital.

The British settlers in the Albany region were allocated land that had been stolen from the amaXhosa.¹¹ Many British settlers found that the agricultural project was too difficult in the arid climate, and left the land as soon as they could, gathering in Grahamstown. Others began farming sheep, which given the climate was much more profitable than crop-farming. Both groups traded with the nearby amaXhosa, although it was illegal to do so until 1828. By the 1830s, the combination of trade, fear and agricultural expansion had led to a strong desire among the white residents of the Eastern Frontier for imperial expansion into amaXhosa territory – and, if possible, the capture of Xhosa labour.¹² As a result, settler politicians came out strongly in favour of expansion into Xhosa territory.¹³ The settler stance was a combination of fear and a wish for agricultural expansion. The long-established settler communities of the Western Cape were instead in favour of assimilation by gentler, possibly religious means.¹⁴

⁸ As of 2018, Grahamstown is known as Makhanda. Another name for the town is iRhini. For consistency, the term Grahamstown shall be used throughout this thesis.

⁹ Lester, “Otherness”, pg. 5.

¹⁰ Lester, “Otherness”, pg. 8.

¹¹ Stanley Trapido, “Imperialism, Settler Identities and Colonial Capitalism: the Hundred-Year Origins of the 1899 South African War”, in Robert Ross, Anne Kelk Mager and Bill Nasson (eds.), *The Cambridge History of South Africa, Volume 2: 1885 – 1994* (Cambridge 2011), pg. 68.

¹² Lester, “Otherness,” pg. 8.

¹³ Norman Etherington, Patrick Harries and Bernard K Mbenga, “From Colonial Hegemonies to Imperial Conquest, 1840-1880”, in Carolyn Hamilton, Bernard K Mbenga and Robert Ross (eds.), *The Cambridge History of South Africa, volume 1: from Early Times to 1885*, (Cambridge, 2010), pg. 320.

¹⁴ Trapido, “Imperialism”, pg. 69.

In 1835, the Sixth Xhosa War began, and proved to be one of the Eastern Frontier's most brutal and intractable conflicts, becoming the event that truly solidified the settler position that the amaXhosa were barbarians who should be entirely defeated.¹⁵ Even following British victory in 1836, the settlers remained convinced that the humanitarians of the western Colony were sadly deluded in their support of missionary activity among the Xhosa. As historian Stanley Trapido states,

"As the pillaged and the plundered tried to defend themselves, they became the murderers and destroyers. The victims had become the source of their own victimhood, and this became a central feature of settler ideology. For the rest of the [19th] century, most of Albany's settlers concurred in Britain's frontier policy, strategic and economic."¹⁶

In May 1835, following British victory, the land between the Keiskamma River and the Great Kei River fell under British control, came under martial law, and was renamed Queen Adelaide Province.¹⁷ The annexation of Queen Adelaide Province was rescinded shortly thereafter. Only the loyalist Mfengu, settled around Fort Peddie, remained under British control, and diplomatic agents were placed among the amaXhosa to broker relations with the British.¹⁸ While politicians in the Colony's west applauded this, the eastern contingent once again saw it as evidence that their interests were not important to those in power.¹⁹

The period between the mid-1840s and the latter 1860s was a time of setbacks for the imperial project, as resistance to colonial rule flared up across the Empire.²⁰ The Cape Colony was experiencing wide-ranging conflict along its borders with the amaXhosa once again, and the image of the "savage" took hold in the Cape as it did elsewhere in the Empire. Race became the primary way that people were socially classified, and thus became a major mechanism of determining who was included in or excluded from various social, political and economic contexts. This was also the point at which race began to be used as a scientific *explanation* for perceived differences.²¹

¹⁵ Lester, "Otherness", pg. 9

¹⁶ Trapido, "Imperialism", pg. 70.

¹⁷ Lester, "Otherness", pg. 21.

¹⁸ Etherington, Harries and Mbengu, "Colonial Hegemonies", pg. 320.

¹⁹ Lester, "Otherness", pg. 22.

²⁰ Richard Parry, "'In a Sense Citizens, But not Altogether Citizens...': Rhodes, Race and the Ideology of Segregation at the Cape in the Late Nineteenth Century", *Canadian Journal of African Studies*, 17, 3, 1983, pg. 380.

²¹ Etherington, Harries and Mbenga, "Colonial Hegemonies", pg. 319.

In the early 1850s, settler interests began to move into the ascendant in Colonial politics. The Colonial government was ever more reliant on the income derived from wool-farming in the eastern reaches of the Colony, although this situation became precarious owing to severe drought in the 1840s. The Seventh Xhosa War broke out in 1846, and continued into 1847. It was to be largest war of its kind in the Colony, with 14 000 British and colonial troops mobilising against the amaXhosa forces of chiefs Maqoma and Sandile. Seeking to end the conflict and leave little likelihood of resurgence, the British employed scorched-earth tactics, burning Xhosa crops and villages. Starving and without the resources to continue fighting, Maqoma and Sandile sued for peace. Despite being short of resources to continue fighting, the British did not accept these overtures, preferring to pursue a clear victory. Sir Harry Smith was brought to the Cape to end the conflict, which he achieved by forcing the amaXhosa to abandon all territory east of the Keiskamma except for a few reserves. In these reserves, he introduced land tax and re-introduced martial law.²² Xhosa territory to the east of the Keiskamma was annexed as far east as the Great Kei River, becoming British Kaffraria.²³

The situation continued in a tight spiral of land degradation and deprivation among the amaXhosa for nearly a decade until the outbreak of the Eighth Xhosa War in 1850. Like those before, this was another long-drawn-out conflict, and was worsened by drought. Despite British victory in 1853, the Eighth Xhosa War further entrenched settler hatred of the amaXhosa.²⁴ After this war, dispossession among the amaXhosa was worsened by a lungsickness epidemic that threatened cattle herds, and then by crop failures in several consecutive seasons. The resulting famine killed approximately 40 000 amaXhosa and left 150 000 without the means to support themselves at all. Almost 60 000 crossed into the Cape Colony, looking for work. It was, effectively, the end of independent amaXhosa polities in the area. In 1857, Governor George Grey opened British Kaffraria to white settlement, and made it illegal for Xhosa to enter the Colony without a pass.²⁵

²² Etherington, Harries and Mbenga, "Colonial Hegemonies," pg. 323.

²³ Lester, "Otherness", pg. 13.

²⁴ Etherington, Harries and Mbenga, "Colonial Hegemonies", pg. 323.

²⁵ Etherington, Harries and Mbenga, "Colonial Hegemonies", pg. 326.

Representative government for the Cape Colony was granted by the Constitution Ordinance in 1853.²⁶ The newly-established Cape Parliament consisted of a 15-member Upper House and a 46-member Lower House.²⁷ Members of the Upper House tended to be wealthier than those of the Lower: the property qualification for entering the Upper House was £2000 in fixed or £4000 in unfixed property, while the Lower House was open to any elected official who met the Cape's franchise requirements of £25 worth of property or £50 of wages a year. At this point, the Cape franchise was open to all adult men, of any race, who met those criteria.

While representative government promised more administrative efficiency, it created negative complexity in that Members of Parliament from the eastern Colony began to agitate for East Cape separatism.²⁸ Factions from the east and west of the Colony battled for dominance in the Lower and Upper House.²⁹ Unfortunately, the Eastern Frontier settler mentality was gaining mainstream prominence throughout the Cape and the Empire alike: "scientific" studies of "the Bantu" had analysed a culture that the so-called scientists made little effort to understand. These studies portrayed indigenous Africans as living in an earlier stage of evolution, in danger of dying out if they were not forcibly saved by Colonial care.³⁰ This mainstream racism would only become more entrenched after the discovery of diamonds in 1868, and expanding ostrich and sheep farming, pushed the Colony's revenue up into previously unforeseeable ranges and increased the likelihood of full responsible government.³¹ Responsible government was granted in 1872, with John Molteno, the MP for Beaufort West, becoming Prime Minister. Once responsible government was granted, the Cape Colony now had responsibility for its own affairs, albeit with a Governor of the Cape Colony³² – in the shape of Sir Henry Barkly until 1877, and then Henry Bartle Frere – still nominally outranking the new Prime Minister.³³

²⁶ Abel Gwandiepi and Krige Siebrits, "The Cape Colony (1854-1910)", unpublished paper, Department of Economics, Stellenbosch University, February 2017, pg. 3.

²⁷ Gwandiepi and Siebrits, "The Cape", pg. 5.

²⁸ Gwandiepi and Siebrits, "The Cape", pg. 4.

²⁹ Etherington, Harries and Mbenga, "Colonial Hegemonies", pg. 330.

³⁰ Etherington, Harries and Mbenga, "Colonial Hegemonies", pg. 329.

³¹ John Laband, "'The Direction of the Whole of the Forces Available: the Disputed Spheres of Military and Civil Authority in the Eastern Cape 1877 – 1878), Natal (1879) and Zululand (1888)", *South African Journal of Military Studies*, 41, 2, 2013, pg. 62.

³² In this period, the role of Governor of the Cape Colony and High Commissioner for South Africa were shared by the same incumbent.

³³ Laband, "Disputed Spheres", pg. 62.

The outbreak of the Ninth (and final) Xhosa war in 1877 did not improve the relationship between Frere and Molteno. In mid-1878, Molteno effectively ceased to co-operate with Frere.³⁴ This was an error on Molteno's part, as Frere had the power and the petulance to dismiss Molteno and, indeed, his government, and did so in early February 1878.³⁵ Without Molteno to act as a brake on Frere's imperial ambition, he annexed the territory of the Ngqika Xhosa in 1878, adding half a million amaXhosa to the population of the Cape.³⁶ Frere's choice for Molteno's replacement was John Gordon Sprigg, MP for East London and, along with Grahamstown's Robert Godlonton,³⁷ a career Eastern Cape separatist. In his first term in office Sprigg went on record as opposing the Cape Qualified Franchise, and his opposition strengthened after Frere's conquests added a large number of amaXhosa to the Cape's population. The increase in population in the Colony's eastern reaches meant that, in some areas, it was potentially possible that black qualified voters might outnumber white qualified voters. This was anathema to many people in the eastern Colony, Sprigg's home base.³⁸

At the same time, black workers returning to rural homes came with new and often uncomfortable ideas and artefacts – including firearms and money as well as evangelical Christianity.³⁹ Resistance to colonial rule across the South African region was fierce: there were more wars under Frere's governorship than ever before,⁴⁰ including the Anglo-Zulu War (1879), the First Boer War (1880-1881), and the Basotho Gun War (1880), and existing socio-political tensions in the region worsened.⁴¹ Possibly the only reason this did not result in a tenth war with the amaXhosa was the implementation of the co-called Peace Preservation Bill of 1878, which demanded that all black Africans in the Cape hand in their guns. On top of this, hut taxes doubled in 1879.⁴²

³⁴ Laband, "Disputed Spheres", pg. 62.

³⁵ Laband, "Disputed Spheres", pg. 65.

³⁶ Gwandiepi and Siebrits, pg. 12.

³⁷ Godlonton's beliefs carried significant weight in the Colony as a whole, but particularly the eastern regions, as he was the editor and publisher of one of the region's major newspapers, *The Graham's Town Journal*.

³⁸ Gwandiepi and Siebrits, "The Cape", pg. 6.

³⁹ Etherington, Harries and Mbenga, "Colonial Hegemonies", pg. 375.

⁴⁰ Etherington, Harries and Mbenga, "Colonial Hegemonies", pg. 383.

⁴¹ Shula Marks, "Class, Culture and Consciousness in South Africa, 1880 – 1899", in Robert Ross, Anne Kelk Mager and Bill Nasson (eds.), *The Cambridge History of South Africa, Volume 2: 1885 – 1994* (Cambridge, 2011), pg. 106.

⁴² Marks, "Class, Culture and Consciousness", pg. 114.

The Colony's financial state had been poor throughout most of the 1870s and early 1880s, when revenue had been spent on expanding rail and telegraph networks.⁴³ Despite infrastructural expansion, most people in the Colony were still rural agriculturalists,⁴⁴ with wool remaining one of the Colony's most valuable exports. In 1880, the Cape took over control of the diamond fields, leading to a period of political dominance, at first as *eminence gris*, by Cecil John Rhodes. Sprigg presided over the 1887 Parliamentary Registration Act, the first of three acts of the late 1880s and early 1890s aimed at removing the multiracial franchise. The Act removed recognition of voters who qualified for the franchised base on land owned under traditional, communal practices, therefore barring a large percentage of formerly-eligible black voters.⁴⁵ Combined with the fact that black Africans were barred from owning diamond or gold claims, but were needed to do the heavy manual work on them, this drew a distinct line between white supervisors and owners, and black labourers, in the boomtowns that sprung up in the mineral-rich hinterland.⁴⁶ Waged work, where available, sucked African migrants into dependence on the Cape's increasingly capitalist economy.⁴⁷ In some areas, communal land ownership was still possible but overcrowding and labour migrancy were undermining the ability of many black communities to subsist without surrendering to the wage-work system.⁴⁸

The last remnants of humanitarian impulse and non-racialism in the Cape Colony were cleared away with the ascension of Cecil John Rhodes to the post of Prime Minister in 1890. Under Rhodes, the focus of "native policy" shifted from improvement to simple control.⁴⁹ This approach took widespread hold: imperialists in the Empire adopted a Social Darwinist approach, espousing an adapt-or-die attitude towards the indigenous people they had overthrown.⁵⁰ Rhodes, certainly, made efforts to mute the black political voice in the Colony with the 1892 Franchise and Ballot Act, which raised the threshold for enfranchisement from £25 to £75, eliminated eligibility for those who earned £25 in wages, and introduced literacy as a requirement for voting. It was the last that struck the hardest blow: on a continent where most indigenous cultures had oral rather than literary traditions, most people were illiterate.

⁴³ Gwandiepi and Siebrits, "The Cape", pg. 20.

⁴⁴ Marks, "Class, Culture and Consciousness", pg. 102.

⁴⁵ Parry, "In a Sense Citizens", pg. 384.

⁴⁶ Etherington, Harries and Mbenga, "Colonial Hegemonies", pg. 374.

⁴⁷ Marks, "Class, Culture and Consciousness", pg. 118.

⁴⁸ *Ibid.*

⁴⁹ Parry, "In a Sense Citizens", pg. 380.

⁵⁰ *Ibid.*

After the Act was passed, only 4% of the African male population was still eligible to vote. With the multiracial franchise effectively destroyed, Rhodes followed up with the Glen Grey Act of 1894, which was intended to drive as many of the Colony's black residents into wage labour as possible by removing communal land tenure. Only individual tenure was possible, and the sizes of plots were regulated. This severely limited African access to land and made black farmers' economic margins extremely narrow. With the addition of labour tax, quitrent and survey fees to each allotment, Rhodes intended that any African who did not personally own an allotment would be forced to join the Cape's labour force as waged labourers.

The pro-imperialist, pro-British, anti-Xhosa and effectively racist mindset of the Colony's eastern settlers sprung from an erstwhile threat that was exaggerated into the spectre of conquest for an entire Frontier by canny politicians. Tensions between pro-British and pro-Colonial political factions were resolved, in the latter half of the century, by the ascendance of pro-Empire parties. The result, for white settlers, was a Colonial culture into which expansion, imperialism and racism were ingrained. For black residents of the region, the result of the political flow of the 19th century Cape was unceasing deprivation and marginalisation, set in motion by economic imperatives and kept in motion by increasingly mainstream racism and exploitation. The Grahamstown Asylum is a child of the latter 19th-century Cape and Empire's preoccupation with white ascendancy and the attendant disregard for the humanity of the region's black inhabitants.

The Selection of Grahamstown as the Site of an Asylum

Before the discovery of substantial mineral deposits in the 1860s, the Cape Colony was not one of the British Empire's most treasured possessions: it was small and remote, and did not offer very alluring commercial or agricultural prospects for British emigrants, most of whom opted to go to Australia or New Zealand.⁵¹ This was especially true for the eastern half of the Cape Colony, which, as well as being distant from the colonial capital, Cape Town, was also a site of constant contestation over land and resources. Moreover, the infrastructure of the Cape Colony, particularly the eastern regions, was undeveloped and this, combined with rudimentary infrastructure, made transport and communication slow.

⁵¹ Anne McClintock, *Imperial Leather: Race, Gender and Sexuality in the Colonial Contest* (New York, 1995), pg. 232.

The British imperial ambition to expand the Cape Colony eastward had led to prolonged periods of ongoing conflict along the shifting frontier between 1817 and 1858 as isiXhosa-speaking groups already established in the region resisted the annexation of their territories between the Fish River and the Kei River.⁵² Despite this, a small portion of British emigrants – of the estimated 12 000 000 emigrants from Britain to British colonies between 1815 and the 1880s, only a very small minority opted for the eastern frontier of the Cape Colony – that settled in the region did so with the intention to re-creating Britain in this far-removed corner of the Empire.⁵³

British immigrants to the eastern frontier were faced, even before they left Britain, with problems: not only were they headed for contested territory, they were in fact intended to act as a buffer between the British territories creeping ever eastward and the amaXhosa chieftaincies to the east of the Fish River.⁵⁴ The rural and completely unindustrialised nature of the region meant that settlers had to support themselves by farming – despite only a relatively small percentage having any agricultural experience.⁵⁵ According to Jill Payne, only 36% of emigrants to the region had any experience as farmers or agricultural workers.⁵⁶ The majority of emigrants to the Grahamstown region had been urban residents in Britain, and were mostly artisans, shopkeepers or small traders, or clerical-type workers.⁵⁷

⁵² John S Galbraith, *Reluctant Empire: British Policy on the Eastern Frontier 1834 – 1854* (Berkeley, 1963), pg. 6. Given that only 12000 square kilometres were gained over twenty years of near-constant war with the amaXhosa, this works out as a total £5496 000, a distinctly eye-watering £458 per square kilometre.

⁵³ Jill Payne, “Re-creating home : British Colonialism, Culture and the Zuurveld Environment in the Nineteenth Century”, Unpublished MA Thesis, Rhodes University, 1998, pg. 21.

⁵⁴ Penelope Silva, “Introduction” in Penelope Silva (ed.), *The Albany Journals of Thomas Shone* (Cape Town, 1992), pg. 3. Interestingly, HJM Johnston in *British Emigration Policy 1815 – 1830: “Shovelling Out Paupers”* (Oxford, 1972) argues that their use as a buffer was incidental, and that the Grahamstown region was chosen as a destination for the settlers because it was not already densely settled by the British (Johnston, “Shovelling Out Paupers”, pg. 33).

⁵⁵ Richard Marshall, “A Social and Cultural History of Grahamstown. 1812 To c1845”, Unpublished MA Thesis, Rhodes University, 2008, pg. 66.

⁵⁶ Payne, “Re-Creating Home”, pg. 23.

⁵⁷ Patricia Elena Scott, “An Approach to the Urban History of Early Victorian Grahamstown, 1832 – 1853, with Particular Reference to the Interiors and Material Culture of Domestic Dwellings”, Unpublished MA Thesis, Rhodes University, 1997, pg. 111.

Although the emigration scheme was intended to alleviate post-Napoleonic War poverty in the industrial cities of northern England, it was underfunded by the British Parliament (only £50 000 was allocated), and did not allow for many truly poor Britons to emigrate.⁵⁸ In effect, emigrants to the eastern frontier were artisans, or from the middle- and upper-classes.⁵⁹ This had positive ramifications for the socio-economic and cultural make-up of Grahamstown in the decades following the 1820s wave of emigration, but was not beneficial in terms of fostering a thriving agricultural project along the Eastern Frontier.⁶⁰

Those settlers who could abandon farming did so with alacrity and moved to towns such as Grahamstown, Uitenhage and Port Elizabeth, where they resumed their previous occupations as clerks, artisans, merchants and so forth.⁶¹ The population of Grahamstown grew rapidly, from 200 'white'⁶² residents in 1820 to nearly 3000 by 1828, rising to 5000 residents by 1845.⁶³ Grahamstown had been established as a military outpost in the 1810s, and the socioeconomic growth of the town was supported by the presence of imperial troops there. However, from the 1830s onward, Grahamstown regarded itself as a trading centre rather than an agricultural region, although farming remained the cornerstone of the local economy.⁶⁴ The farming of merino sheep became the most important economic activity in the region from the late 1830s onward: by 1842, there were over 200 000 sheep in Albany, and numbers rose steadily over the next decade as farmers abandoned grain- or cattle-farming in favour of farming wool to supply the expanding metropolitan textile market.⁶⁵

A diminishing market for Cape wool in the 1860s caused Grahamstown to decline in importance in the region, especially with the growing economic power and industrial development of the port cities of Port Elizabeth to the west and East London to the east. In

⁵⁸ Scott, "An Approach", pg. 110; Johnston, "Shovelling Out Paupers", pg. 32; Johnston, "Shovelling Out Paupers", pg. 40.

⁵⁹ Scott, "An Approach", pg. 110; Payne, "Re-Creating Home", pg. 23.

⁶⁰ Marshall, "Grahamstown, 1812 – c. 1845", pg. 66.

⁶¹ HJM Johnston, *British Emigration Policy 1815 – 1830: "Shovelling Out Paupers"* (Oxford, 1972), pg. 47.

⁶² "White" in this context indicates people of European descent. "Black" indicates people of African descent.

⁶³ Scott, "An Approach", pg. 115.

⁶⁴ *Ibid.*

⁶⁵ Tony Kirk, "The Cape Economy and the Expropriation of the Kat River Settlement, 1846 – 53" in Shula Marks and Anthony Atmore (eds.), *Economy and Society in Pre-Industrial South Africa* (Johannesburg, 1980), pg. 229.

addition, the discovery in the 1860s of substantial mineral deposits in the Kimberley area and, in the 1880s, on the Witwatersrand, drew economic focus away from the largely agricultural Albany region.⁶⁶ In 1870, the region's military headquarters were moved eastwards from Grahamstown, where they had been situated since 1817, to King William's Town.⁶⁷ Despite this, Grahamstown maintained some status as an ecclesiastical and educational centre, as well as the seat of the Eastern Districts Court from 1864.⁶⁸ It also displayed "Victorian self-confidence," including an acute awareness of its status as an outpost of the British Empire.⁶⁹ The increasingly middle-class inhabitants of the town aspired, now that the region had stabilised (in favour of settler and colonial interests, that is), to attain all the refinements of the prosperous British towns that they wished Grahamstown to resemble. It already had a court, schools and churches; it only needed respectable medical facilities to be complete.

Dr John Atherstone's valiant attempts since 1829 to establish a public hospital in Grahamstown had been routinely defeated. This was largely due to a lack of funds, but was also the result of the view that Grahamstown did not need a hospital, "in view of the salubrity of the climate, the absence of dangerous contagious disease, and the small population."⁷⁰ The first hospital available in Grahamstown was the military Drostdy Hospital, established after 1840. Although the town's general practitioners worked closely with army surgeons, no civilians received treatment in the Drostdy, but were rather accommodated in rooms set aside at the town gaol, a leaky and cold building that probably did not do much to improve the prognosis of anyone already ill enough to need hospitalisation.⁷¹

The Albany General Hospital was opened in 1858 to serve "all sick, wounded and diseased persons ... regardless of their colour or religious beliefs."⁷² This included, from 1859 onwards, 'lunatics', who were treated on the general wards, often to the alarm and hostility of other

⁶⁶ Melanie Gibbens, "Two Decades in the Life of a City: Grahamstown 1862 – 1882", Unpublished MA Thesis, Rhodes University, 1982, pg. 19.

⁶⁷ Gibbens, "Grahamstown 1862 – 1882", pg. 61.

⁶⁸ Gibbens, "Grahamstown 1862 – 1882", pg. 19.

⁶⁹ Marshall, "Grahamstown 1812 – c.1845", pg. 44; Gibbens, "Grahamstown 1862 – 1882", pg. 61.

⁷⁰ LG Couch, *A Short Medical History of Grahamstown* (Grahamstown, 1976), pg. 24; Sally Sampson, "The Campaign for a Lunatic Asylum in the Eastern Provinces", in LM Els (ed/compiler), "History of Fort England Hospital: Unedited Version", Unpublished manuscript, date unknown, in private hands, pg. 93.

⁷¹ Sally Sampson, "The Campaign for a Lunatic Asylum in the Eastern Provinces", in LM Els (ed/compiler), "History of Fort England Hospital: Unedited Version", Unpublished manuscript, date unknown, in private hands, pg. 94.

⁷² LG Couch, *A Short Medical History*, pg. 25; Couch unfortunately does not give his sources.

patients.⁷³ The only other place in Grahamstown willing to house 'lunatics' was the town gaol, which gave rise to other problems, such as abuse of lunatics by criminals also incarcerated therein. Aside from the inadvisability of housing criminals and 'lunatics' together (which had not been general practice in Europe or Britain since the 1840s), there was already a shortage of space in the region's gaols.⁷⁴

Before the establishment of the Grahamstown Asylum, the Cape Colony had only one institution for the mentally ill: Robben Island in Table Bay, off the coast of Cape Town, which had accommodated 'lunatics' from 1846 onwards. Robben Island was a deeply unpopular solution to the question of what to do with 'lunatics' from the eastern half of the Cape Colony. This was because of the length of the journey from the Eastern Cape to Robben Island – over 1000km – and the low life expectancy of anyone interned there because of disease, malnutrition and harsh conditions. The Island's reputation had, moreover, suffered from the negative findings of several public investigations that followed allegations of mismanagement in the 1850s and 1860s.⁷⁵ Unsurprisingly, then, it was decided that the eastern half of the Colony needed a lunatic asylum to furnish the needs of the rising population there. Robben Island was distant, dangerous, and very much a place of last resort.

King William's Town and Queenstown, both further east and more recently established than Grahamstown, were potential locations for this new asylum, but neither town was enthusiastic about the prospect of being home to it – King Williams Town on the grounds that it had a military garrison, and Queenstown on the grounds that it already had an extensive tuberculosis sanatorium. Grahamstown, on the other hand, actively campaigned to be the site of the future asylum. Central to the establishment of a lunatic asylum in Grahamstown was, as Melanie Giddens suggests, the town's civic pride, which had engineered the transition from a small "ragged military encampment"⁷⁶ to a mercantile centre with a thriving population of

⁷³ Sampson, "The Campaign", pg. 96.

⁷⁴ *Ibid.*

⁷⁵ This changed slowly from 1875 onwards: Valkenberg Hospital was established in 1891, Port Alfred Asylum in 1888, and Fort Beaufort Asylum in 1894 (Sally Swartz, "The Black Insane in the Cape", pg. 399 – 400); Harriet Deacon, "Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town", *Journal of Southern African Studies*, 22, 2, 1996, pg. 294.

⁷⁶ Marshall, "Grahamstown 1812 – c. 1845", pg. 42.

merchants and artisans⁷⁷ who could potentially become more economically and politically powerful than the existing landed elite.⁷⁸

In many ways, Grahamstown had ceased to be a 'frontier town' by 1832, despite being located in a frontier region. Instead, it was – at least for its 'white' inhabitants – a solidly middle-class village; as Giddens observes, “there appears to have been a consensus of belief in a common moral code based on the Christian ethic, duty, self-respect, work and charity” – in effect, a transplanted Victorian ethos.⁷⁹

Although hardly the economic powerhouse it had been before the wool-market slump of the 1860s, the town nevertheless had the civil structures, social ambition, and medical practitioners necessary to facilitate the establishment of an asylum. It also, crucially, had a number of empty military buildings, which could be converted into an asylum, thus avoiding the expense of constructing a new building; consequently the town was recommended as a site in 1872.⁸⁰ This timing was not merely fortuitous: from the 1870s onward, the Cape Parliament enthusiastically legislated on many medical and public health matters, including rabies, leprosy, the regulation of the medical profession, contagious diseases, and lunacy itself.⁸¹

In 1873 the colonial government allocated a sum of £1500 to purchase the abandoned Fort England and convert it into suitable accommodation for an asylum, which was opened in 1875. This conversion would take time, as the buildings were slowly modified from basic barracks to wards, day rooms and dormitories.

⁷⁷ Marshall, “Grahamstown 1812 – c. 1845”, pg. 72. The party-leaders, a group made up of “gentlemen” and their families, had not migrated into town, preferring to stay on their allotted land and eke a living from agriculture. Despite this, they regarded Grahamstown as the region's social and cultural centre. (Marshall, “Grahamstown 1812 – c. 1845”, pg. 70).

⁷⁸ Scott, “An Approach”, pg. 115.

⁷⁹ Giddens, “Grahamstown 1862 – 1882”, pg. 21.

⁸⁰ Giddens, “Grahamstown 1862 – 1882”, pg. 114.

⁸¹ Sally Swartz, “Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920”, Unpublished PhD thesis, University of Cape Town, 1996, pg. 1.

Although the Asylum would later become one of three asylums in the western half of the Eastern Cape alone, in 1875 it was the only one in the Colony's eastern reaches. In the 1850s and 1860s, the urban areas of the eastern Colony expanded rapidly due to the region's successful wool-farming economy, assisted by economic injections courtesy of the diamond-mining boom of the later 1860s. Port Elizabeth, King William's Town and Grahamstown all expanded significantly in physical size and population during this period. However, the establishment of a solid civil society in the former Eastern Frontier region followed a long period of conflict in the area; colonial expansion and territorial consolidation had come at the price of a series of Frontier Wars and the Cattle-Killing of 1856-7, with the result that the area's rates of poverty and vagrancy among the black population had increased sharply. At the same time, people of all racial classifications and social classes entered the Colony to take advantage of the area's economic expansion. As with all economic expansion, widespread change occurred in the affected area, disrupting existing social networks and community strategies for dealing with social difference and deviance; the ways in which families had dealt with their insane members changed. It became less feasible to confine them at home.

The Design and Location of the Grahamstown Asylum

The Grahamstown Asylum met the first requirement of asylums administered according to the tenets of the system moral treatment⁸² that governed the establishment of asylums in Britain and British colonies in the later nineteenth century: it had a pleasant, elevated site on the semi-rural edge of Grahamstown. The original buildings on the site were military barracks on rising ground at the southern edge of town. A map of Grahamstown drawn in 1834 shows the barracks surrounded by open plots, commonage and farmland stretching along the banks of the Kowie River. A map drawn by Grahamstown's City Electrical Engineer's Office in 1932 shows that in the intervening 100 years, Grahamstown had not expanded much towards the Asylum – although residential streets had spread up to the perimeter of the Asylum grounds, the country to the east was still open, as were the slopes behind the Asylum. Although the philosophy of moral treatment had fallen out of general use by the early 1900s, the Asylum nevertheless continued to provide congenial surroundings to those within. The Asylum grounds, over the period 1875 to 1905, were extended to the south-east, providing extensive grounds and gardens. As the Grahamstown Asylum was not purpose-built all of a piece but

⁸² For a discussion of moral treatment, see Chapter 2.

rather developed from an existing building that was *not* designed as a therapeutic space in the first place, expansion caused a patchwork of architectural styles.

According to Andrew Scull, the corridor model was the most prevalent asylum design in British Asylums until the 1860s. Under that schema, the central parts of the building housed administrative offices and indoor recreational spaces, while the corridors – which doubled as dayrooms – had wards opening off them on both sides.⁸³ From the 1860s onwards, the pavilion model became more common: uniform blocks arranged either in parallel rows or echelons, with males in one block, females in another, and administration in the middle.⁸⁴ (Ironically, by the 1870s, while colonial asylums were finally adopting the pavilion model and housing large numbers of patients, asylums in the colonial metropole were returning to the smaller cottage model.)⁸⁵ Gardens, farm areas and outdoor recreational spaces were clearly well-established and easily accessible.

Asylums were spaces designed to create order. They were therefore themselves fairly ordered.⁸⁶ Elizabeth Malcolm points out that symmetry, or at least balance, in asylum design created and helped to maintain this sense of order, but also had the important function of reflecting and enabling the internal gender (and racial, and class) divisions.⁸⁷ Separate wards, dayrooms, work-spaces and dormitories enforced the separation of men from women and, in Colonial asylums such as the Grahamstown Asylum, groups of different racial classifications.

The situation of the Grahamstown Asylum was fortuitous: the old military buildings were still habitable, vacant and available, and the lobby to establish a second asylum in the Cape was seated in Grahamstown. However, the economic depression that gripped the Cape Colony between the late 1860s and early 1870s meant that the Colonial government did not have the money to pay for a bespoke asylum building to be constructed.⁸⁸ However, Felicity Swanson

⁸³ Andrew Scull, "A Convenient Place to Get Rid of Inconvenient People: the Victorian Lunatic Asylum", in Anthony D. King (ed.), *Buildings and Society: Essays on the Social Development of the Built Environment* (London, 1980), pg. 52.

⁸⁴ Scull, "Convenient Place", pg. 53.

⁸⁵ Elizabeth Malcolm, "Australian Asylum Architecture through German Eyes: Kew, Melbourne, 1867", *Health and History*, 11, 1, 2009, pg. 60.

⁸⁶ Malcolm, "Kew, Melbourne", pg. 51.

⁸⁷ Malcolm, "Kew, Melbourne", pg. 53.

⁸⁸ Swanson, "Of Unsound Mind", pg. 8.

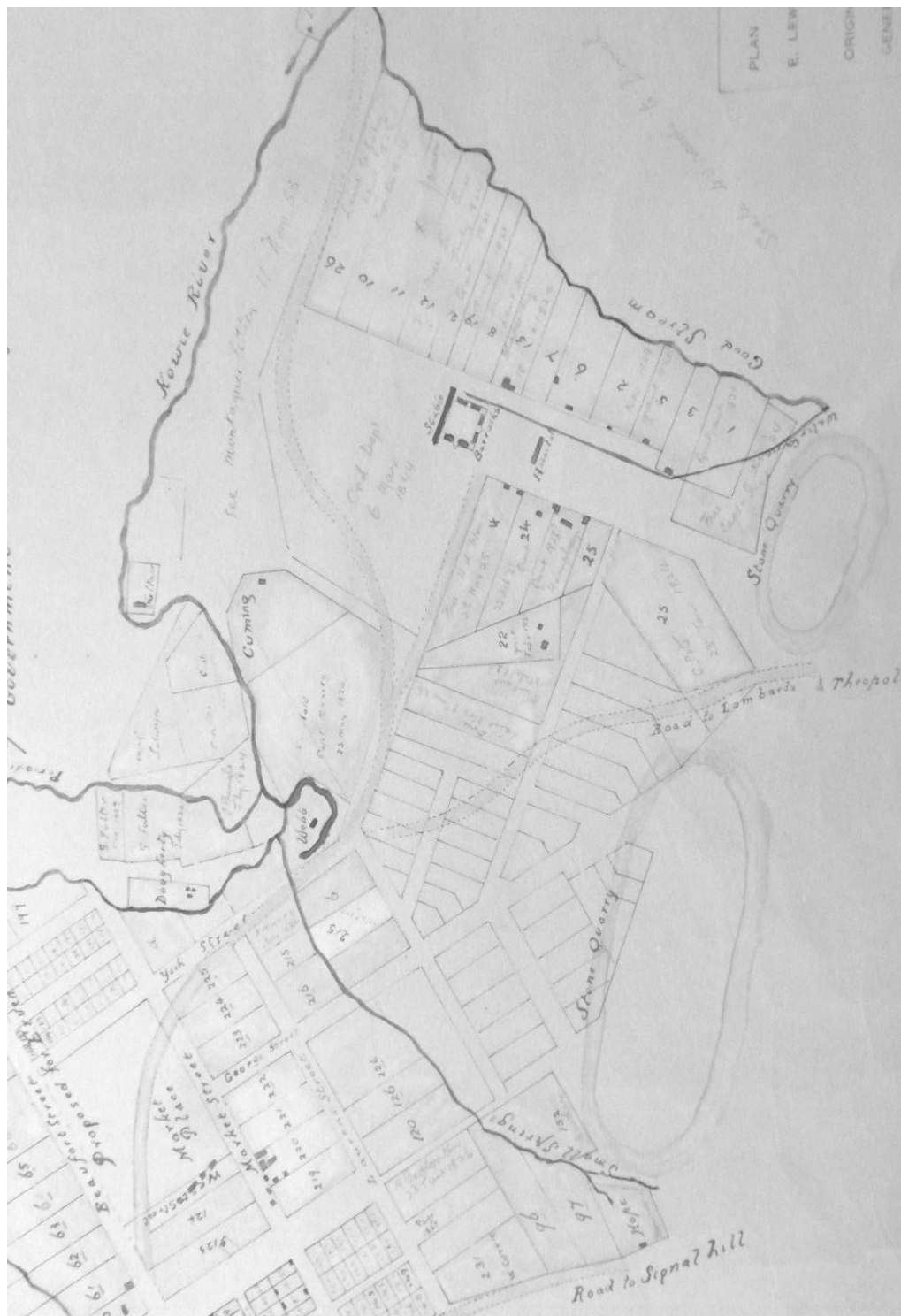
contends that the Cape government's reluctance to purpose-build asylums until the whites-only Valkenberg was constructed in Cape Town in 1891 was "indicative of the level of government interest in providing for the colony's mentally ill,"⁸⁹ that is, that the Colony was not much concerned with providing good-quality care. This is certainly part of the truth, but it is also likely that it was at least partly a matter simply of too many demands and too little money to satisfy them all, across the board, as is often the case with publicly-funded institutions of any kind. Furthermore, Swanson's assertion hold significantly more true for the period prior to 1889 than thereafter; once the Inspector of Asylums post was established and Dr William Dodds appointed to it, and the Lunacy Act of 1891 passed into legislation (see Chapter Four), provision for lunatics was much improved.

Asylums in their modern form arise from a complex system of social needs, sociocultural values and morals, humanitarian obligations, government requirements, and infrastructural limitations. Their operations are influenced by much the same set of constraints; favouritism and prejudice result from the tension that exists within this structure. This chapter has sought to understand the pre-existing social attitudes and government approaches to the treatment of the mentally ill, the system of moral treatment, and the social situation of Grahamstown. These systems combined to make up the particular nature of the Grahamstown Asylum, and were influenced on a macro-level by the prevalent philosophy of kind and equal treatment for all asylum inmates and on a local level by the social context and hierarchies of privilege in Grahamstown and the Cape Colony.

The interaction of the macro and local levels may have led to a pervasive culture of favouritism and dispossession among the Grahamstown Asylum's authorities, with considerable ramifications for those committed there. It is possible that the authorities of the Grahamstown Asylum experienced tensions between the philosophy of providing equal care to all inmates and the local tendency to regard certain groups of people as inferior and others as superior, and consequently provided inferior care and facilities to some while privileging others.⁹⁰

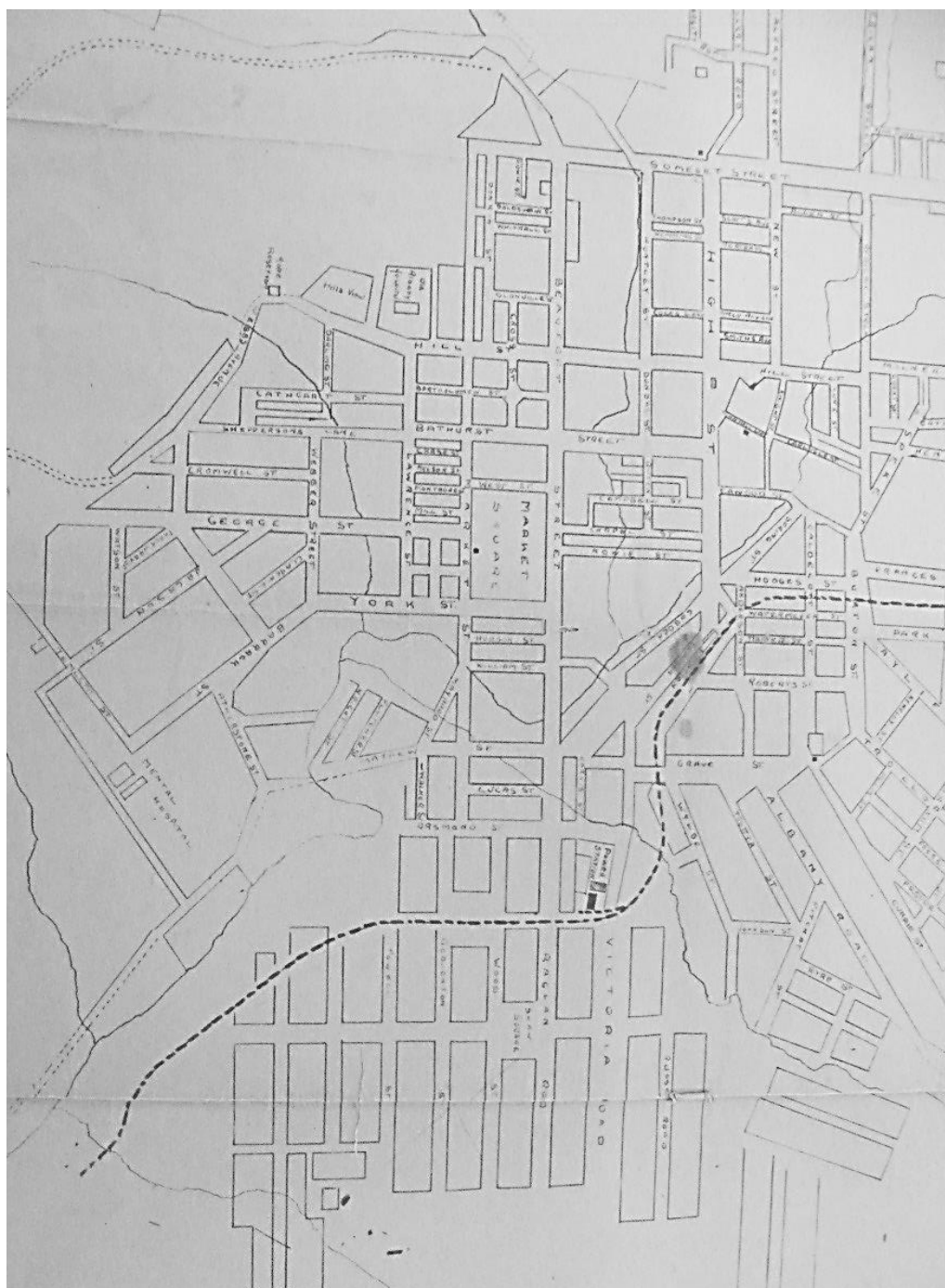
⁸⁹ Swanson, "Of Unsound Mind", pg. 9.

⁹⁰ See Chapter 6.



⁹¹ Surveyor General, Plan of Grahamstown, 1825, revised 1962, MP 485, Cory Library, Rhodes University, Grahamstown.

Map 2: Grahamstown, 1932.⁹² The asylum is on the left, just below the visible centre fold.



⁹² City of Grahamstown Electricity Scheme Map, 1932, MP 240, Cory Library, Rhodes University, Grahamstown.



Map 3: Aerial view of the Fort England Hospital, as of 2018.⁹³

Two Very Different Medical Superintendents: Robert Hullah (1875-1890) and T Duncan Greenlees (1890 – 1909)

Robert Hullah, born in 1846 to composer John Pyke Hullah and his wife Caroline Foster Hullah, grew up in London, qualified as a doctor in the 1860s, and worked as an assistant medical superintendent at Redhill Asylum for Idiots in Surrey before coming out to the Cape Colony and taking up the superintendence of the Grahamstown Asylum. The Redhill Asylum for Idiots, known after 1862 as the Royal Earlswood Hospital, was superintended by John Langdon Down, after whom Down Syndrome is named, who took the position immediately upon completing medical school in the mid-1850s. Under Down's leadership, the Redhill Asylum was

⁹³ Image via Google Maps.

transformed into a model institution of its kind. Among other things, the Redhill Asylum attempted to adhere to the principles of moral treatment, and new buildings there were designed with an eye to providing a pleasantly-designed environment for the 150-odd residents. Hullah, after being admitted to the Royal College of Surgeons in 1866,⁹⁴ would have found Redhill to be a site of fully-fledged moral treatment, and his early experiences there informed his wish for the Grahamstown Asylum to be a pleasant environment for patients. However, transplantation to the Cape Colony made some modifications to his goals inevitable.

Robert Hullah died suddenly in early 1890. In June 1890, he was replaced by Thomas Duncan Greenlees, a MB CMed graduate of the medical school of Glasgow University in 1882 who had served as the Assistant Medical Officer at the City of London Asylum at Stone before migrating to the Cape.⁹⁵ He also obtained an MD from the University of Edinburgh during his time in the Colony, graduating in 1901, when he was still Superintendent of the Grahamstown Asylum.⁹⁶ By all accounts, Greenlees appears to have been a man to whom professional success was vital. He was a prolific author of medical articles, receiving a prize from the Medico-Psychological Association, as well as being a Fellow of the Royal Society of Edinburgh, a leading figure in the South African branch of the British Medical Association, and a member of the Medical Association's Central Council. Upon his return to the United Kingdom in 1907, he became the Resident Physician and Superintendent of the Fenstanton Asylum in Streatham, London.⁹⁷ Something of a careerist, he brought to the Grahamstown Asylum a determination to increase its income and facilities, with self-sufficiency and hence a degree of autonomy in mind.

⁹⁴ List of recent graduates admitted to Royal College of Surgeons, "Medical News", *British Medical Journal*, 24 November 1866.

⁹⁵ Obituary of Dr T Duncan Greenlees, *British Medical Journal*, 9 February 1929, pg. 272. This obituary notes, also, that upon his return to the United Kingdom in 1907, Greenlees became the Superintendent of the Fenstanton Asylum in Streatham, Borough of London. He was also an active member of the British Medical Association from early in his career, being elected the South African branch of the Association's representative for the eastern and central regions, and, later in life, serving on the BMC's Central Council. He died in 1929.

⁹⁶ Obituary, *British Medical Journal*, 1929, pg. 272.

⁹⁷ Obituary, *British Medical Journal*, 1929, pg. 272.

The Origins of Internal Segregation: The Robert Hullah Era, 1875 – 1890

The Grahamstown Asylum was constructed with a view to providing care, rather than just custody, for its patients. This included, first and foremost, providing a pleasant environment within which patients could recover. This was partially successful: in early 1875, Superintendent Robert Hullah attributed the ongoing good health of the Asylum's patients to the Asylum's good physical site: high up on a hilltop, where the air was clear of smoke and surroundings were pleasant and uncrowded, both factors which were believed to aid recovery in the insane.⁹⁸

But Hullah may be expected to be somewhat biased in his appraisal of the Asylum's facilities, as he was in charge and expected to make the Asylum into a viable institution. This evidently entailed a degree of public relations management. In the Asylum's 1875 Annual Report, he praised the male wards, as "the best he had ever seen." This appraisal is selective: although Hullah did not distinguish between the white and black male wards, the former were segregated from the latter and that the latter were relatively less comfortable and well-equipped than the former.⁹⁹ He did not mention the state of the black male ward, and the was almost silent on the matter of the female wards.

The Grahamstown Asylum was not established with the intention of housing female patients, and no accommodation for female patients was provided for initially. This led to problems in accommodating female inmates right from the beginning of the Asylum's history, with temporary and jerry-rigged accommodation being set up as quickly as possible. The female wards, described as 'rooms' in the 1875 report, were overcrowded, and at night some women had to sleep in single private rooms. Hullah found this unacceptable: there was already a shortage of space in the Asylum overall, and taking up single rooms as sleeping quarters when wards should have been available meant that they would not be available to paying patients or for any patients who needed to be segregated because of violent behaviour or illness.¹⁰⁰

⁹⁸ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report of the Surgeon Superintendent of the Grahamstown Asylum for 1875*, CCP1/2/1/29, G21-'76, Western Cape Archives and Records Service, Cape Town, pg. 1.

⁹⁹ Hullah, *Report of the Surgeon Superintendent for 1875*, pg. 1.

¹⁰⁰ Hullah, *Report of the Surgeon Superintendent for 1875*, pg. 2.

In that expression of concern we see the first sign of the Asylum authorities' struggle between being a place of care, open to all, and a place where patients were more akin to fee-paying clients. Ideally, the question of where to house paying patients should have been secondary to how to provide space for existing patients, whatever their circumstances, to sleep. The problem of ensuring that there was enough space to keep paying and non-paying patients apart occupied the Grahamstown Asylum's administration from the very beginning, illuminating the issues of class and race already in force in greater society, and continuing the processes of discrimination made implicit in the Lunacy Acts.¹⁰¹

Implicit in Hullah's abovementioned concern was the assumption that non-paying patients were less welcome than paying patients, and that they were more likely to come from lower social strata than their paying counterparts. Housing inmates from poorer backgrounds carried with it the possibility that the sponsors of wealthier patients would not think it fair that they, paying patients, would receive the same treatment as people who did not have to contribute to their own upkeep. Of course, it is not impossible that these two reasons were related to one another. Another issue that concerned Hullah was that poorer patients, even on the female wards, might behave in ways that patients from wealthier social strata might find unacceptable.

This equation of economic status and race with negative behaviour is more obviously expressed in the case of the female dormitory. In that room Hullah noted, "ladies have constantly to associate with violent, degraded and *even with* [my italics] coloured patients."¹⁰² Placing 'coloured', 'degraded' and 'violent' women all on the same footing in the same sentence removes important distinctions, and implies that 'coloured' women in the Asylum were inherently less capable of proper behaviour than the white women also there. It was one thing to keep quiet patients away from violent patients; that was generally understood to be a safety precaution for both parties. But to suggest that 'coloured' patients were prone to violent behaviour hints at prejudice about black patients' (largely imaginary) poor behavioural patterns, and, in revealing Hullah's opinion that 'coloured' patients were inferior to white

¹⁰¹ See Neil Mostert's *Frontiers: the Epic of South Africa's Creation and the Tragedy of the Xhosa People* (New York, 1992), as well as the work of Sally Swartz, Melanie Giddens, and Richard Marshall.

¹⁰² Hullah, *Report of the Surgeon Superintendent for 1875*, pg. 2. The Lunacy Acts are discussed in Chapter 4.

patients, hints at a pattern of administrative prejudice that would later become much more obvious.

Deprivation in an asylum can, as will be seen in this and subsequent chapters, take many forms, but as mentioned above the most obvious and enduring form (long-lasting because it stretches beyond any one inmate's term of detention) of discrimination is the provision of different accommodation for different groups. In adapting the physical facilities of the Grahamstown Asylum to accommodate different groups of patients, Asylum authorities had the choice to equip them equally. Instead, as will be illustrated, they opted not to, and began a process of implementing – in the shape of the space provided and the ways in which it was furnished, equipped and made habitable – discriminatory practices.

Given that the Asylum was only months old at the time that the report for 1875 was published in early 1876, it is unsurprising that in it Hullah notes that the Asylum's staff had experienced a great deal of difficulty in adapting the buildings, which had formerly been barracks, to their new purpose: they had barely had time to do so. There were no recreational spaces to ensure that patients could get exercise in the Asylum's precincts without needing to be constantly attended by staff, as the fencing was not adequate to prevent escape or wandering off. The lack of space was especially problematic because some patients – those displaying what the report terms 'excitement', presumably manic, violent or threatening behaviour – had to be kept separate from those of more placid demeanour. In the airing court, an outdoor area, 'excited' patients would be kept in an area cordoned off from the others.¹⁰³ This meant that staff had to be set to maintain the spatial segregation, and monitor the effect that the upset inmates had on the others, as well as forestall any attempts to move from one group to the other.

These problems would persist, but by 1876, the Asylum's physical space had expanded and been made more habitable. They were also now more acceptable to the sensibilities of those who wished the different classes of patients to be separated. The patients' sleeping quarters had been re-organised to separate paying and non-paying patients, which, it was believed, would assist the appearance and conduct of both groups of patients. Here we see a clear

¹⁰³ Hullah, *Report of the Surgeon Superintendent for 1875*, pg. 2.

correlation being drawn, by the Asylum's Medical Superintendent, between wealth and conduct. Asylum doctors believed this segregation to be helpful in effecting an improvement in patients' conduct; the same was true of Hullah's decision to separate patients' sleeping quarters from dayrooms.¹⁰⁴ The 1876 Annual Report makes no mention of the need to segregate white from black patients, but dwells on the issue of separating paying patients from unpaying patients. It can probably be taken as read that separation by class of patient included separation by race.¹⁰⁵ As was the case in all Cape asylums, in the 1870s as well as in the 1880s when the system expanded, black and white patients were kept separate, just as men and women were.

The returns of the 1865 Census of the Colony of the Cape of Good Hope¹⁰⁶ divided the region's population into "European", "Hottentot", "Kafir" and "Other" – evidence that racial classification was a preoccupation of Colonial officialdom for at least ten years before the Grahamstown Asylum was established. However, it is not enough to say that the Asylum's officials were simply reflecting governmental practice by segregating the Asylum's residents. Classification does not inexorably lead to segregation, and indeed, *de facto* racial segregation can occur – under different labels¹⁰⁷ – even where classification is discouraged.

Appended to the Medical Superintendent's report from 1877 is an extract from the Visitors' report for that year, which confirms that the male wards were separated according to racial classification and sex, as well as whether or not the patient was a fee-paying patient or state-supported. The closing paragraph of their report states that "[w]e consider that it would be desirable, if practicable, to have some further communication of the inmates, and should have preferred to have seen the coloured people separated from the white people", although they did add that "the arrangement of the building...seems to make this difficult."¹⁰⁸ It should be

¹⁰⁴ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report of the Surgeon Superintendent of the Grahamstown Asylum for 1876*, CCP1/2/1/33, G22-'77, Western Cape Archives and Records Service, Cape Town, pg. 2.

¹⁰⁵ Hullah, *Grahamstown Asylum 1876*, pg. 2.

¹⁰⁶ *Census of the Colony of the Cape of Good Hope 1865*, accessed via the Hathi Trust Digital Library, <https://babel.hathitrust.org/cgi/pt?id=uc1.l0074071051>.

¹⁰⁷ For example, in cases where socioeconomic status and access to infrastructure more or less coincide with racial divisions, for example the current South African public health, school and welfare systems.

¹⁰⁸ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report of the Surgeon Superintendent of the Grahamstown Asylum for 1877, together with the Report of the Visiting Committee to that Institution for the same period*, CCP1/2/1/35, G24-'78, Western Cape Archives and Records Service, Cape Town, pg. 5.

noted that the remarks at issue here are those of the Asylum Visitors rather than of the Superintendent himself. This attitude may have been influenced by the behaviour of some patients the Asylum Visitors¹⁰⁹ observed while touring the Asylum: in the female ward of the Chronic Sick Hospital, attached to the Asylum, a 'Hottentot' woman reportedly used such offensive language that the Visitors had to leave the room. In the female dining hall later the same day the behaviour of the same woman— she is described as a "Hottentot virago"¹¹⁰ — made them note that they "could not but regret that comparatively quiet women should have to associate with such a character". This woman's behaviour is detached from her mental disorder, and ascribed to her racial classification: she is not yelling because she may be experiencing hallucinations or delusions, the Visitors' Report implies, but rather because she is a Hottentot. In making this unfounded association, she ceases to be an object of sympathy or empathy and instead becomes one of distaste.

Apart from the issue of keeping the various races at an appropriate physical and social distance from one another in order that black patients did not disturb the sensibilities of white patients,¹¹¹ the behaviour of all patients was a concern to the Asylum's staff. The Visitors note that those patients deemed to be 'refractory' were confined in single rooms overnight.¹¹² These rooms were situated on the male side of the Asylum, and opened onto the single corridor that bisected it, which, because the Asylum was cramped and crowded, was the same space used for the male patients' meals. Presumably this would have been an inconvenience rather than a problem if not for the Visitors' observation that as "the refractory patients [were] often very uncleanly [*sic*] in their habits, we should have expected that their sleeping arrangements would have been altogether separated from the room in which male patients take their meals."¹¹³ This uncleanness was especially worrying as the male side of the Asylum was also undersupplied with sinks, basins and lavatories.

The layout of the wards was geared towards keeping the various groups of inmates apart. On the female side, the dormitory, sitting-room (where paying female patients took their meals) and dining-room (where non-paying female patients took their meals) occupied the ground

¹⁰⁹ A group of Grahamstown doctors and civil worthies, including W.G. Atherstone. This body, however, had no real power to force change, and could only make suggestions.

¹¹⁰ Hullah, *Grahamstown Asylum 1877*, pg. 4.

¹¹¹ And we know from earlier chapters that disruptive behaviour knows no race or class.

¹¹² Hullah, *Grahamstown Asylum 1877*, pg. 3.

¹¹³ *Ibid.*

floor, while the second floor was divided into two “clean, airy and well-ventilated dormitories,” one for white men and the other for coloured men. The half of the ground floor demarcated for males held the corridor-cum-dining hall and, opening off that, a number of small rooms used by the ‘refractory’ patients of both sexes.¹¹⁴ This layout was, apparently, intended to keep the paying and non-paying, male and female, well-behaved and disruptive patients separate. Dr WG Atherstone, one of the Asylum Visitors, noted that the apparently undesirable state of the Asylum was the result of the fact that three of the four groups it housed were not originally intended to be there, and motivated for rapid expansion:

[In] the incipient stages of a progressive institution¹¹⁵ like this, temporary arrangements have to be made to meet the requirements as they arise...The inconvenience alluded to, and the apparent defective state of this ward, only shows the necessity for proceeding with the second wing so soon as the necessary funds are available.¹¹⁶

In 1878, Hullah turned over a mess hall originally built for the storekeeper division’s staff to the coloured men’s division, to be used as a dining hall, when it proved too small for the original purpose. Hullah’s report for the year, noting this, goes on to add that no new buildings had been constructed despite being very badly needed, particularly to accommodate non-paying patients.¹¹⁷ The same Annual Report includes the suggestion that paying male patients might be accommodated in a house purchased near the Asylum.¹¹⁸ An underlying concern among Asylum authorities was the provision of accommodation for male paying patients in such a form that they were exposed to as few of the Asylum’s other patients as possible. It is notable that the two changes to the fabric of the Asylum mentioned in the 1878 report seem to have been intended to remove less-favoured groups from the vicinity of the white male patients, even to the point of allowing them to occupy newer parts of the Asylum. There were 15 black male inmates, compared to 17 white males, which makes it somewhat unlikely that the former storekeepers’ mess became the coloured men’s dining-hall because it was too small to accommodate the white men. Likewise, the non-paying patients would in time occupy the new wing, at least in theory. This was a change apparently made to increase distance

¹¹⁴ *Ibid.*

¹¹⁵ The Asylum was considered progressive owing to its philosophy of kind treatment, and possibly also simply because it provided better facilities and care than did Robben Island, the only institution in the Cape to which it could be compared.

¹¹⁶ Hullah, *Grahamstown Asylum 1877*, pg. 5.

¹¹⁷ Hullah, *Grahamstown Asylum 1878*, pg. 1.

¹¹⁸ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report on the Grahamstown Lunatic Asylum for 1878*, CCP1/2/1/39, G31-’79, Western Cape Archives and Records Service, Cape Town, pg. 1.

between the groups rather than simply a decision based on making the best use of available facilities.

The segregation of asylum facilities was the norm in British colonial asylums of the time. At the Natal Government Asylum, established in 1877 in Pietermaritzburg in the neighbouring colony of Natal, the living quarters were racially segregated right from the very beginning. Men and women were, furthermore, housed in separate wings, though they shared dining rooms and recreational areas.¹¹⁹ The superintendent of the Natal Government Asylum, Dr James Hyslop, noted that he believed that keeping contact between black and white patients was in and of itself beneficial to the state of mind of black patients.¹²⁰

Hullah was very much in favour of purchasing properties in the vicinity of the Asylum rather than 'patching' the existing buildings or waiting for new ones to be built.¹²¹ When Hullah explicitly stated this in the 1879 report,¹²² a large part of his motivation seemed to be to improve the accommodation of white male paying patients. Of course, the construction or at least acquisition of new space for wealthier white male patients would open up more space in the existing buildings. This was a significant point of pressure for the Asylum: continued intakes of patients and delays in obtaining Government funding for constructing new wards meant that overcrowding was becoming a problem. In particular, a new female wing was needed,¹²³ partly because more women were being admitted overall, and partly because the number of male admissions was also rising,¹²⁴ and by moving the female patients into a different building, more space would be left in the original Asylum building for male patients.

The Asylum had been constructed by the Grahamstown Civil Commissioner's Offices with a maximum patient body of 72 in mind. This was the number of patients that the existing buildings could house; the planners had intended all 72 patients to be white males. By the end

¹¹⁹ Julie Parle, *States of Mind: Searching for Mental Health in Natal and Zululand, 1868 – 1918* (Scottsville, 2007), pg. 97.

¹²⁰ Parle, *States of Mind*, pg. 98.

¹²¹ Hullah, *Graham's Town Lunatic Asylum 1878*, pg. 2.

¹²² Robert Hullah, "Grahamstown Asylum 1878", pg. 20; Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report on the Grahamstown Lunatic Asylum for 1879*, CCP1/2/1/43, G53-'80, Western Cape Archives and Records Service, Cape Town, pg. 2.

¹²³ Hullah, *Graham's Town Lunatic Asylum 1879*, pg. 2.

¹²⁴ *Ibid.*

of 1880 the Asylum already housed more than 100 patients.¹²⁵ Overcrowding had progressed until several female patients had to be turned away “to the great inconvenience of themselves and their friends.”¹²⁶ That the Asylum was full to capacity was not only problematic for potential patients in the immediate vicinity who needed to be admitted somewhere, but to any in the Eastern Districts of the Cape Colony. At the time, no other asylums existed in the region,¹²⁷ and Robben Island was both very distant and overcrowded.

By 1881, however, the problem overcrowding was somewhat ameliorated. The Chronic Sick Wards had been separated from the main body of the Asylum and moved to another site, and the former chronic sick wards became the female wards. This increased amount of space became available at the same time as Hullah’s renewed his quest to acquire new space for paying patients.¹²⁸ These patients, however, Hullah notes, paid too little, and as the Government seemed unlikely to come up with money for new construction, it seemed that the funds for making any large-scale changes to the Asylum’s physical plant would have to be funded by private enterprises. The Superintendent made particular mention of the unsatisfactorily low paying patients’ fees in his Report; in the same pages he stated that it seemed unfair that they should pay more but still associate with non-paying patients. At this time, the Asylum made no provision to enable black patients to contribute to their own upkeep by paying fees, so perforce no direct income could be derived from them. This therefore put all black patients in a position where they were implicitly regarded as drains on the Asylum’s resources, especially compared to white patients and paying patients.¹²⁹

By 1885, the overcrowding problem was temporarily solved, despite the fact that repairs and expansions had not been effected and no solution to the problem of segregating races and paying from non-paying patients had been implemented.¹³⁰ The respite, however, was temporary – by 1886, Hullah’s annual report stated that “very shortly it [would] be necessary

¹²⁵ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report on the Grahamstown Lunatic Asylum for 1880*, CCP1/2/1/39, G31-’81, Western Cape Archives and Records Service, Cape Town, pg. 1.

¹²⁶ Hullah, *Grahamstown Lunatic Asylum 1880*, pg. 1

¹²⁷ Hullah, *Grahamstown Lunatic Asylum 1880*, pg. 1

¹²⁸ Hullah, *Grahamstown Lunatic Asylum 1880*, pg. 1

¹²⁹ Swanson, “Of Unsound Mind”, pg. 134.

¹³⁰ Robert Hullah, “Part VI: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1885*, CCP1/2/1/67, G2-’86, Western Cape Archives and Records Service, Cape Town, pg. 1.

to refuse admission to any more [patients]; now this painful course has not been necessary for the last three or four years.”¹³¹ Further complicating matters was that measures to keep costs down had led to the unpleasant compromise where overcrowding had resulted from the lack of expenditure on new housing, and there were not enough staff to run the Asylum as efficiently as Hullah would have liked. At some point in the early 1880s, the dining hall had been converted into a ward. This was a definite step backwards – the switch deprived patients both of a designated place to take their meals (which were now eaten in the wards, causing difficulties not only in the serving of food and keeping order during meals, but also in keeping the wards clean) and of a space for recreation.¹³²

As the 1880s progressed, the overcrowding in the Asylum caused the death rate to rise and the recovery rate to drop to levels that Hullah considered unsatisfactory (see Chapter Five). Very little space for new patients was available at the end of 1886.¹³³ This situation did not appreciably improve over the year, when Hullah once again requested, in his Annual Report, that the Government step in and assist in the construction of a new dining hall and wards, as well as expand the laundry (which had become too small to handle the volume) and provide better accommodation for the female attendants.¹³⁴ Always impatient with delay, Hullah here let his irritation show by stating that without new wards he would have to revert to the practice of keeping patients in yards (presumably only non-paying and/or black patients were made to sleep outdoors). Hullah noted that “the wards [were] even more crowded than they were last year, and can with difficulty be kept clean and sweet.”¹³⁵ He also noted that the lack of space prevented any entertainments being held in the Asylum because of the lack of a dining hall.¹³⁶ He did, however, note that a new dining hall and laundry had been slated for construction in 1889.

¹³¹ Hullah, “Grahamstown Asylum 1885”, pg. 1.

¹³² Hullah, “Grahamstown Asylum 1885”, pg. 1.

¹³³ Robert Hullah, “Part VI: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1887*, CCP1/2/1/71, G15-’88, Western Cape Archives and Records Service, Cape Town, pg. 1.

¹³⁴ Hullah, “Grahamstown Asylum 1887”, pg. 1.

¹³⁵ Robert Hullah, “Part 6: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1888*, CCP1/2/1/73, G5-’89, Western Cape Archives and Records Service, Cape Town, pg. 19.

¹³⁶ Hullah, “Grahamstown Asylum 1888”, pg. 19.

The year of 1889 held change for the Asylum. Not only was it to be Hullah's last year as Medical Superintendent, but it also saw the establishment of the Port Alfred Asylum, which was, by Hullah's reckoning, likely to remove some of the pressure on Grahamstown's overcrowded facilities. Many long-term patients believed to be incurable had been transferred there from the Grahamstown Asylum, opening up considerable space at Grahamstown Asylum and somewhat relieving the overcrowding (and incidentally also changing the shape of the year's statistical returns by lowering the number of incurable cases occupying the Asylum's halls).¹³⁷ Despite this, Hullah's report stated that yet more space was needed for new admissions, particularly black males, many of whom had to be turned away pending the construction of new wards.¹³⁸ Much to Hullah's chagrin, however, although new construction was slated to begin, it did not, and indeed he died before seeing his plans come anywhere near fruition.

The method of admitting patients to Port Alfred Asylum did not do much to relieve the pressure on Grahamstown Asylum; it was intended to provide accommodation "of a simple character" for about 100 patients who were deemed irrecoverable, mainly those suffering from dementia and chronic-sick cases.¹³⁹ Patients at Port Alfred had to pass through Grahamstown Asylum first, as direct admissions were not possible.

Although there were now four asylums in the Cape Colony, they were effectively at opposite ends of the country: Port Alfred and Grahamstown, barely 80km apart on the Eastern Frontier, with Robben Island and the Old Somerset Hospital almost a thousand kilometres away at the Cape, with none in between. Those lunatics not accommodated in actual asylums or cared for at home often resided in gaols, assuming that they had come to that attention of the authorities at all.¹⁴⁰ The need for expanding asylum accommodation was therefore a primary concern for the newly-appointed Inspector of Asylums, Dr William J Dodds, from the outset.

¹³⁷ Robert Hullah, "Part 6: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1889*, CCP1/2/1/77, G29-'90, Western Cape Archives and Records Service, Cape Town, pg. 27.

¹³⁸ Hullah, "Grahamstown Asylum and Chronic Sick Hospital 1889", pg. 7.

¹³⁹ WJ Dodds, "Part 3: Inspector of Asylums", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1889*, CCP1/2/1/77, G29-'90, Western Cape Archives and Records Service, Cape Town, pg. 11.

¹⁴⁰ Dodds, "Inspector of Asylums 1889", pg. 11.

Dodds, who was also the Superintendent of the newly-established Valkenberg Asylum in Cape Town, inspected the Grahamstown Asylum for the first time in September 1889, and felt that although the overcrowding was a concern, Hullah was managing well. He noted that the female wards were clean and nicely kept, but that the male wards were less so, especially the black male ward, where 59 men were in a room with only 43 beds. On the female side, 26 women were accommodated in 18 single rooms.

In this report, Dodds also noted that the Grahamstown Asylum's sanitary arrangements were not satisfactory, as white and black males shared the same latrines and airing court, which were situated on the black male side of the Asylum.¹⁴¹ There is of course no medical reason to insist on separate ablution facilities, and therefore this insistence must have been based on racially-based prejudicial social conventions rather than anything else. The only real objection one can think of, one which is not in fact included in Dodd's thoughts on the matter, is that white men might have had to walk slightly further to the latrines than would have been ideal. The objection voiced here, however, was not this, but rather that the men of two different races had to share facilities.

The Entrenchment of Favouritism: The Superintendence of T Duncan Greenlees, 1890 – 1905

In his very first Annual Report, that of 1890, the newly-appointed Medical Superintendent, Dr Thomas Duncan Greenlees stated outright that he wanted to increase the number of patients of a "better class" admitted, when they were "at an early stage of insanity, a time when the chances of recovery under proper treatment [were] greatest."¹⁴² He hoped that this would make the Grahamstown Asylum a hospital for the treatment of acute and recoverable cases of insanity, rather than a holding-pen for patients with poor prognoses (most of which Greenlees preferred to send to Port Alfred Asylum or, later, Tower Hospital in Fort Beaufort).¹⁴³ It may be that Greenlees saw the Grahamstown Asylum as fertile ground for the practice of model

¹⁴¹ T. Duncan Greenlees, "Part 6: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1890, part VI: Grahamstown Asylum and Chronic Sick Hospital*, CCP1/2/1/79, G37-'91, Western Cape Archives and Records Service, Cape Town, pg. 15.

¹⁴² Greenlees, "Grahamstown Asylum 1890", pg. 42.

¹⁴³ *Ibid.*

institutional care, at least for some, and it would have been in the interests of his career to create such an asylum. 1891 saw the largest number of patients admitted since the establishment of the Asylum in 1875: 91 patients entered the Asylum, and although many of these were discharged shortly thereafter, the Asylum was nevertheless filled to capacity.¹⁴⁴

Especially challenging, in Greenlees' opinion, was the demand for asylum accommodation for black males, the presence of whom meant that quiet but chronically insane inmates of the Grahamstown Asylum had to be transferred out, rather than kept at the Asylum where their fees might go towards expenses.¹⁴⁵ In the Annual Report for 1891 Greenlees noted that the method of securing a bed for acutely-affected lunatics by transferring more settled cases to other asylums was not ideal because it did not really solve the issue of asylum space on a Colony-wide scale. This was true enough. Moreover, Greenlees pointed out that the Government would eventually have to face the reality that more asylums were needed, both to ensure that the various groups were kept separate and to facilitate the admission of lunatics to asylums rather than leaving them languishing in gaols.¹⁴⁶ Nevertheless, few major changes were made at the Grahamstown Asylum in 1890; the number of single rooms was increased, and a number of minor alterations were made to equip the Asylum for the treatment of acute or recently-developed cases of insanity.¹⁴⁷ Much needed as these changes were, they did not significantly alleviate the pressure increased admissions had placed on the Asylum, especially in terms of space for male patients.

Between 1880 and 1891, the population of Grahamstown Asylum increased from 53 men and 29 women to 124 men and 73 women,¹⁴⁸ which illustrated the urgency of constructing or purchasing new wards or housing. While the size of the patient body had doubled, the number of beds had not. At the same time, however, the Asylum's income from fees paid by private patients had increased by £500, and Dodds noted that this "show[ed] the growing

¹⁴⁴ Greenlees, "Grahamstown Asylum 1891", pg. 38.

¹⁴⁵ *Ibid.*

¹⁴⁶ WJ Dodds, "Part 3: Inspector of Asylums", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1890, part VI: Grahamstown Asylum and Chronic Sick Hospital*, CCP1/2/1/79, G37-'91, Western Cape Archives and Records Service, Cape Town, pg. 10.

¹⁴⁷ Dodds, "Inspector of Asylums 1890", pg. 12.

¹⁴⁸ WJ Dodds, "Part 17: Inspector of Asylums", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1891, part VI: Grahamstown Asylum and Chronic Sick Hospital*, CCP1/2/1/82, G36-'92, Western Cape Archives and Records Service, Cape Town, pg. 96.

favour of the Asylum in the Eastern Districts and elsewhere, and an increasing disposition to take advantage of its curative agencies.”¹⁴⁹ Greenlees was succeeding his aim of improving the Asylum’s reputation as a place of healing, at least among his fellow Colonial medical practitioners and wealthier sectors of white Colonial society.

Despite this, the Grahamstown Asylum was becoming overcrowded, posing practical and administrative problems. While Greenlees’ report for 1891 listed the improvements made to the Asylum by the Government’s Public Works Department, none of them made significant difference to the issue of overcrowding. Bathrooms and lavatories had been installed on the white male side of the Asylum, telephonic communication had been established between the Medical Superintendent’s house and the Nurses’ Home, several private rooms had been furnished for paying patients, and six new rooms were added to the female quarters of the Asylum.¹⁵⁰ Only the last of these did anything to address the overcrowding, and even then, Greenlees’ was unsatisfied. While he did appreciate these additions, he noted pointedly that he trusted that a start would soon be made on the new dining-hall, recreation hall, and kitchen.¹⁵¹

The Grahamstown Asylum’s income from paying patients had increased from £1150 in 1890 to £1689 in 1891, and this income was put into the Asylum’s general account to offset expenditure.¹⁵² The degree to which private patients were considered preferable to non-paying patients is indicated by Greenlees’ suggestions that this income be ploughed back into a building fund, as was done in the English county asylum system, which would allow the Asylum to arrange its own construction and improvements without waiting for the Government to vote to allocate funds.¹⁵³ This suggests that some of the income derived from paying patients subsidised non-paying patients.

¹⁴⁹ Dodds, “Inspector of Asylums 1891”, pg. 104.

¹⁵⁰ T. Duncan Greenlees, “Part 6: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1891, part VI: Grahamstown Asylum and Chronic Sick Hospital*, CCP1/2/1/82, G36-’92, Western Cape Archives and Records Service, Cape Town., pg. 40.

¹⁵¹ Greenlees, “Grahamstown Asylum 1891”, pg. 40.

¹⁵² Greenlees, “Grahamstown Asylum 1891”, pg. 42.

¹⁵³ *Ibid.*

Patients at the Grahamstown Asylum were distinctly classified by both race and sex, although not perhaps to the satisfaction of the newly-established Inspector of Asylum's office. William J Dodds, making his first inspection in June 1891, stated that further levels of classification were needed, because at that stage all white patients were kept together regardless of 'class' and type of insanity. Interestingly, Dodds did not advise that further classification was needed among black patients.¹⁵⁴ However, he did go on to say that once the Grahamstown Asylum had black male wards available, Greenlees would be able to make a "racial and to some extent a mental classification."¹⁵⁵ The classification of patients was crucial to the effective deployment of moral therapy: only by existing in an improving environment could patients recover, and mixing disruptive patients with calm ones or, indeed, patients of different races or classes was believed to disrupt environments, rendering them chaotic and un conducive to recovery (as was commonly believed, as indicated by the remarks of James Hyslop of the Natal Government Asylum). Given these as well as earlier observations about the presumed disruptive behaviour of black patients relative to that of white patients, the main concern was to make sure that white patients received the full benefit of this environment, with the peacefulness of the black wards perhaps being less of a concern. This suggests that the attitude of asylum authorities towards white patients was curative or kindly custodial, while that towards black patients remained an uneasy hybrid of curative and carceral.

That the wards were somewhat crowded was indubitable: in the male wards, Dodds notes, the beds were too close together, while the female side had only recently acquired enough space so that it was no longer necessary to put two women into each single room.¹⁵⁶ This improvement had taken place despite the conversion of one female dormitory into a dayroom for convalescent and "better class" patients. This conversion suggests that there were some sort of classification already in operation among the white patients.¹⁵⁷ A dayroom is not more important than adequate space to sleep, but seems to have been considered enough of a necessity to justify replacing the dormitory. It should be noted that it appears that all groups had their own dayrooms, evidence of ongoing segregation inside the Asylum not based on the type or degree of insanity or apparently on non-paying/paying status.

¹⁵⁴ Dodds, "Inspector Of Asylums 1891" Pg. 110.

¹⁵⁵ *Ibid.*

¹⁵⁶ Dodds, "Inspector Of Asylums 1891" Pg. 111.

¹⁵⁷ Dodds, "Inspector Of Asylums 1891", Pg. 112.

While the issue of segregating white and black patients had retreated from the forefront of the reports in late 1880s and early 1890s, it is still possible to discern the traces of the original levels of concern. One instance of this was the aforementioned dayroom, apparently reserved for patients of higher social status; it is possible that “better-class” meant “paying” (or at least “wealthier”), and that these women were probably white and presumably middle-class. Further, in the 1891 Annual Report, Greenlees discussed at some length the improvements effected to the Asylum fabric by the newly-constituted artisan group (two “artisan attendants”, assisted by patients). Among these were included improvements to the “female native” dayroom, which had been cemented to a height of six feet to replace the previous plaster which had not withstood “the destructive tendency of the patients.”¹⁵⁸ The particular mention of this issue of plaster and brickwork is telling. No mention is made of this occurring in any other dayroom. While it is possible that this dayroom was the only one with defective plaster that subsequently came off when scratched, it is difficult to explain the observation that this was due to the “destructive tendencies” of the room’s users rather than more prosaic causes as anything other than racist. Indeed, such an observation probably stems from pre-existing assumptions about the behaviour that could be expected from black patients.

Writing in early 1893, Greenlees noted that while the Public Works Department had not made any progress on the construction of the long-awaited dining hall and kitchen,¹⁵⁹ the in-house crew of artisans had fitted marble mantelpieces to the “ladies and gentlemen’s rooms,” and installed fireplaces in all wards.¹⁶⁰ Irrespective of these improvements, Greenlees said, there was still a pressing need for more single rooms because “from the habits of the insane natives, I should really require to use a single room for each case.” It will be noted here that Greenlees evidently considered the behaviour of black patients to be much worse, in all respects, than that of white patients. He would have liked separate rooms for white patients to make them comfortable, with the aim of making living conditions good enough to make paying fees for

¹⁵⁸ Greenlees, “Grahamstown Asylum 1891”, pg. 40.

¹⁵⁹ T. Duncan Greenlees, “Part 6: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1892*, CCP1/2/1/84, G17-’93, Western Cape Archives and Records Service, Cape Town, pg. 16. They had also finally installed underground drains, but using the wrong kind of pipe.

¹⁶⁰ Grahamstown winters are by no means the most severe in South Africa, but winter overnight temperatures can drop to 0° and daytime temperatures often hover at 10° or so for days on end. Snowfall is rare but not unknown. Spring and Autumn are both often rainy, and the region can see nocturnal maximum temperatures reaching only into the high teens well into September. Spending time in stone or brick uncarpeted rooms without fireplaces would have been uncomfortable.

upkeep seem like a reasonable outlay. Conversely, in this schema black patients required separate rooms because this made them easier for attendants to manage. Later in the same report, in a section detailing the years' injuries and accidents, he describes the difficulty, as he saw it, of preventing "native insane" from doing damage to the Asylum's facilities, because: "They have no knowledge of the value of property, and their ideas with regard to clothing are so primitive, that their destructive tendencies are excessively developed when their minds give way."¹⁶¹ It is likely that the Asylum attendants and medical staff also regarded the black patients' supposed "ideas with regard to clothing" to be distressing to white patients. It is also telling that the word "accident" is used even to describe incidents that were clearly at least partly deliberate: by naming an accident, it becomes impossible to impart malice to it. Swartz notes that this "transforming fiction" transmuted the violence of one person against another – be they patients, nurses or attendants – into something unintentional and therefore relatively inoffensive.¹⁶² In this way, the narrative of therapeutic psychiatry and moral treatment was sustained: if no deliberate violence occurred in an asylum, that asylum was perforce a calm, peaceful and kind environment.

By 1893, the Grahamstown Asylum housed approximately 190 patients (a daily average of 197, according to the years' Inspector of Asylums reports)¹⁶³ but could house a maximum of only 200.¹⁶⁴ Despite this, there was still no expansion in the physical plant of the Asylum. The Public Works Department built a wall around the female division, but nothing else. Greenlees admitted, however, that money had finally been allocated towards the construction of a dining-hall, laundry, and "cottage for imbeciles" (which would later become the Institute for Imbeciles).¹⁶⁵ The lack of increased accommodation was a continued vexation to Greenlees, who wrote, "That so many insane patients...many violent and dangerous, should be congregated together in a building so unsuited...for this purpose...is surely a matter for which

¹⁶¹ Greenlees, "Grahamstown Asylum 1892", pg. 20.

¹⁶² Swartz, "Psychiatric Knowledge in the Cape:", pg. 94.

¹⁶³ WJ Dodds, "Part 18: Report of the Inspector of Asylums", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1893, part VI: Grahamstown Asylum*, CCP1/2/1/89, G24-'94, Western Cape Archives and Records Service, Cape Town, pg. 31.

¹⁶⁴ T. Duncan Greenlees, "Part 6: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1893, part VI: Grahamstown Asylum*, CCP1/2/1/89, G24-'94, Western Cape Archives and Records Service, Cape Town, pg. 48.

¹⁶⁵ Greenlees, "Grahamstown Asylum 1893", pg. 51.

we may congratulate ourselves.”¹⁶⁶ The next paragraph noted that the opening of the Fort Beaufort Asylum “should enable us to *get rid* [my italics] of all our native patients, for there is a strong feeling in this part of the Colony that European and black cases of insanity should not be treated in the same building.”¹⁶⁷ He then explained that his enthusiasm for the impending complete segregation of all black and white patients stemmed from the increased income that could be derived from paying (white) patients once the Grahamstown Asylum was divested of its black patients. To his mind, the income the Asylum derived from paying patients justified segregation because those people responsible for the upkeep of paying patients did not wish their “friends” to associate with the “native insane.”¹⁶⁸

Apart from providing Grahamstown Asylum’s authorities with somewhere to send black male patients once they had been diagnosed and stabilised, the Fort Beaufort Asylum, according to 1893 Inspector of Asylums Report, would “greatly relieve the pressure in the Eastern Districts” by freeing up the Grahamstown Asylum to become a hospital for recent and curable cases, and for better classes.¹⁶⁹ Under this new schema, the Port Alfred Asylum would receive chronically insane white patients and Fort Beaufort would become the asylum to which black patients (mostly chronically insane) were sent. Dodds added that the Grahamstown Asylum would still need a new block for acute black cases to make segregation of black and white patients possible there.

By the end of 1894, the Grahamstown Asylum was the second largest asylum in the Cape Colony, housing 199 of the Colony’s 994 certified lunatics.¹⁷⁰ The recreation hall had finally been constructed, which meant that recreations could once again be carried out on a scale large enough to include all white patients (separate entertainments were supplied for black patients).¹⁷¹ Despite all these new facilities, the Asylum still housed almost as many residents

¹⁶⁶ Greenlees, “Grahamstown Asylum 1893”, pg. 54.

¹⁶⁷ *Ibid.*

¹⁶⁸ *Ibid.*

¹⁶⁹ Dodds, “Inspector of Asylums 1893”, pg. 140.

¹⁷⁰ WJ Dodds, “Part 19: Report of the Inspector of Asylums”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1894, part VI: Grahamstown Asylum*, CCP1/2/1/92, G16-’95, Western Cape Archives and Records Service, Cape Town, pg. 146.

¹⁷¹ T. Duncan Greenlees, “Part 14: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1894, part VI: Grahamstown Asylum*, CCP1/2/1/92,

as it could hold, with a daily average residency of 199,¹⁷² and was still, Greenlees maintained, in need of separate blocks to accommodate black and white patients. As Dodds wrote, “At present it is a blot on this Hospital that the white and coloured patients are so closely associated, and let the authorities manage as they may, satisfaction will never be given to the friends of patients and the public until separate blocks for coloured patients are built.” Greenlees had finally gained government support for this segregation by raising the income from paying patients to £2000 a year¹⁷³ although he had been told that it would not be possible to reserve the income from these patients for use as a building fund. Greenlees, unsatisfied with this response, stated that the Asylum’s expenditure for 1894 would therefore be more than the Government would like, and once again reminded the authorities that “provision should be made for those cases who more than pay for their maintenance.”¹⁷⁴ This implies that the office of the Colonial Undersecretary, which administered the Asylum, did not embrace Greenlees’ segregationist schemes. However, they did not forbid Greenlees to use Asylum income solely for the betterment of white patients. For his part, Greenlees seemingly regarded the construction of new accommodation for “coloured” patients as being primarily for the benefit of white paying patients. Regarding the attitudes of these present and future patients and their sponsors, Dodds held that they not be satisfied until segregation was implemented. Greenlees further felt that wealthier patients deserved special provisions.

While the behaviour of the majority of white patients was not generally viewed as problematic (with some exceptions, discussed in Chapter Four), that of black patients often was, and, further, this behaviour was never attributed to specific individuals behaving unusually as a result of the particular manifestation of their mental disorder, but instead was characterised as a result of their race. In other words, the Asylum’s authorities believed that white patients behaved as they did because they were mad, but black patients behaved as they did because they were black. It is this misattribution of cause and effect that drove the persistent racism underlying Hullah and Greenlees’ (as well as Dodds’) ongoing efforts to segregate the Grahamstown Asylum.

G16-’95, Western Cape Archives and Records Service, Cape Town pg. 61. Recreation had come to a halt because of the lack of space.

¹⁷² Dodds, “Inspector of Asylums 1894”, pg. 146.

¹⁷³ Dodds, “Inspector of Asylums 1894”, pg. 156.

¹⁷⁴ *Ibid.*

The Grahamstown Asylum finally received the long-awaited new kitchen in 1895, which, Greenlees noted, meant that “meals can be served hot and more comfortably than under the old system”; previously, meals had been cold and difficult to prepare.¹⁷⁵ In the same year, a new administration block had begun to be constructed by the Public Works Department. This building would also provide lodging for the Assistant Medical Officer.¹⁷⁶ But as much as the kitchen and new offices were needed, the real issue still confronting the Grahamstown Asylum was overcrowding. Greenlees had asked for a block big enough to house 50 black men and also an infirmary, because “evidently it never occurred to the architect, that it was possible that a lunatic could be ill physically, and yet somehow they die.”¹⁷⁷ Without an infirmary, sick patients had to be kept on the wards with patients in good health, which resulted in the spread of contagious illnesses and, though rarely, injury.

The opening of Fort Beaufort Asylum in 1894 had not had much of an effect on the number of black males that required admission to the Grahamstown Asylum, a development which had upset Greenlees, as he wrote in the Annual Report for 1895 that,

Indeed the question of dealing with the native insane is becoming a serious one...Even admitting there is only one insane native to every ten European,¹⁷⁸ then such is the population of this Colony that at the present time there is not provision made in the Colonial Asylums for a tenth part of insane natives requiring Asylum treatment. The annexation of British Bechuanaland, a country teeming with natives, has not simplified this question much, and I would here strongly urge the increased accommodation I have asked for treatment of acute cases.¹⁷⁹

Complicating matters was Greenlees’ ongoing campaign to acquire more paying patients; income from such patients had increased, and Greenlees noted that this obligated the Asylum to provide them with better accommodation.¹⁸⁰

¹⁷⁵ T. Duncan Greenlees, “Part 2: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1895, part VI: Grahamstown Asylum*, CCP1/2/1/97, G27-’96, Western Cape Archives and Records Service, Cape Town, pg. 22.

¹⁷⁶ Greenlees, “Grahamstown Asylum 1893”, pg. 22.

¹⁷⁷ Greenlees, “Grahamstown Asylum 1893”, pg. 23.

¹⁷⁸ Greenlees’ concern here appears to be that the number of black “lunatics” would overwhelm the meagre resources the Colony had to accommodate them with. He appears to be referring to the relatively lower rates of insanity that he believed prevailed in the black population (see Chapter Three), but within the context of the large black population.

¹⁷⁹ Greenlees, “Grahamstown Asylum 1895”, pg. 25

¹⁸⁰ *Ibid.*

Much as improving the facilities for paying patients increased the Asylum's income, it was simply not the case that much more accommodation for white patients was needed in 1896. With the Asylum's average daily population risen to 221,¹⁸¹ some lunatics were turned away. All of these were black rather than white, "the pressure being confined to the native cases entirely."¹⁸² Greenlees wrote that he might have been able to handle the increased intake of black patients if he was authorised to build accommodation for 50 black patients of either sex for between £10 000 and £15 000 over the space of two years, but he was not so authorised.¹⁸³

In the same report, he once again returned to the subject of paying patients' housing. The income from this group had risen to £3129 10s, which spurred him once again to "earnestly urge" the Government to provide for better housing for 'those patients who contribute towards their maintenance.'¹⁸⁴ As the Public Works Department had spent £2986 13s 5d for many things (the new administration block, a veranda on the male side, a fire escape, prisoners' barracks, improvements to the water supply, improvements to the kitchen, and ordinary repairs) but not, in fact, more space in which to house patients, this was evidently not a priority for them.¹⁸⁵ Dodds, however, was in favour of the Government allocating more money to the Grahamstown Asylum, suggesting that since the increase in revenue from paying patients indicated that the Asylum had attracted great public favour, the Government should be inclined to "deal liberally" with them:

"The white and coloured patients are in too close proximity in this establishment... [and] they should be housed in separate buildings, and this year [in fact 1897] I hope that a sum will be put on the estimates for a separate block for male coloured patients."¹⁸⁶

¹⁸¹ T. Duncan Greenlees, "Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1896, part VI: Grahamstown Asylum*, CCP1/2/1/101, G20-'87, Western Cape Archives and Records Service, Cape Town, pg. 1.

¹⁸² Greenlees, "Grahamstown Asylum 1896", pg. 1.

¹⁸³ Greenlees, "Grahamstown Asylum, 1895", pg. 5.

¹⁸⁴ *Ibid.*

¹⁸⁵ WJ Dodds, "Part 8: Report of the Inspector of Asylums for the year ending 31st December 1896", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1896, part VI: Grahamstown Asylum*, CCP1/2/1/101, G20-'87, Western Cape Archives and Records Service, Cape Town, pg. 133.

¹⁸⁶ Dodds, "Inspector of Asylums, 1896", pg. 129.

Dodds also noted that “coloured patients...should be more economically provided for than white patients,”¹⁸⁷ which would function to keep costs low. He repeated this exact opinion in 1899.¹⁸⁸ The exact mechanisms by which “coloured patients” were “more economically provided for” extended to food and recreation.¹⁸⁹

Quite clearly, then, the preferred type of patient at the Grahamstown Asylum was white and preferably male, and supported by fees. Black patients, the very vast majority of which were non-paying and therefore effectively Government-sponsored, were tolerated rather than encouraged by Greenlees, and in almost all cases enjoyed inferior facilities and food, space, and entertainment.¹⁹⁰ Despite Greenlees’ ongoing complaints about the lack of and desperate need for more ward space for black males at Grahamstown Asylum (Fort Beaufort Asylum having already reached capacity), his Annual Reports repeatedly returned to the subject of building better private-patient housing, and thereby attracting paying customers.

An economic depression in the Colony in 1899 hindered the Asylum’s bids to build more housing for paying patients: only £529 was derived from that source in 1899, a decline of revenue that Greenlees attributed to rinderpest, drought and the beginnings of the South African War.¹⁹¹ Despite this, new accommodation *had* been constructed; a new block built to house black male patients had been slated for occupation by 130 white patients and accompanying nursing staff.¹⁹² The new building was to be furnished for no more than £120 per head, and would house, among others, 30 patients who paid a “small fee,” and 20 patients “of better class.”¹⁹³

All asylum construction in the Cape Colony had stopped by the end of 1899, which meant that there was no space for the number of new lunatics, many of them war veterans, needing admittance.¹⁹⁴ Furthermore, Cape Town’s whites-only Valkenberg Asylum and Grahamstown Asylum were full to capacity, Fort Beaufort Asylum and Robben Island were overcrowded, and

¹⁸⁷ Dodds, “Inspector of Asylums, 1896”, pg. 132.

¹⁸⁸ Dodds, “Inspector of Asylums, 1896”, pg. 79.

¹⁸⁹ See Chapter 6.

¹⁹⁰ See Chapter 6.

¹⁹¹ Hullah, “Grahamstown Asylum, 1899”, pg. 4. The South African War ran from 1899 to 1902.

¹⁹² Hullah, “Grahamstown Asylum, 1899”, pg. 7.

¹⁹³ Hullah, “Grahamstown Asylum, 1899”, pg. 5.

¹⁹⁴ Dodds, “Inspector of Asylums, 1899”, pg. 81.

Port Alfred Asylum had space for only ten more patients.¹⁹⁵ Dodds, compiling his annual report for 1899 in early 1900, wrote that the Cape provided only half the number of beds for white patients that other countries did, if calculated per thousand of the white population, which, he said, made him feel as though

[w]e are again to go through the bitter experience of either doing nothing for our insane or relegating them to the prisons of the country. Bad as the times are, I hope the country will not acquiesce in such inhumanity.¹⁹⁶

In the 1899 Annual Report for the Grahamstown Asylum, Greenlees described the paying-patient housing there as “excellent,” and included a request that the Government assist in creating better private accommodation for “ladies” but then added that this was necessary not just to cope with the usual problems of finding space for a “better class” of patients but also for ordinary ones. “Hitherto,” wrote Greenlees, “we have [had] to go on in a hand-to-mouth fashion – always full, and to secure a single vacancy [here] we have to secure an empty bed in some other asylum.”¹⁹⁷

By 1901, the average number of patients in the Asylum had risen to 314, higher than 1900’s 242. The admissions for that year show the highest number of black females ever admitted to the Asylum.¹⁹⁸ Exactly where all these patients were to be housed still concerned Greenlees, who in that year’s report wrote that although space was always found for white patients, particularly if they were suffering from acute mental illness, it frequently happened that black patients had to be placed elsewhere: either in other asylums, or gaols.¹⁹⁹ Most black patients were admitted under Sections 11 or 18 of the 1891 Lunacy Act,²⁰⁰ both of which allowed, via either a Summary Reception Order or a Removal Warrant signed by the Under Colonial Secretary, for lunatics to be kept in gaols until space became available in an asylum. The

¹⁹⁵ Dodds, “Inspector of Asylums, 1899”, pg. 81.

¹⁹⁶ *Ibid.*.

¹⁹⁷ T. Duncan Greenlees, “Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital”, *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1900, part VI: Grahamstown Asylum*, CCP1/2/1/115, G41-’01, Western Cape Archives and Records Service, Cape Town, pg. 82.

¹⁹⁸ T. Duncan Greenlees, “Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital”, *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1901, part VI: Grahamstown Asylum*, CCP1/2/1/118, G70-’02, Western Cape Archives and Records Service, Cape Town, pg. 94.

¹⁹⁹ Greenlees, “Grahamstown Asylum, 1901”, pg. 95.

²⁰⁰ See Chapter 4.

longer the wait for an asylum bed, the longer the sojourn in gaol, and the worse the eventual prognosis. In the case of black patients, the scarcity of asylum accommodation in the system as a whole meant that they often spent much longer in a goal than their white counterparts.

The first two decades (1875- c. 1905) of the Grahamstown Asylum's history were, at least in terms of supplying and arranging living space, characterised by ongoing debates and issues around accumulating a patient body that included as many preferential patients as possible while excluding those less desirable. This had a direct bearing upon the issue of funding. Fee-paying patients were preferred over state-funded patients. The reality of the situation at the time was that black patients were all state-funded, making them less desirable than white patients. To this end, first Hullah and then Greenlees, both as the officers-in-charge of the Asylum, tried to remove black patients, or at least keep them in the minority, while attracting the maximum number of white patients, particularly paying ones. The relative unimportance of black patients relative to white, and especially paying, patients is evident from early on, and is mirrored by an equally persistent image of the black insane as being altogether less suitable for the sort of Asylum treatment and custody being practiced at Grahamstown. Further, it is possible that Hullah and Greenlees both were of the opinion that focusing on white patients with a good prognosis would ensure a good reputation for curative care, and thus that the Asylum would come to be seen as a model institution.

The Grahamstown Asylum was a closed institution: those inside were all administered by the same bureaucracy, and inmates could not come and go freely. Furthermore, "membership" of the Asylum was limited to staff and inmates. However, not everyone inside the walls was treated the same way; in fact it is almost as if there were two, three or four different asylums operating at the same time, in parallel, inside the same campus and with the same authorities. The level of comfort and consideration afforded to white patients, especially paying white patients, was so vastly different to that given to black patients – who could apparently set themselves on fire, or dangle from a noose long enough to suffocate, without anyone in authority noticing in time to help²⁰¹ – that it is awkward to refer to the Grahamstown Asylum as one institution. The intent of this chapter has been to highlight the successive Medical Superintendents' constant preoccupation with the acquisition and improvement of facilities for the white patients, and the comparative reluctance they felt to supply accommodation for

²⁰¹ These injuries/deaths are recorded in Annual Reports.

black patients, despite acknowledging that it was needed. This reluctance to truly embrace truly extend care to all patients in their control undoubtedly hampered the Asylum's delivery of care. The following chapters seek to examine the degree to which this disregard extended into other aspects of the Asylum's daily regime.

Chapter 2: Total Institutions, Moral Therapy and the Cape Asylums

Today, the Grahamstown Asylum is known as Fort England Hospital. From the outside, it appears pleasant and innocuous, a sprawling green campus with tennis courts, lawns, large trees and red-brick buildings. The guard-booth and the high cyclone fence around its perimeter do not seem particularly unusual in 21st-century South Africa. There is little to suggest either that the Hospital is a psychiatric facility rather than, for example, a public retirement home or boarding school. In the early 2010s, I accompanied several groups of final-year undergraduate History students on field trips to the campus of the Hospital. Most students remarked on how extremely *ordinary* it all appeared to be. Psychiatric clinics are an entirely normal and accepted part of the 20th- and 21st-century landscape and, whatever the dire fictional versions presented in popular fiction might suggest, they are, for the most part, quite commonplace. This ordinariness, however, should not be taken to suggest that so-called asylums were always understood and accepted as necessary or at least commonplace elements of the landscape, or that they have no genuinely unique attributes compared to other institutions. Recently-constructed psychiatric hospitals blend more or less unobtrusively into their surrounding suburbs, but this was not the case in the 19th century.

Asylums were a relatively new feature of the Colonial landscape, and indeed had only been commonplace in Britain, the metropole, since the later 18th century. Public asylums, i.e. those administered by government bodies rather than private owners, became the primary resource for the housing of “lunatics” in Britain in the early 19th century, following the passing of the 1808 County Lunacy Act. This proliferation of public asylums in Britain resulted from the development of the philosophy of “moral treatment” in 18th century Europe, coming upon the heels of changing Enlightenment attitudes towards the mentally ill.

The moral treatment regime did not begin all at once or originate with any one practitioner, but rather took root in individual asylums scattered across Europe and the United Kingdom. As early as 1750, William Battie founded St Luke’s Hospital for Lunatics [sic] in London, and based its treatment regime on calm, order and kindness. In Italy, Vincenzo Chiarugi took over management of the Bonifazio Hospital in Florence 1788 and transformed it into an early precursor of institutions based on moral treatment, providing the inmates with gardens, good

meals, and a calm and quiet environment in which they could undertake moderate exercise and be treated humanely.¹ Interestingly, both Battie and Chiarugi are considered to be among the first doctors to practice psychiatry as a distinct medical field (Battie, in fact, was among the first psychiatrists to base his work on case studies rather than theory),² suggesting that the therapeutic asylum tradition and medical specialisation developed alongside the realisation that kind treatment should replace the custodial asylum tradition. Philippe Pinel attempted to introduce therapeutic practices to various small French asylums in the late 1780s and 1790s, finally achieving success in the psychiatric wing of the Bicêtre Hospice in Paris in 1793 (although he did not, in fact, personally unchain the lunatics). Taking up the post of chief physician at the Salpêtrière Hospice, he began to have more success in persuading other asylum physicians and supervisors to implement humane treatment.³ This included talking to patients to gain their confidence, providing regular, enjoyable meals and otherwise making asylum life more orderly and organised, and treating patients fairly.⁴ The idea that it was possible to talk to lunatics about how they felt and what they thought was revolutionary. (It also needs to be noted at this point that Pinel, at least, remained in favour of isolating dangerous patients.) Pinel, one of early psychiatry's most dedicated taxonomists of insanity, also stressed the importance of a more holistic understanding of asylum patients when it came to determining the origins and form of mental illness: he pointed out that it was helpful to look into the affected person's family and community when trying to understand them.⁵

In 1796, the Quaker merchant William Tuke, who was not a medically trained in any way, co-founded with his son Henry Tuke, the York Retreat, after a friend died in the York County Asylum. The York Retreat, which has become the benchmark for asylums offering moral therapy in English-speaking countries, was a small institution which aimed to restore its inmates to sanity through a combination of compassion, work, leisure, and reward rather than punishment. The York Retreat set the template for the county asylums that were soon established throughout the United Kingdom.⁶ The innovations made by Battie, Chiarugi, Pinel and Tuke now seem obvious but were *not* obvious changes to make in a system previously predicated on keeping lunatics out of the public eye rather than curing them. As Samuel Tuke

¹ Edward Shorter, *A Historical Dictionary of Psychiatry* (Oxford, 2005), pg. 53.

² Shorter, *Historical Dictionary*, pg. 38.

³ Shorter, *Historical Dictionary*, pg. 221.

⁴ Shorter, *Historical Dictionary*, pg. 180.

⁵ Shorter, *Historical Dictionary*, pg. 221.

⁶ Edginton, Barry, "Moral Architecture: the Influence of the York Retreat on Asylum Design", *Health and Place*, 3, 2, 1997, pg. 91.

(grandson of William) noted, “Much may be done towards the cure and alleviation of insanity by judicious modes of management, and moral treatment.”⁷ Pinel, Chiarugi, Battie and the later Tukes, who did train as physicians, may not have shared an understanding of what *caused* insanity beyond that it originated in the mind and could therefore be cured by trying to help the mind, but they do all appear to agree that kindness, order and decent quality of life would help to effect improvement. It is from Pinel and Chiarugi, rather than the Tukes, that the term “moral treatment” or “moral therapy” arises. Pinel would later teach Jean Esquirol, who although most famous for his work on nosology and refining psychiatric diagnoses, was also deeply involved with asylum reform in eighteenth-century France.

However, in neither Europe nor Britain nor the British Empire did improved culture of care *within* asylums did not automatically result in good treatment for each and every asylum inmate, or translate into a seamless acceptance by surrounding communities and societies of asylums as unproblematic elements of 19th-century society. Asylums had a certain liminal position in society; they housed those individuals that had, for whatever reasons, become physically removed from mainstream society on the grounds of mental instability, real or supposed. This position resulted in ambivalence towards asylums on the part of mainstream society, as well as ambivalence on the part of asylum authorities towards the individuals in their charge. Asylums attempted hold several requirements in equilibrium: the need to care for their inmates, and the need to administer their institution in a way that was acceptable to the controlling government bodies as well as surrounding communities. Not all asylums factored the wishes of their patients into their administrative and restrictive decisions.

Privilege, Oppression and Power in Institutions: A Brief Theoretical Overview

Underpinning this thesis is an interpretation of the manner in which society divides itself into the sane and the insane, or more broadly, the sick and the well. Susan Sontag’s seminal *Illness and Metaphor*, first published in 1978, illustrates the ways in which societal preconceptions of disease and illness – particularly cancer and tuberculosis – add to the degree of suffering patients experienced by affecting the attitudes the people around them

⁷ Edginton, Barry, “Moral Architecture: the Influence of the York Retreat on Asylum Design”, *Health and Place*, 3, 2, 1997, pg. 91.

hold towards their afflictions.⁸ This, in turn, affected the ways in which they react to them. Sontag posits that some physical afflictions attract more societal disapprobation than others, including, often, a judgement that relegates those affected by certain disorders into a class of people considered to be in some way inferior and often more threatening than those not so affected. Sontag notes that

Illness is the night side of life...Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick.⁹

The relationship between the well and the sick is not inherently oppositional, but is rather a question of where an individual is at any given point in their lives. In most cases, moving from the “kingdom of the well” to the “kingdom of the sick” could be labelled migration rather than permanent resettlement. It is quite possible to recover (whether fully or just enough to resume normal function) from many diseases – those affecting the body as well as those, more intangible, affecting the mind, such as moderate depression or anxiety: citizenship of the “kingdom of the sick” is only temporary. Some diseases, however, are regarded as more intractable than others – cancer, HIV/AIDS, and severe mental illnesses such as schizophrenia, for example – and in such cases the affected individual remains in exile from the kingdom of the well for much longer. Eventually, in some instances, the border between the two kingdoms is sealed and re-entry becomes impossible.

Sontag advocated for society as a whole to reject such prejudicial thinking, on the grounds that a disease is not a judgement. It is possible to extend Sontag’s schema, which was devised in the 1970s and 1980s, to an examination of psychiatric institutionalisation. As Roy Porter notes, in the 19th-century and before, as now, insanity carried stigma, and the insane were regarded with some pity and often with fear; most of all they were considered *different*, in some unspecified threatening way.¹⁰ As such, Sontag’s thesis is applicable, and in fact goes to explaining the deep-seated ambivalence that Westernised societies¹¹ held towards the insane and which prompted their urge to separate the sane from the insane. Susan Sontag was, of course, writing in the 1970s, 1980s and 1990s in the United States of America, and

⁸ Sontag, Susan, *Illness and Metaphor* (New York, 1978), pg. 3.

⁹ Sontag, *Illness*, pg. 3.

¹⁰ For a broader discussion of this, see Roy Porter’s *Madness: a Brief History* (Oxford, 2002).

¹¹ That is, the various closely-related Christian, largely Protestant, text-based societies of Western Europe and the United Kingdom, and those descended from them – those of North America, the Antipodes, British India, and the British colonies in East and South Africa.

concentrated her work very particularly on the tropes surrounding cancer, tuberculosis and HIV/AIDS. As a result, *Illness and its Metaphors* presents an effective lens through which to recast the issue of the ways in which so-called “lunatics” move between the mainstream world and the world of the Asylum. In the context of this thesis, Sontag’s schema is useful when taken in conjunction with the work of Erving Goffman and Allan G Johnson.

“The insane” are not an abstract pathological population, permanently and inevitably walled off from the rest of humankind by some abstract consensus, but are instead people who live the bulk of their lives enmeshed in the same social fabric everyone else inhabits. They are subject at that time to the same pressures, prejudices and systems of privilege as the so-called “sane” are. For this reason, it is profitable to examine the work of Allan G Johnson on the ways in which difference affects individuals’ experiences of power and privilege.

As Johnson notes, race, class and sex and all their sub-categories have no significance outside systems of privilege and oppression,¹² such as that which existed in the late 19th-century Cape. Although Johnson’s work is focused on 20th-century America, his work has an application beyond its immediate historical context, and is applicable across a wide range of contexts, including the 19th century Cape. Categories of difference, then as now, is a construct, and the ways in which people identify, categorise and react to difference are dictated, at least partially, by prevailing ideas and discourses? These ideas are derived from the social attitudes, practices and values of the surrounding communities. Difference, although artificial, has real-life implications, and it is not automatically pathological. All individuals have multiple identities: gender, race, class, age, etc. However, reducing individuals to one or, at best, a handful of dimensions and exaggerating their importance can cause difference to *become* pathological.

Asylum authorities’ understandings of difference and the ways they used these understandings to leverage favouritism and deprivation inside the Grahamstown Asylum forms the backbone of this thesis. Patients belonging to groups that were privileged on the outside experienced, by and large, the same privileges on the inside as they did on the outside – and vice versa. These men and women entered the Asylum because one of their characteristics – being insane – had been pathologised and made to outweigh all their other attributes. In some cases, the level of otherness foisted on them by insanity was accentuated

¹² Allan G. Johnson, *Privilege, Power and Difference*, 2nd Edition (New York, 2004), pg. 18.

– and once inside the Asylum, outweighed - by their membership of other groups cast as subordinate by the asylum authorities: being black, female, violent, and/or poor.

As Megan Vaughan notes, while the Eurocentric Foucauldian understanding of difference and power as regards the insane or ill does not comfortably sit with the reality of African colonial experience, there was nevertheless a deeply entrenched and all-pervasive system of power and difference in operation in colonial Africa, especially as it affected black Africans who came within the reach of colonial medicine.¹³ Colonial medicine relied on descriptions and practices of difference to constitute its own authority as well as, in part, that of the colonial power project as a whole.¹⁴ There was a distinct need to identify the Other in colonial medicine: as a member of a group rather than an individual, in many cases, and as such as possessing few or no attributes other than those that could be applied to the entire group. If one member of a group was a certain way, all were; if the entire group was a certain way, all members were the same. In fact, some strands of colonial medicine, particularly psychiatry, leant so heavily on this aggregative approach that they expressed doubt about whether individual black Africans might even have individual identities or self-awareness.¹⁵ Race, rather than individual identity, became the primary means of expressing, differentiating and practicing difference. Race was negative: black Africans were regarded as less physiologically and psychologically complex than white Europeans. That this attitude was certainly in play in the Grahamstown Asylum is clear if one refers to the comments of Hullah and Greenlees regarding the behaviour of black patients, as discussed in Chapter One, or the diagnostic trends discussed in Chapter Three. As such, because black Africans were regarded as faceless members of a group, and that group was already identified and objectified as the intrinsically foreign, there was little need still to single out mentally ill black Africans as even more ‘othered’. As expressed elsewhere, it may be said – if phrased simplistically – that white lunatics were identified as lunatics, while black lunatics identified as black.

Deciding what is negative, subordinate, ‘other’ or threatening is within the power of whichever group is dominant within a particular section of society at a particular time.¹⁶ To be

¹³ Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Cambridge, 1991), pg. 25.

¹⁴ Vaughan, *Curing Their Ills*, pg. 22

¹⁵ Vaughan, *Curing Their Ills*, pg. 26.

¹⁶ Johnson, *Privilege*, pg. 19.

dominant is to have privilege; to have privilege is to be allowed to move through the world without being marked as an outsider.¹⁷ Johnson observes that a person is usually most readily identified by others as a member of the lowest-status group of which they are a member. Any category that lowers someone's status relative to those around them can be used to socially 'demote' them.¹⁸ To be privileged is to be able to avoid, as much as possible, demotion in this way. Not all forms of privilege are equal, however; one can be privileged by gender or racial classification, but forego such privilege by identifying oneself, or being identified, with marginal groups.¹⁹

The interlocking layers of privilege and prejudice that Johnson unpacks are crucial to my understanding of the practices of the Grahamstown Asylum in the period under consideration. As shown in this thesis, enjoyment of privileges in the Asylum was determined not only by the specific nature of the privilege in question, but also by who was in competition for it, and what advantages were at stake. The individuals inside the Asylum were, arguably, subject to prejudicial attitudes from individuals outside the Asylum, on the grounds that the former were not sane and the latter were sane. Their insanity undermined other states of privilege. Whatever their status in life, once determined to be insane, their primary imposed identity became that of an insane person, and they were thus othered. However, a hierarchy of 'otherness' existed *vis-à-vis* the insane: if one was 'othered' as insane, it was still better to be a wealthy white man than it was to be a wealthy white woman, poor white man, poor white woman, wealthy black man, wealthy black woman, poor black man, or poor black woman. Nevertheless, when it came to discerning privilege and otherness on the grounds of sanity, the insane were far more othered than the sane.

The othering of the insane was further achieved by the distribution of various diagnoses. As will be shown in Chapter Three, certain disorders were diagnosed more often among some groups than others. This was only partially related to the actual prevalence of those disorders. Preconceptions, stereotypes and racial science combined to create what was almost a racial hierarchy of mental illness, in which disorders occurred not according to individual circumstance but to group membership.

¹⁷ Johnson, *Privilege*, pg. 33.

¹⁸ Johnson, *Privilege*, pg. 33.

¹⁹ Johnson, *Privilege*, pg. 36.

Inside the Asylum, where all patients had been categorised as insane and further pigeonholed by the diagnosis of a particular mental disorder, insanity ceased to apply as a means of 'othering', to some extent. Not entirely, of course: the presence of sane medical staff, ward attendants, officials and servants in the same environment meant that there was indeed othering on the grounds of insanity, in the creation of the categories of 'patient' and 'staff' and in the resulting hierarchy in which staff were privileged over patients. However, among those categorised as patients, further othering and categorisation in colonial asylums was done on the grounds of race and socioeconomic status rather than sanity. The same patterns of privilege that were present outside the asylum were replicated, and it is the particular ways in which this affected life inside that is the focus here. Johnson's thesis of context-based privilege bequeathing power to some groups and disadvantage to others is fundamental to arriving at this understanding.

The divisions between the mad and the sane are sometimes treated, usually by those who are not mad themselves, as fixed. However, this ability to discriminate itself bespeaks privilege. Privilege creates power, and power can further the ends of prejudice. The fact that institutions to house the insane away from the sane indicates the presence of prejudice against the insane, and that the sane were in charge of the insane at these institutions suggests that their dominance was largely unquestioned. Susan Sontag, Allan Johnson and Erving Goffman, when read together, form an important strut of the intellectual framework that supports the scaffolding of this thesis. Sontag's work provides the means for understanding how mainstream society conspires to split the population of the insane off from the mainstream, and then attach stigma to this artificially-separated group. Johnson examines the ways in which power and privilege combine to create difference, which in turn creates hierarchies and consequently enables discrimination and disenfranchisement. At this point Goffman picks up the thread; the schemata delineated in *Asylums* explain, to a large degree, the patterns which asylums follow in developing their internal organisational configurations.

Control of groups was a major consideration for both the Grahamstown Asylum itself and the Lunacy Acts that controlled the entry of the Colony's lunatics into the Asylum (discussed at length in Chapter Four). It was also fundamental to other Colonial legislations governing

labour, ownership and travel. In terms of the thesis, this insistence on control harks back to the theses of Vaughn, Goffman and Johnson: control maintains the status quo, allowing the privileged to remain ascendant over those against whom they are privileged. At the same time control is crucial to the maintenance of the form and order within a total institution. Outside of the total institution of the asylum, the control that civil authorities wished to manifest over lunatics was built into the three Lunacy Acts (1879, 1891 and 1897) that were passed within the period under discussion. Inside the Asylum, control was implemented through the daily routine – patients ate, bathed, worked, and enjoyed recreation according to a timetable and within a hierarchy that hinged on wealth and race. Predetermined timetables eased administrative loads and operational difficulties and facilitated ease of control. Hierarchies of wealth and economy delimited the distribution of resources and facilities and therefore influenced patient prognoses.

In some ways, the Grahamstown Asylum between 1875 and 1905 was a total institution: its body of inmates did indeed live in close and constant proximity to one another, under the control of a set of attendants and medical staff who managed the flow of information in and out of the institution, and according to a particular timetable, with the eventual goal of effecting their cure or at least providing safe custody. Moreover, the differences in treatment arose directly from the norms that prevailed in the world outside the gates. The Asylum constituted a space of exclusion in that it housed individuals who were fenced off from the societal mainstream but the exclusion worked both ways: the sane were kept out, and the insane were kept in. When a particular individual shifted from membership of the former group into the latter, or vice versa, it was their label – that of “sane” to “insane” - that changed.

Space inside the Grahamstown Asylum was reserved for members of colonial society judged to be insane by Colonial medical practitioners and judicial systems. This space was regulated quite strenuously; access to the Asylum was determined by insanity first and thereafter by socioeconomic class, race and to a lesser extent by gender. The physical site of the Asylum was segregated according to these divisions, which mirrored those of the society outside: wards were divided up into Male Wards and Female Wards, Black Wards and White Wards;

besides this, they were divided up by whether or not a patient was paying or non-paying, which effectively added up to being divided by class.

To end up in the Asylum, an individual had to depart from societal norms, ordinarily by dint of being deemed to be of unsound mind by various agents of the Cape's government and members of the Cape's Western-style biomedical establishment (i.e. two physicians). Once inside the Asylum, however, inmates found themselves sorted by the same criteria that applied on the outside, which affected their standing in the Asylum just as much as their mental illness did. Consequently one could argue that the Grahamstown Asylum perpetuated social exclusions. People in the Asylum were excluded from the rest of the society by virtue of being in the Asylum; in fact, they were doubly excluded. At the same time, the hierarchies of the outside world were reproduced inside the Asylum, which created a situation in which the additional exclusion of being within the Asylum existed in conjunction with the inclusions and exclusions individuals experience outside.

Moral Treatment, Asylums, and Total Institutions: An Uneasy Co-existence

Then as now, access to and egress from asylums was restricted: just as inmates could not freely leave, nor were outsiders supposed to freely enter. Staff occupied a liminal position. As American anti-psychiatry sociologist Erving Goffman notes in *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*,

Social establishments – institutions in the everyday sense of that term – are places such as rooms, suites of rooms, buildings, or plants in which activity of a particular kind regularly goes on. Some establishments...are open to anyone who is decently behaved; others...are felt to be somewhat snippy about who is let in. Some, like shops and post offices, have a few fixed members who provide a service and a continuous flow of members who receive it. Others, like homes and factories, involve a less changing set of participants. Some institutions provide a place for activities from which the individual is felt to draw his social status, however enjoyable or lax these pursuits may be; other institutions, in contrast, provide a place for associations felt to be elective and unserious, calling for a contribution of time left over from more serious demands. Every institution captures something of the time and interest of its members and provides something of a world for them; in brief, every institution has encompassing tendencies.²⁰

²⁰ Goffman, Erving, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York, 1961), pg. 15.

Goffman further defines a total institution as “a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life.”²¹ All institutions of course show some of these characteristics, but asylums are among the most encompassing of institutions, in that they have control over pretty much the entirety of an inmate’s life, and are distinctly selective about who they admit.

Goffman describes five major types of total institution: the first, those for people who cannot care for themselves but are harmless (homes for children, the indigent, or the aged); the second, those who cannot care for themselves but supposedly present a threat to their community (lepers, TB sufferers, or the mentally ill). The third, for those who are perceived to present an actual danger to society, and whose welfare is not an immediate issue (prisons, concentration camps, prisoner-of-war camps); the fourth, those designed as a retreat from the world (monasteries, convents, lay religious communities); and the fifth, those established for work purposes (boarding schools and army barracks, for example).²² Goffman points out that many of the more selective types of total institution have actual, physical barriers to social intercourse with the outside world, such as walls and fences, or are situated near impassable natural feature such as the sea or a cliff.²³ Natural and constructed barriers are incorporated into the design of total institutions to regulate the movements and lives of the inmates therein. These may be as simple as the fence around a boarding school or as impassable as the two kilometres of sea separating Alcatraz Island from the San Francisco shore.

Obviously, not all total institutions are the same. Some, such as boarding schools, are far more permeable than others, such as prisons or prisoner-of-war camps. Goffman’s theory of total institutions, though North American in focus and formulated in the mid-20th century, is a useful *starting-point* for understanding the ramifications of the divide between the sane and the insane that leads to the establishment of asylums, but it should not be seen as an entire explanation. Goffman, who did research at St Elizabeth’s Hospital in the American state of Maryland in the mid-1950s (the beginning of the period in which “antineurotic” drugs such as

²¹ Goffman, *Asylums*, pg. 11.

²² Goffman, *Asylums*, pg. 16

²³ *Ibid.*

meprobamate²⁴ and methylphenidate²⁵ and antipsychotics such as chlorpromazine²⁶ were commonly used, and thus a point of change for the American asylum system), and was a sociologist rather than a psychiatrist. His conclusions were, therefore, unsurprisingly, that total institutions could be quite sinister.²⁷ I do not wholly agree, nor wholly disagree; in fact, I see Goffman's argument as particularly useful in terms of this thesis because of its focus on the nature of institutions that stem from their surrounding communities but separated from them by their nature. It also useful in terms of understanding how an institution can be therapeutic and restrictive at the same time. One could use Goffman as easily to understand the workings of a prison, boarding school, military base or religious order.²⁸

In Goffman's schema, the insane who ended up in mental asylums resided in so-called "total institutions." A total institution is one which provides a "barrier to social intercourse with the outside and [a barrier] to departure."²⁹ Cut off from the society outside, for whatever period, the inmates of a total institution must live in the world the total institution provides for them.³⁰ This world cannot be totally divorced from the "world outside" – there are visitors, tradespeople, official inspectors, families and friends, new staff, and so on – but it is nevertheless total. The people entering the institution have until then lived in a social milieu, or social milieus, with certain hierarchies and dominant norms, as have those holding authority within it; both are inescapably imbued with those norms.

The characteristics of Goffman's "total institutions" differ from the basic social arrangements in place outside of them, in which individuals usually live, work and engage in recreation in a variety of locations with a variety of different people. In this social arrangement members of the household, work colleagues, and sports team mates or club members all tend to be different groups of people without significant overlap and control or influence over these

²⁴ Commonly known as Miltown.

²⁵ Commonly known as Ritalin.

²⁶ Commonly known as Thorazine or Largactil.

²⁷ Edward Shorter, *A Historical Dictionary of Psychiatry* (Oxford, 2005), pg. 23.

²⁸ It should be acknowledged that although military personnel, monks, nuns and school boarders can all leave the institution and have contact with the outside world, they are nevertheless classified as total institutions by Goffman, according to his criteria which are outlined below.

²⁹ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, (New York, 1961), pg. 4.

³⁰ Goffman, *Asylums*, pg. 4.

groups may be exercised by different authorities.³¹ In total institutions, a single authority – in the case of the Asylum, the Asylum staff – has control over the single location in which the individuals concerned live, and controls every aspect of that place's social arrangements. Goffman includes prisons, mental asylums, concentration camps, and boarding schools as examples of total institutions, albeit with widely differing means and ends. Common to all of these total institutions, and in contrast to social arrangements outside of them, all aspects of daily life are controlled by a single authority, and many aspects of life are carried out in the company of a large group of others. Everyone inside is on the same timetable, and all of this occurs with the intention of fulfilling a single plan devised by the institution's overall authorities.³² Moreover, these total institutions usually have a structure in which a small group of attendants supervise and survey the inmates, and serve as a conduit between the higher staff and the inmates;³³ the goal of this supervision is both guidance and control over inmates.³⁴

In this thesis I am concerned with the second kind of total institution described by Goffman, those concerned with people who cannot care for themselves but supposedly present a threat to their communities. This is most certainly the case of the Grahamstown Asylum where, much effort on that part of the authorities was concerned with 'neutralising' the supposed threat to society posed by so-called lunatics. It should be noted that there is conversely an argument to be made that the encompassing nature of the Asylum (or any asylum) also in some measure provided protection for the inmates against those outside. In fact, this is the a point of contact between moral therapeutic practices/moral treatment, and Goffman's theory of total institutions. Unlike prisons or monasteries, and partly like boarding schools, asylums run on the therapeutic model provide an environment in which the welfare of the inmates is a strong consideration. This is partly why they are closed off from much of the outside society at least in terms of physical access; but in terms of social and political norms, the institution remains permeable.³⁵ Moral therapy in the Cape Colony was implemented *despite* existing racial prejudices, and in asylums the two schools of thought coexisted uneasily. The Grahamstown Asylum existed at a place and in a time where, although the population of the

³¹ Goffman, *Asylums*, pg. 6

³² *Ibid.*

³³ Goffman, *Asylums*, pg. 19.

³⁴ Goffman, *Asylums*, pg. 7.

³⁵ This is true of all of Goffman's levels of total institution, with the possible exception of those which function as a *retreat* from the world.

region was heterogeneous and therefore of various cultures, one particular culture held sway: that of the region's British-descended, English-speaking population.³⁶

It is also true that there existed a flow of influence from the asylum into surrounding society; the valve went both ways. Inside asylums in the Cape and Natal, in parallel with moral treatment, the lineaments of nineteenth-century Colonial psychiatry were becoming clearer. Psychiatrists at these institutions used science, supposedly objective by nature, to measure and classify colonial subjects. In asylums in Natal and the Cape, as Parle notes, racism and the universalism of moral treatment existed uncomfortably side by side: the observations and conclusions made by doctors such as T Duncan Greenlees fed the development of a pervasive and longstanding tradition of scientific racism.³⁷ This became particularly noticeable in the later years of the nineteenth century, when increasing numbers of people needing asylum beds and decreasing rates of recovery or improvement among those already in asylums led to a sense that asylum treatments simply did not work for many patients. The hardening of racist attitudes that accompanied this failure among asylum authorities led to the concomitant ossification of racial attitudes, and subsequently of racial policies. The appreciation of common humanity fell away and was replaced by a concentration on difference and separation.³⁸

The nature of the colonial asylum as a total institution is therefore complex. In one sense, it fulfils Goffman's typical requirements. In another, it is not closed off from the world but is both influenced by it and influences it, without necessarily being literally open to the world. The Grahamstown Asylum, like all asylums, was a space separated but not divorced from the world outside, different enough to warrant being treated as a space with special qualities, but ultimately still bound to greater societal trends and norms. This chapter briefly examines the origins and form of the confinement of the insane, and the system of moral therapy, which was the dominant philosophy governing the management of asylums in the 19th century. It moves on to examine the motivations that led to the establishment of an asylum in Grahamstown. This chapter seeks to examine the effects that the philosophy of moral

³⁶ For further discussion, see Chapter One.

³⁷ Julie Parle, *States of Mind: Searching for Mental Health in Natal and Zululand, 1868 – 1918* (Scottsville, 2007), pg. 57.

³⁸ Parle, *States of Mind*, pg. 33.

treatment had on the Grahamstown Asylum's earliest forms, especially in combination with the Colony's existing societal norms.

Moral Treatment and the Design of Asylums

Moral treatment arose as a system of treatment in British asylums, and consequently in British colonial asylums, in the closing years of the 18th century, following several centuries of what might broadly be called informal care of the community combined with incarceration in custodial asylums.³⁹ Vagrants, minor criminals, the indigent and homeless, and the insane were all treated more or less the same way, with only the most dangerous or troublesome members of each group being detained or having their movements curtailed.⁴⁰ That the system of community care and *laissez-faire* approach to the insane persisted until the late 1700s strongly suggests that there is nothing inevitable about separating the insane from the sane, and incarcerating them in designated spaces of separation.⁴¹ The process of sequestering the insane away in institutions was a matter of social isolation as well as the division of space, as mainstream society created dedicated spaces for them, to which they were removed, whether involuntarily or willingly. The idea that the mad deserved to be sequestered appeared earlier in Western European, specifically British, society than the idea of medical treatment itself did.⁴²

The earliest asylums did not provide much more than a space, resembling in some ways a prison, where lunatics were restrained and received little attention beyond being fed and detained in one place. The early asylums in Britain, most famously Bethlehem Hospital in London, better known as Bedlam, were unregulated. At Bedlam, under the control of four generations of Drs Monro, the regime was not designed for the benefit of the patients.⁴³ The

³⁹ Andrew Scull, "A Convenient Place to Get Rid of Inconvenient People: the Victorian Lunatic Asylum", in Anthony D. King (ed.), *Buildings and Society: Essays on the Social Development of the Built Environment* (London, 1980), pg. 38.

⁴⁰ Scull, "Convenient Place", pg. 38.

⁴¹ Philo, Chris, "'Fit Localities for an Asylum': the Historical Geography of the Nineteenth-Century 'Mad-Business' in England as Viewed through the Pages of the *Asylum Journal*", *Journal of Historical Geography*, 13, 4, 1987, pg. 401.

⁴² Philo, "'Fit Localities for an Asylum'", pg. 399.

⁴³ Roy Porter, *Madness: a Brief History*, (Oxford, 2002), pg. 97.

cruelty in these old-style asylums disgusted the members of the reform movement, who consequently devised the philosophy of moral treatment.⁴⁴

Asylums were not, at first, the inevitable destination for lunatics; that they began to be separated from mainstream society was the result, Andrew Scull suggests, of profound shifts in British society, particularly its class relations.⁴⁵ The old orders, based on rank and social status, had – in increasingly industrialised and centralised society – been replaced by one based on income and thus on class.⁴⁶ The middle and lower classes, being dependent on regular income, were no longer willing or indeed particularly able to tolerate individuals who did not contribute economically.⁴⁷ The insane, and others such as criminals and the indigent, were adults *should* have been contributing economically but were not, and were therefore a burden in a way that children and the elderly were not.⁴⁸

Like prisons and hospitals, asylums are related to social control within the polity.⁴⁹ Those kept inside them were, in one way, judged to be different in some crucial way from the mainstream of society, by dominant groups of that society. Reactions to the difference of the mad from the sane did differ across time and space. As Chris Philo notes, reactions ran the gamut from calls for tolerance and inclusion of the mad into the mainstream, to demands that all of them be locked up and kept away. Somewhere in between these two poles lies the wish to see the mad given their own special significance and kept in specialised spaces – madhouses and asylums, that is, rather than gaols or hospitals intended for the physically ill.⁵⁰

Asylums arose as an alternative to hospitals, workhouses and prisons (although lunatics still ended up in all of these places, albeit temporarily).⁵¹ They posed particular challenges to their designers and operators: their roles were complicated – asylums had to be places of custody, humane treatment and, occasionally, also confinement. These roles could conflict with one

⁴⁴ Philo, “Fit Localities for an Asylum”, pg. 400.

⁴⁵ Scull, “Convenient Place”, pg. 40.

⁴⁶ *Ibid.*

⁴⁷ Scull, “Convenient Place”, pg. 41.

⁴⁸ Scull, “Convenient Place”, pg. 38.

⁴⁹ King, “Introduction”, pg. 10.

⁵⁰ Philo, “Fit Localities for an Asylum”, pg. 402.

⁵¹ *Ibid.*

another.⁵² As the mainstream society of the early- to mid-1800s became more accepting of asylums as a legitimate and indeed preferable option for the custody of the insane, communities became accustomed to having a convenient place to isolate problematic people.⁵³ With other options becoming available, communities became less willing to deal with lunatics on their own. Therefore, the role of asylum doctors became more concrete, and asylums became specific spaces that had to be operated by doctors and nurses in possession of specific skills.⁵⁴

In Africa, asylums established during the colonial era did not introduce a method of handling the insane, instead merely joining established methods and practices. Western psychiatry did *not* introduce the very concepts of sanity and insanity, and failed to realise this, instead superimposing Western ideas of what constituted normal and abnormal behaviour onto existing or evolving indigenous ideas. And, as Megan Vaughan observes, this led to some missteps as colonial medical, judicial or administrative specialists attempted to define insanity in individuals whose normal behaviour they did not understand and generally already considered to be quite alien.⁵⁵ Writing of criminal proceedings against perpetrators believed to be insane in colonial Malawi, she remarks that,

The colonial magistrate and district officer were, for most of the colonial period, enjoined to rule through 'custom', except where 'custom' was deemed 'repugnant'. For this to be done, 'custom' had constantly to be defined and deviations from it to be identified. Logically this would result in a highly relativistic view of madness – the mad could only be so defined by close reference to the particular norms and customs of a 'tribal' group. 'Custom' frequently proved an inadequate instrument of colonial rule, leaving the magistrate to work with his own, quite different, legal and cultural categories. The African participants in these courtroom dramas meanwhile attempted to provide their own interpretations of 'customary' behaviour, and to understand the implicit working categories of the magistrate's mind.⁵⁶

In addition to this mutual unintelligibility, there was the fact that despite the arrival of a small number of European-trained colonial psychiatrists, colonial psychiatry had limited power, and African interpretations and understandings of mental illness both predated colonisation and

⁵² Scull, "Convenient Place", pg. 46.

⁵³ Scull, "Convenient Place", pg. 50.

⁵⁴ Philo, "'Fit Localities for an Asylum'", pg. 399.

⁵⁵ Vaughan, *Curing Their Ills*, pg. 117.

⁵⁶ Vaughan, *Curing Their Ills*, pg. 117.

survived it.⁵⁷ Western-style psychiatry – or rather, Western modes of dealing with insanity and insane people – co-existed with local ideas, and became one of a number of options.⁵⁸ Colonial psychiatrists' lack of understanding of indigenous African systems of understanding insanity, their unwillingness or inability to understand Africans as individuals, and imperfect understandings of how African societies functioned all combined to make Western-style colonial asylums a problematic space for black inmates.

Prior to the development of drug-based therapies in the 1900s, most asylums subscribed or at least paid lip service to the philosophy of moral treatment.⁵⁹ By the mid- to late-1800s, medical understandings of insanity were moving away from the idea that madness was a purely physical disorder (as Daniel Hack Tuke believed) and towards the understanding that emotional factors played a role in the origins of insanity and could therefore play a role in the restoration of the lunatic to sanity.⁶⁰

The importance of providing lunatics with a pleasant living environment that would restore their sanity influenced all aspects of asylum design and administration, at least in theory. In practice, real-life considerations derailed the best of intentions, and nowhere more so than in the Cape's asylums, especially those of the Eastern Cape. Felicity Swanson maintains that,

The Eastern Cape asylums [Grahamstown Asylum, Port Alfred Asylum, and Fort Beaufort Asylum] were not so much a humanitarian project but rather a cynical exercise in the long and dismal history of public provisioning for the mentally ill in South Africa.⁶¹

While this is broadly true, it may be misstating the case to call it "cynical." In fact, Robert Hullah, the Asylum's first Medical Superintendent and his successor T. Duncan Greenlees, both believed that they were doing a good, or at least adequate, job of providing for everyone within the Asylum gates, each according to their need. However, their ideas of what these needs were included the creation of deep-seated inequality within Asylum practices, and

⁵⁷ Parle, *States of Mind*, pg. 13.

⁵⁸ Parle, *States of Mind*, pg. 88.

⁵⁹ Clare Hickman, "The Picturesque at Brislington House, Bristol: the Role of Landscape in Relation to the Treatment of Mental Illness in the Early Nineteenth-Century Asylum," *Garden History*, 33, 1, 2005, pg. 48.

⁶⁰ Hickman, "The Picturesque", pg. 48.

⁶¹ Swanson, "'Of Unsound Mind'", pg. 2.

thereby created a clash between the intention to provide moral treatment and the inability or unwillingness to adequately institute it. Therapeutic models, discrimination and control are not mutually exclusive.

Anthony D. King, in the introduction to *Buildings and Society*, explains the complicated interplay between the needs of a society and the built environment it produces:

Buildings result from social needs and accommodate a variety of functions – economic, social, political, religious and cultural. Their size, appearance, location and form are governed not simply by physical factors (climate, materials or topography) but by a society's ideas, its forms of economic and social organisation, its distribution of resources and authority, its activities, and the beliefs and values which prevail at any one period of time.⁶²

The development of the Grahamstown Asylum was dictated by at least the socioeconomic, beliefs and value systems of the 19th-century Cape, as well as two sometimes-conflicting considerations: the provision of an environment suitable to moral treatment, and the wish to provide a superior environment for white patients in keeping with the Cape's segregationist aims.

Constructing an asylum along the lines required for moral treatment required asylum authorities and architects to keep in mind that the central tenet of the entire movement was that being placed in the asylum would, in itself, assist the lunatic in regaining his or her sanity.⁶³ As such, the regime at these asylums was supposed to employ kindness over restraints, and the provision of a pleasant physical environment was paramount.⁶⁴ Doctors who espoused moral treatment believed that removing lunatics from their environments (i.e., those in what I term the mainstream world), in which they failed to function according to the 'normal' rules of society, and placing them in a location far removed from those harmful environments, where the asylum society⁶⁵ and the preferably tranquil settings,⁶⁶ complete with recreational activities and opportunities for fruitful employment, would restore them to their faculties.

⁶² King, "Introduction", pg.1.

⁶³ Barry Edginton, "Moral Architecture", pg. 91.

⁶⁴ Hickman, "The Picturesque", pg. 48.

⁶⁵ Hickman, "The Picturesque", pg. 48.

⁶⁶ Philo, "'Fit Localities for an Asylum'", pg. 404.

Therefore, the ideal site for an asylum building would be on an elevated spot that could provide both extensive rural views and good ventilation, adequate access to grounds for exercise and excursions, as well as gardens and farms, good drainage, and a good water supply.⁶⁷ All of these factors suggested the suitability of rural or semi-rural locations for asylums, both because more space was available outside dense urban areas and because urban areas themselves were considered harmful to the mental state of those predisposed to mental illness.⁶⁸ This seems to align with a romantic view of the countryside as idyllic, and in opposition to the corruptive urban environment. At the same time, asylums had to be within a reasonable distance of the populated areas they served.

Asylum architects had to strike something of a balance when it came to choosing where to locate an asylum. The building had to be far enough removed from the urban setting to provide the aforementioned rural peace. As Philo dryly points out, this was intended to spare lunatics the upsetting sight of the unafflicted going about their daily lives - and presumably the so-called unafflicted were thereby spared the upsetting sight of lunatics going about *their* daily lives. However, the asylum's location could not be too remote for patients and suppliers of provisions and services to reach it easily.⁶⁹ This approach to situating asylums certainly applied in the colonial sphere. Valkenberg Asylum, which opened in Cape Town in 1891, was situated on what had been farmland before being purchased for by the Cape government, near the Black River and surrounded by open land.⁷⁰ A 1910 newspaper article described Valkenberg as being in a "picturesque position on the summit of a gentle eminence overlooking a landscape that, except for the mighty mass of Table Mountain overshadowing it, might well be an English one."⁷¹ It was also within an easy ride of Cape Town itself. The Natal Government Asylum on Town Hill near Pietermaritzburg, established in 1880, has been described as "[resembling] a country estate, with a farm, quarry and extensive grounds."⁷² It overlooked Pietermaritzburg, and was planted around with many trees to give shade to the grounds. The Grahamstown Asylum, also, is situated on a slight rise with a long hillside behind

⁶⁷ Philo, "Fit Localities for an Asylum", pg. 406.

⁶⁸ Philo, "Fit Localities for an Asylum", pg. 407.

⁶⁹ Philo, "Fit Localities for an Asylum", pg. 410.

⁷⁰ Sally Swartz, "Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920", Unpublished PhD thesis, University of Cape Town, 1996, pg. 32

⁷¹ Swartz, "Psychiatric Knowledge in the Cape", pg. 34.

⁷² Parle, *States of Mind*, pg. 144.

it and a view over the town. At the time of its establishment, the area was mostly gardens and vegetable farms, and the town was nearby.

But although the provision of grounds and gardens was very important to moral treatment, it was perhaps less crucial to the asylum's ongoing existence than the supply of living space, especially sleeping areas, dining halls, dayrooms and indoor recreational and work spaces. Asylums required space to expand, and to expand in forms that allowed the provision of moral treatment without compromising the institution's other roles: to be a place of custody and from time to time also confinement; to be a place of treatment; to provide as much of a home as possible for the patients living there.⁷³ For these reasons, the design of the Asylum – and asylums in general – had to develop while holding two often-conflicting needs in balance: to provide moral treatment for lunatics, but to do so within the framework of other requirements (such as security and efficiency) and financial constraints.

The gaols and general hospitals of the Colony were not equipped to house insane men and women; this was not a good option for either the lunatics *or* the authorities charged with administering the gaols and hospitals.⁷⁴ They neither wanted nor were equipped to deal with the mentally ill.⁷⁵ Moreover, the practices that medical authorities needed to put in place to deal with increasing numbers of lunatics necessitated the development of special spaces. The challenges that arose when lunatics were gathered together were quite different from, and of greater magnitude than, those that had occurred when lunatic were scattered throughout the community in the custody of friends or families.⁷⁶ Inside asylums, in order for authorities to run efficient institutions, they had to impose order and keep discipline in environments in which most of the people were not readily susceptible to threats or punishment, or reward.⁷⁷ Therefore, other methods of maintaining order had to be devised so that asylum staff could provide kind and humane care without risking a chaotic environment and/or becoming heavy-handed.⁷⁸ The provision of a tranquil environment relied on the coalescence of three factors – staff, the patients themselves, and the built environment in which the three came together.

⁷³ Scull, "Convenient Place", pg. 46.

⁷⁴ Swanson, "Of Unsound Mind", pg. 6.

⁷⁵ Swanson, "Of Unsound Mind", pg. 7.

⁷⁶ Scull, "Convenient Place", pg. 42.

⁷⁷ *Ibid.*

⁷⁸ Scull, "Convenient Place", pg. 43.

As such, the site and structure of asylum buildings contributed to the asylum's effectiveness as a place of therapy and cure.⁷⁹

Andrew Scull maintains that the architecture and design of asylum buildings were employed as methods of classification within asylums, enforcing separation between various classes of patient, the patients, and the outside world, as well as staff and patients, and acting as the patients' home and place of recuperation.⁸⁰ This is certainly true of the Grahamstown Asylum – but only up to a point. As Swanson states, moral treatment at the Grahamstown Asylum was provided by staff according to a fairly strict, if mostly unspoken, hierarchy of patients within the Asylum. It proceeded along fairly rigid gender, class and racial classificatory lines – patients received different quality of care and treatment from Asylum staff according to their ability to pay.⁸¹ Where patients slept and spent the day, what they ate, how they engaged in recreation, and in what work they were employed differed: paying patients experienced a considerably more plush existence inside the Asylum than did unpaying, particularly black, patients, who were used as a source of free labour.⁸² There was a distinct gap between the ideal and the reality – a distinct and uncomfortable tension existed between the wish of Asylum doctors and Colonial authorities to provide humane treatment for all lunatics, regardless of race and class, and the urge to reinforce the colonial society's racialised divisions, as Swartz notes.⁸³ Differential treatment within the Asylum was determined, also, by the idea, prevalent even in asylum-reform circles, that not all patients inside asylums were equally likely to benefit much from the pleasant surroundings that asylum authorities took pains to provide.⁸⁴ Differences in the biology between black and white lunatics were thought, by asylum doctors in the Cape, to affect not only the rates and types of insanity, but also their responses to treatment.⁸⁵ Indeed, only white and particularly white paying patients were believed to be really likely to benefit from moral treatment.⁸⁶ In fact, throughout the asylum movement in the United Kingdom and its colonies, there had been something of a tendency to ignore, to a degree, the therapeutic requirements of lower-class patients in favour of

⁷⁹ Scull, "Convenient Place", pg. 45.

⁸⁰ Scull, "Convenient Place", pg. 46.

⁸¹ Swanson, "Of Unsound Mind", pg. 133.

⁸² Swanson, "Of Unsound Mind", pg. 134.

⁸³ Swartz, Sally, "'Work of Mercy and Necessity: British Rule and Psychiatric Practice in the Cape Colony, 1891 – 1910", *International Journal of Mental Health*, 28, 2, 1999, pg. 73.

⁸⁴ Hickman, "The Picturesque", pg. 57.

⁸⁵ Swartz, "Mercy and Necessity", pg. 83.

⁸⁶ Harriet Deacon, "Landscapes of Exile and Healing: Climate and Gardens on Robben Island", *The South African Archaeological Bulletin*, 55, 172, 2000, pg. 150.

providing better care to upper-class patients.⁸⁷ In many cases, lower-class patients provided a workforce for the asylum.

With this in mind, it needs to be noted that when the Grahamstown Asylum was set up in 1875, it was intended to provide care – both custodial and therapeutic – to chronically sick individuals and “indigent lunatics” of all races.⁸⁸ Only after the establishment of the post of Inspector of Asylums in 1889 and the arrival of Dr T Duncan Greenlees as Asylum superintendent was the Asylum structured along the lines of gender, class and racial classification that later became so entrenched.

Staffing the Grahamstown Asylum

In a total institution in which no individual inmate has much influence over the nature of their immediate environment, minor decisions and elements of choice are magnified. For the most part, asylum inmates go through each day in the enforced company of a group of others whom the institution, rather than the inmates themselves, has decided are their equals.⁸⁹ Implicit in this categorisation is the understanding that not all inmates are on the same level, and it is impossible that inmates themselves do not realise that this assumption exists; some of them may even personally believe that they are superior, or inferior, to other groups in the asylum, and it is furthermore inevitable that they will not accept that each of their designated peers is in fact their equal.

The Grahamstown Asylum was an institution that implemented daily regimes and protocols with two aims; the primary aim was to make the handling of large groups of people easier to do with a relatively small staff; the secondary was to ensure that this was done as economically as possible. It is possible to do this if a firm set of ‘house rules’ is established, because they allow planning in advance and establish a set of precedents and practices against which the asylum inmates are powerless to act. In total institutions, the staff are more or less unassailable in their ascendancy over inmates and their authority is rarely questioned; this has extensive ramifications for the inmates’ experience of discrimination and deprivation.

⁸⁷ Hickman, “The Picturesque”, pg. 57.

⁸⁸ Swanson, “Of Unsound Mind”, pg. 2.

⁸⁹ Goffman, *Asylums*, pg. 127.

Asylums were built for the benefit of their inmates, but they were ruled by the staff. As Du Plessis notes, *per* RD Laing, the staff of an asylum are in a way as institutionalised as those in their care are; the difference between staff and inmates is a constructed relationship in which staff are given more social power.⁹⁰ The staffs of asylums were, themselves, ruled by civil servants above them in the Colonial hierarchy. The Colonial hierarchy began with the Governor, but actual power resided with the Prime Minister, whose role included that of the Colonial Secretary (for more information see Chapter One). Much of the actual day-to-day administration of the Colony, however, was done by the civil servants that made up the Under Colonial Secretary's staff. After 1890, among these was included the post of the Inspector of Asylums, a role that the incumbent, Dr WJ Dodds, filled alongside his own post as Superintendent of Valkenberg Asylum. While Dodds was not, technically, in authority over the Grahamstown Asylum's own Superintendent, his role as Inspector did give him an advisory authority. The Grahamstown Asylum's Superintendent was, however, directly responsible to the Under Colonial Secretary (see figure 3 below).

There is no self-governance by institutional inmates; whether the institution is a school, a prison or an asylum, all inmates are under the control of – and to a degree, at the mercy of – the institution's staff, even the least of whom outranks all inmates simply by virtue of *not* being one of them. As Erving Goffman points out, there is a very basic distinction: staff can leave at the end of the day, and inmates cannot.⁹¹ Inmates of total institutions are, albeit in some cases temporarily, removed from the world outside, while staffs are still integrated with it. Inmates must abide by the rules of the institution; staff must see that they do. The inmates of jails, prisoner-of-war camps, detention centres and asylums are very often there involuntarily, and may or may not be in full control of their own behaviour. Staffing such institutions as these last-named becomes, therefore, quite a tricky prospect.

⁹⁰ Du Plessis, Rory, "Constructing patient–psychiatrist relations in psychiatric hospitals: the role of space and personal action," *Social Semiotics*, 23, 3, 2013, pg. 424.

⁹¹ Goffman, *Asylums*, pg. 18.

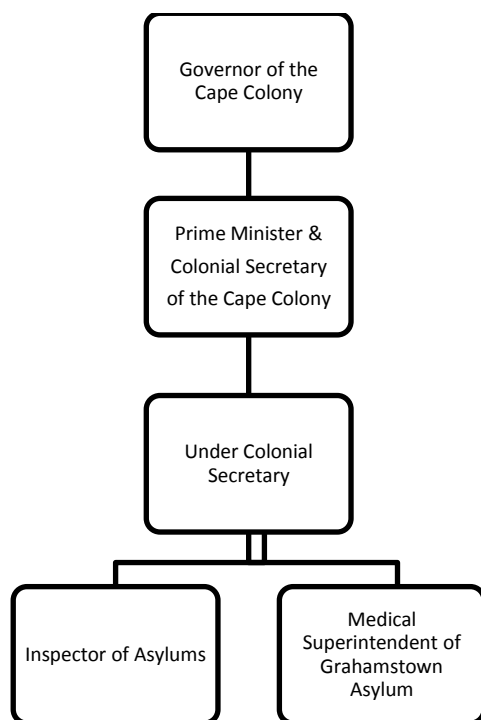


Figure 2: Chain of command from Governor to Medical Superintendent.

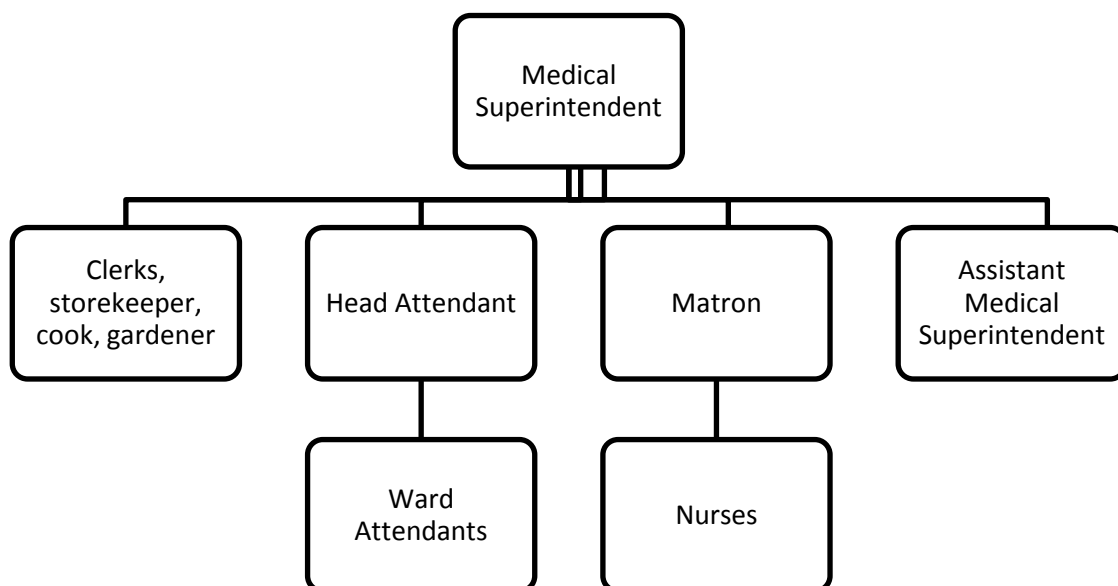


Figure 3: Chain of Command, Superintendent of Asylum to Nurses and Ward Attendants.

In the case of asylums such as the Grahamstown Asylum, there was a split between the majority of the asylum's residents – that is, the inmates – and the minority, made up of ward staff, support staff administrators, and medical staff (see figure 3 above).⁹² The effective running of an asylum relies on the entrenchment of a distinction between inmates and staff. In the case of the Grahamstown Asylum, in particular, it is obviously impossible to say with any degree of certainty that no staff befriended any inmates; especially since, as will be seen below, the staff were enjoined to practice kindness and tolerance.

For new inmates, entering the Asylum could be a disorienting process: being “re-coded” as an inmate⁹³ could be embarrassing and physically unpleasant, as Asylum staff interviewed inmates; inventoried their possessions, confiscated some and sent others into storage; undressed, bathed, shaved and weighed inmates; issued them with asylum-appropriate gear and assigned them to their new sleeping quarters.⁹⁴ Inmates ceased to be whoever they had been before, and became residents of an institution with a pre-existing power structure in which they had little say. New inmates found themselves in the company of people they did not know and whose fellowship they may well have declined to seek out if given the choice; they were under the control of a similar, but more powerful group – the attendants – whose orders had to be followed for fear of punishment. Much of an inmate's first intimation of what their time in the Asylum would be like therefore depended on the demeanour of the attendants he or she first encountered.

But at the same time, maintaining the distinction between the two groups was crucial to ensuring that the Asylum functioned properly; mass-management of people is only really possible when the subservient group does not routinely defy the dominant group. Furthermore, the Grahamstown Asylum was, at least in theory, committed to the provision of kind and careful treatment to its inmates. Maintaining the balance between tight control and kindness while dealing with a population of people who could behave unpredictably or violently required a special sort of personality among staff members.

⁹² Goffman, *Asylums*, pg. 18.

⁹³ Goffman, *Asylums*, pg. 24.

⁹⁴ Goffman, *Asylums*, pg. 26.

Ward staff were the ones who could either intercede with the Superintendent or other medical staff on inmates' behalf, or effectively choke off any attempts of an inmate to gain access to him.⁹⁵ Likewise, but perhaps less likely, they could choose not to pass on information from the Superintendent. This power to move an inmate in or out of "the loop" gave Asylum attendants a great deal of power over an inmate's experience, quite aside from their role as the overseer of meals, dormitories, work and recreation. Ward staff – attendants and nurses – formed the buffer between the inmates and the authorities, and, consequently, wielded considerable power.

Whatever their power over small daily details, ward staff made no major institutional decisions. Overall in charge of the Grahamstown Asylum's everyday workings was the Surgeon – later the Medical – Superintendent, who was the sole member of the staff with any medical training until the post of Assistant Medical Officer was created and filled in the mid-1890s. Medical Superintendents at all Cape asylums faced very heavy workloads: they were in charge of official correspondence and reports, record-keeping, planning and managing provisioning, planning work schedules, meals, entertainments and recreational activities, and clinical work. Assistant Medical Officers were assistants to the Medical Superintendent, and could act as superintendents if the Superintendent himself was away or ill. This pattern of governance was also in place at Valkenberg in Cape Town and the Natal Government Asylum in Natal.⁹⁶

The Medical Superintendent was assisted by the Matron and the Head Attendant, as well as several members of staff not directly involved in the care of the patients: a clerk, storekeeper, cook, gardener, and laundress, messenger and chaplain. The staff structure was not static, with the exact composition and the number of employees fluctuating, but the basic hierarchy was simple: the Medical Superintendent, followed by the Assistant Medical Officer, and then the Matron and Head Attendant, who had authority over the nurses (also known as female lunatic attendants) and laundress, and attendants (also known as male lunatic attendants) respectively. The Medical Superintendent had direct authority over all other members of staff, including the clerk, storekeeper, cook and gardener.

⁹⁵ Goffman, *Asylums*, pg. 20.

⁹⁶ Parle, *States of Mind*, pg. 102

The Matron and the Head Attendant were, respectively, in charge of the female and male halves of the Asylum, nurses and attendants, and female and male asylum servants; they were under the direct authority of the Medical Superintendent.⁹⁷ These “heads of department” were more directly occupied with the everyday quality of life of than were the Medical Superintendent or the AMO, being directly responsible for seeing that the Medical Superintendent’s orders were carried out and translated to action on the wards.⁹⁸ For both the Matron and the Head Attendant, the working day began at 6am and ended after all patients had been put to bed, often after 9pm, which could lead to a working day of more than 12 hours’ duration. During the day, they were enjoined to “use [their] utmost endeavours to promote the recovery, comfort and happiness of the patients under [their] charge.”⁹⁹ The Matron in particular was required to “spend much time in the wards, laundry and workroom, conversing with the patients, supervising work, and encouraging all in useful employment.”¹⁰⁰ These were certainly considerable duties; from the Medical Superintendent to the mostly newly-hired attendant, hours were long, the work unending, and leisure scarce. Asylum staff appear to have been expected to manage all aspects of patients’ lives with the end of making their time in the Asylum as much like care and as little like custody as possible. A good deal of patients’ chances of recovery seem to have been placed on the shoulders of the attendants, especially on their ability to create as pleasant an environment as possible.

Julie Parle notes that many of the Natal Government Asylum’s more senior staff were recruited from Britain, because it was not possible for Hyslop to find satisfactory staff in Natal or the Cape.¹⁰¹ Likewise, Swartz notes that at Valkenberg, staff at the top of the medical and nursing hierarchies were recruited from Britain.¹⁰² These senior staff tended to remain in their positions for some time, although there was considerable turnover among more junior ward and medical staff.

⁹⁷ Author Unknown, *Rules and Regulations for the Officers and Servants of the Graham’s Town Asylum*, Folio 1171, CO 7641, Western Cape Archives and Records Repository, Cape Town., pg. 7.

⁹⁸ *Officers and Servants*, pg. 7

⁹⁹ *Ibid.*

¹⁰⁰ *Ibid.*

¹⁰¹ Parle, *States of Mind*, pg. 101.

¹⁰² Swartz, “Psychiatric Knowledge in the Cape”, pg. 38.

Asylum working conditions and staffing challenges

Working at the Asylum did not offer much of what would now be known as “work-life balance”. The “General Rules” in the 1899 edition of *Rules for the Management of Asylums*, which was the handbook used by all Cape asylums, list the rules governing the movement and freedom of speech of attendants early on, suggesting that they were meant to be taken very seriously and quickly understood by new staff. Attendants were not allowed to leave the Asylum without the Medical Superintendent’s permission, and had to obey the curfew he set. Furthermore, anything they saw that they deemed to be improper had to be reported to the Medical Superintendent immediately, and any complaints they wished to make had to be made to the Medical Superintendent. Attendants were furthermore not allowed to make any communications or transactions about the Asylum or anyone connected with it without the Medical Superintendent’s permission, and any communications any staff member wished to make with the government had to go via him as well.¹⁰³ Aside from creating a great deal of administrative work for the Medical Superintendent, these rules also allowed him to exercise a great deal of control over what kind of information entered and left the Asylum, while less senior staff were reliant upon his goodwill and/or professionalism if they wished to complain or otherwise report about Asylum matters.¹⁰⁴ Attendants, evidently, were required to toe the line and follow orders. They were in fact required to sign an undertaking that they would abide by these rules.¹⁰⁵

Staff turnover appears to have been quite high at Grahamstown Asylum, which is unsurprising given the nature of the work and accompanying lifestyle: wages paid to Asylum staff were on the same scale as those paid to other civil servants, despite the fact that working as an asylum attendant was manifestly nothing like clerking in a government department. The Surgeon Superintendent earned the highest salary, concomitant with his authority and responsibilities: £360 a year and three “rations”¹⁰⁶ a year in lieu of rent.¹⁰⁷ The other members of the Asylum’s

¹⁰³ *Rules for the Management of Asylums*, Folio 1171, CO 7641, Western Cape Archives and Records Repository, Cape Town, pg. 1

¹⁰⁴ The case of Miss Hickey, a former nurse who levelled complaints about the Asylum, illustrates that this system did not meet with universal approval; is discussed elsewhere.

¹⁰⁵ Swartz, “Psychiatric Knowledge at the Cape”, pg. 39.

¹⁰⁶ A ration was worth approximately £22 14s 5d in 1878, and consisted of 1,5lb of bread, 1.25lb of meat, 4oz of rice, and 30lb of firewood daily, and 5lb of candles monthly.

¹⁰⁷ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report on the Grahamstown Lunatic Asylum for 1878*, CCP1/2/1/39, G31-’79, Western Cape Archives and Records Service, Cape Town, pg. 20.

administrative staff, the clerk and storekeeper, earned £100 a year, supplemented with £50 and two rations a year in lieu of rent. These were by far the three highest salaries earned by Asylum staff. By contrast, the Matron and Head Attendant earned £63 and £65 respectively (note the gender inequality), as well as being supplied with one ration and living quarters at the Asylum. Attendants and nurses earned £55 and £40 respectively (note the even larger gender inequality; there were four of each employed at the Asylum in 1878), as well as quarters and one ration. The cook and laundress, messenger, and ward attendant all earned between £40 and £55, while the gardener, a highly skilled individual, earned £60.

Retaining the services of attendants and nurses was problematic: of those eight employed in 1878, only one attendant and one nurse remained on the staff for 1879;¹⁰⁸ four of the five attendants therefore had been on the job for less than a year, as had three of the four nurses. The 1880 contingent of attendants and nurses was likewise new to the work: all six attendants and four of the five nurses had been hired during the year.¹⁰⁹ In 1880, also, the posts of Deputy Head Attendant (£12 a year, plus two rations) and Under-Laundress (£30 a year, plus two rations) were created.¹¹⁰ The senior staff, however, stayed in Asylum employment for much longer: Robert Hullah served 15 years as Medical Superintendent from 1875 to 1890, and T Duncan Greenlees served 17 years from 1890 to 1907. The disparities in the length of time junior staff and senior staff remained in the Asylum's employ are striking. They may have to do with the relative arduousness of work on the Asylum wards, although certainly senior staff also worked long hours, or the lower pay. Further, while working in the Asylum may have been a vocation for the medical staff, that would not necessarily have been the case for junior staff, who may have seen it as a stopgap measure before moving on to higher-paying, less physically taxing work.

The number of attendants and nurses employed at the Grahamstown Asylum increased considerably between 1880 and the 1890s. In 1891, there were 12 attendants and nine nurses

¹⁰⁸ Hullah, "Grahamstown Asylum 1878", pg. 20; Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report on the Grahamstown Lunatic Asylum for 1879*, CCP1/2/1/43, G53-'80, Western Cape Archives and Records Service, Cape Town, pg. 21.

¹⁰⁹ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report on the Grahamstown Lunatic Asylum for 1880*, CCP1/2/1/39, G31-'81, Western Cape Archives and Records Service, Cape Town, pg. 21.

¹¹⁰ Hullah, "Grahamstown Asylum 1880", pg. 21.

(a staff-to-patient ratio of 1:9.6 for men and 1:7.7 for women).¹¹¹ By 1894, the complement of nurses had increased to 11 and that of attendants to 15, making for a ratio of 1:8 for both sexes; the increase in staff was a reaction to the increasing patient population.¹¹² These proportions remained steady throughout the 1890s and rose only slightly in the early 1900s. In 1900, the Asylum employed 18 attendants and nine nurses, which created a staff-to-patient ratio of 1:11 for men and 1:9 for women. The Asylum population at the time was made up of 204 male patients and 83 females, which accounts for the reduced number of nurses relative to previous years.¹¹³ Indeed, the number of attendants increased from 18 in 1900 to 27 in 1905,¹¹⁴ while the number of nurses rose from nine in 1900 to 14 in 1904, but declined slightly to 13 in 1905. In the intervening years, the ratio of staff to patients remained steady, around 1:9 (in 1905, in particular, the ratio of male patients to attendants was 10:1 and there were seven female patients to each nurse.)¹¹⁵

Keeping a steady staff at the Asylum was a source of some concern for the Medical Superintendents Hullah and Greenlees, although the matter did not receive a great deal of attention in the Annual Reports. These tend to concentrate more on the training of staff, at least after Greenlees' arrival in 1890. What does come through clearly in the Annual Reports, however, is that assembling a competent staff at the Asylum did cause problems on occasion. In 1878, Hullah reported that drunkenness – which carried the penalty of instant dismissal –

¹¹¹ T. Duncan Greenlees, "Part 6: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1891, part VI: Grahamstown Asylum and Chronic Sick Hospital*, CCP1/2/1/82, G36-'92, Western Cape Archives and Records Service, Cape Town, pg. 44.

¹¹² T. Duncan Greenlees, "Part 14: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1894, part VI: Grahamstown Asylum*, CCP1/2/1/92, G16-'95, Western Cape Archives and Records Service, Cape Town, pg. 68.

¹¹³ T. Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1900, part VI: Grahamstown Asylum*, CCP1/2/1/115, G41-'01, Western Cape Archives and Records Service, Cape Town, pg. 83.

¹¹⁴ T. Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and of the Inspector of Asylums for 1905*, CCP1/2/1/137, G32-'06, Western Cape Archives and Records Service, Cape Town, pg. 76.

¹¹⁵ Greenlees, "Grahamstown Asylum 1905", pg. 76.

made keeping male staff difficult;¹¹⁶ incompetence was another bugbear, one not helped at all by the fact that at any given time, many staff were new and inexperienced. Inexperienced staff, particularly attendants, were apparently likely to resort to unacceptable measures to control patients. In 1879, a male attendant was immediately dismissed for injuring a patient while “cruelly and unauthorisedly [*sic*] restraining him.”¹¹⁷ Female staff seemed to give less trouble overall. The amount of personal power that an attendant could exercise over a relatively powerless inmate may have led to trouble more often than was reported in the Annual Reports; given that there were hundreds of patients, a large physical campus and only one Medical Superintendent makes it likely that other instances of minor cruelty and injury went unreported. It is also, as Swartz points out with reference to staffing at Valkenberg, hard to know how closely staff were monitored regarding their treatment of patients: it is likely that staff vouched for one another if patients complained, although when problems were revealed they were usually dealt with quite swiftly. Maltreatment of patients was obviously anathema to the prevailing culture of moral treatment, but of course it is impossible to know what was concealed.¹¹⁸

That they were not attracting the best possible candidates for the job was apparent to both Hullah and Greenlees. Hullah noted that the pay offered to Asylum staff in the Cape Colony was double that which was standard in the United Kingdom, and despaired that despite this, the only people that seemed to think they wanted to work in an Asylum proved inept,¹¹⁹ with Colonial-born applicants being particularly woeful. He thus recommended that the wages, high as they were, be raised even further in order to attract better staff, or that a specific policy of employing only British immigrants be implemented.¹²⁰ The quality of staff native to the Colony did not please Hullah, and neither did the Colonial population’s evident unwillingness to work in asylums despite the obvious perks attached to the job. In the 1879 report he wrote that two advertised vacancies on the Asylum staff had not attracted any applications, despite the high wages, light duties and “numerous privileges” attached to the

¹¹⁶ Hullah, “Grahamstown Asylum 1878”, pg. 2. As well as the most obvious drawback posed by drunk staff – who were potentially dangerous to staff and patients alike – it should also be remembered that instant dismissal meant the Asylum went short-staffed until a replacement could be recruited.

¹¹⁷ Hullah, “Grahamstown Asylum 1878”, pg. 2.

¹¹⁸ Swartz, “Psychiatric Knowledge at the Cape”, pg. 39.

¹¹⁹ Reminiscent of Groucho Marx’s remark that he did not wish to belong to any club that would have him as a member. (Angela Partington (ed.), *The Oxford Dictionary of Quotations*, Revised Fourth Edition (Oxford, 19960, pg. 451).

¹²⁰ Hullah, “Grahamstown Asylum 1878”, pg. 2.

work.¹²¹ By 1886, Hullah was concerned that the Asylum did not have sufficient staff to handle the size of its population;¹²² though this appeared to have improved by 1888, the situation was still not entirely satisfactory: although the medical staff was finally large enough to adequately handle the population, the administrative staff was beleaguered, and clerical work in the stores had become overwhelming.¹²³

The arrival of Greenlees in 1890 brought in a new era for the Asylum staff, particularly in terms of education and staff training. He instituted a series of lectures on the care and management of asylum patients, which appear to have slightly improved matters: "Not only do [the lectures] educate the staff up to a proper standard of excellence but they instil an enthusiasm and interest in work which to uneducated persons is sadly devoid of interest."¹²⁴ This statement implies some dissatisfaction with the type of person the Asylum had been forced to employ. Further, Greenlees requested more staff in his report to the Inspector of Asylums in 1892, mentioning that he had nearly 400 people to manage, spread over a large area, and too much clerical work to do, given that he was the only medical practitioner at the Asylum.¹²⁵ In 1893, it was noted that the post of Assistant Medical Officer had been sanctioned by the Government.¹²⁶ In that year, several attendants and nurses were dismissed;

¹²¹ Hullah, "Grahamstown Asylum 1878", pg. 2.

¹²² Robert Hullah, "Part VI: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1886*, CCP1/2/1/69, G5-'87, Western Cape Archives and Records Service, Cape Town, pg. 21.

¹²³ Robert Hullah, "Part 6: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1888*, CCP1/2/1/73, G5-'89, Western Cape Archives and Records Service, Cape Town, pg. 19.

¹²⁴ T. Duncan Greenlees, "Part 6: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1890, part VI: Grahamstown Asylum and Chronic Sick Hospital*, CCP1/2/1/79, G37-'91, Western Cape Archives and Records Service, Cape Town, pg. 44.

¹²⁵ T. Duncan Greenlees, "Part 6: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1892*, CCP1/2/1/84, G17-'93, Western Cape Archives and Records Service, Cape Town, pg. 21.

¹²⁶ T. Duncan Greenlees, "Part 6: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1893, part VI: Grahamstown Asylum*, CCP1/2/1/89, G24-'94, Western Cape Archives and Records Service, Cape Town, pg. 49.

drunkenness, incapacity, and breaking the curfew were the most common reasons for dismissal.¹²⁷

A small amount of drunkenness and authorised absence seems to have been an understandable reaction to the working conditions experienced by asylum staff, which were certainly not as congenial as Hullah had suggested. It was indoor work and did not require much heavy lifting, making it less onerous than agricultural labour, manual labour, mining, or training as an artisan, but it presented fairly unique challenges. The asylum management, at least once Greenlees was in control, seems to have appreciated this. In 1891, Greenlees noted that the amount of leave available to attendants had been increased to compensate for the long working hours and to ease the stress of duties that he described as “harassing and not infrequently accompanied by danger.”¹²⁸ The injury of attendants by patients was frequent; though usually fairly minor, injuries sustained while on duty occasionally resulted in considerable physical pain, incapacitation or trauma (in one case, at least, death resulted). In most cases, injury sustained at the hands of a patient, Greenlees noted, had “a depressing effect upon the recipients, many of whom are afterwards no longer able to perform duties accompanied by such risks.”¹²⁹ Dodds, in his role of Inspector of Asylums, often brought the inadequate pension, pay and leave to the attention of the Colonial Office, and also reminded administrators there of the hard conditions under which asylum staff worked. The high turnover of asylum nurses and attendants distressed him, as, he believed, it made the proper running of asylums impossible if the staff were always to be inexperienced and overworked.¹³⁰

Although an Assistant Medical Officer had taken up the post at Grahamstown Asylum in 1893, he was sent to Robben Island to act as temporary superintendent there in mid-1895.¹³¹ This man, Dr Walter Adam, had previously been employed at Rainhill Asylum in Lancashire and would have provided much-needed support for the staff at Grahamstown Asylum; consequently Greenlees, having finally secured an AMO, was not pleased to see him

¹²⁷ Greenlees, “Grahamstown Asylum 1893”, pg. 49.

¹²⁸ Greenlees, “Grahamstown Asylum 1891”, pg. 39.

¹²⁹ Greenlees, “Grahamstown Asylum 1894”, pg. 51.

¹³⁰ Swartz, “Psychiatric Knowledge in the Cape”, pg. 39.

¹³¹ Greenlees, T. Duncan Greenlees, “Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1895, part VI: Grahamstown Asylum*, CCP1/2/1/101, G20-’87, Western Cape Archives and Records Service, Cape Town, pg. 21.

transferred away so soon, particularly because a number of changes were occurring at the Asylum at more or less the same time. New rules had recently been drawn up to assist the staff of the Asylum in its management,¹³² at the same time as a number of male staff had resigned to pursue their fortunes in the mining fields opening up to the north of the Colony. These resignations left the male quarters of the Asylum under the control of under-experienced staff; the female quarters remained steady, as nurses generally only left to get married.¹³³ To further complicate matters, when Dr Adam returned from Robben Island, he almost immediately resigned from the asylum service entirely in favour of going into private practice in the Transvaal. His replacement, Dr CG Cassidy, later Superintendent of Valkenberg Asylum, joined Greenlees in June 1896 and stayed for three years.¹³⁴ In 1897, Greenlees requested another assistant, this time to deal with the amount of administrative paperwork and official correspondence that crossed the Superintendent's desk: "Such [an assistant]...is now provided in many English asylums," he wrote, "where this work is not so heavy as it is here."¹³⁵ Greenlees, British by birth and trained in his specialisation in British hospitals, repeatedly cited them as the model for the type of asylum into which he was attempting to mould Grahamstown Asylum.

The later 1890s, then, were a somewhat unsettled time for the staff of the Grahamstown Asylum. In 1898 alone, despite wage increases, four attendants left to "better themselves" (only three of these formally resigned before leaving), a further two were dismissed, and two nurses left to get married (married women were not employed as ward attendants).¹³⁶ In addition, Greenlees was still deluged with administrative duties which he viewed as an unnecessary distraction from his medical work, which was the reason the Asylum existed in

¹³² Greenlees, "Grahamstown Asylum 1895", pg. 25.

¹³³ T. Duncan Greenlees, "Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1896, part VI: Grahamstown Asylum*, CCP1/2/1/101, G20-'87, Western Cape Archives and Records Service, Cape Town, pg. 4.

¹³⁴ Greenlees, "Grahamstown Asylum 1896", pg. 4.

¹³⁵ T. Duncan Greenlees, "Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1897, part VI: Grahamstown Asylum*, CCP1/2/1/108, G21-'99, Western Cape Archives and Records Service, Cape Town, pg. 8.

¹³⁶ T. Duncan Greenlees, "Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1898, part VI: Grahamstown Asylum*, CCP1/2/1/108, G21-'99, Western Cape Archives and Records Service, Cape Town, pg. 4.

the first place. Administrative busywork interfered with his ability to make the Asylum effective: his clerical duties, he said, “materially interfere with my giving that personal and individual attention to my patients which is so essential to their welfare.”¹³⁷

Greenlees did not believe that medical staff should be expected to do all the paperwork on top of their medical work, especially given the time_lag that followed from having to refer every decision to the colonial capital, Cape Town, which was over 1000km distant.¹³⁸ In 1899, the Assistant Medical Superintendent had once again been replaced: Cassidy had transferred to Emjanyana Leper Asylum, to be replaced at Grahamstown by Dr GA Turner. Three male attendants had left the Asylum and been replaced by men even more inexperienced, and the Matron (Miss Robinson, discussed briefly below) had retired on grounds of ill-health and been replaced by Miss Fraser, formerly of Robben Island Asylum. All of this was occurring just as the South African War gathered momentum and began to unsettle the Colony.¹³⁹

As a result of all these changes, the Grahamstown Asylum entered the 20th century staffed by people who were, if not necessarily inexperienced, at least still settling into the situation. Making matters still worse was the military mobilisation of the Colony: those male employees attached to military units were given six months leave to go on active service. The AMO, Dr Turner, had joined the First City Volunteers, but had been replaced by Dr Cassidy, who had fled the Transvaal and re-joined the Asylum staff.¹⁴⁰ It is therefore not too surprising that the Asylum’s one clerk suffered a nervous breakdown due to overwork and stress, and had to be sent away to convalesce.¹⁴¹

¹³⁷ Greenlees, “Grahamstown Asylum 1898”, pg. 10.

¹³⁸ *Ibid.*

¹³⁹ T. Duncan Greenlees, “Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital”, *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1899, part VI: Grahamstown Asylum*, CCP1/2/1/112, G25-’00, Western Cape Archives and Records Service, Cape Town, pg. 3.

¹⁴⁰ Greenlees, “Grahamstown Asylum 1899”, pg. 7.

¹⁴¹ Also in this time, a rumour that Boer commandoes were approaching Grahamstown sent the city’s military units scrambling to battle stations. Greenlees, faced with the imminent abrupt departure of half his staff, had to exercise his utmost charm to persuade them to stay at the Asylum rather than leave to defend the City. In the event, the city was not attacked.

The unsettled staffing situation continued into the early 1900s: *eleven* male attendants left to take up military service; consequently almost half the ward staff had to be replaced. Three female staff also left. In the same year, the number of patients admitted spiked,¹⁴² causing something of a staffing scramble. Similar staff changes kept on during 1901, during which year the AMO changed twice (Dr Carrington Purvis replaced Dr Turner, and was himself replaced by Dr ABS Powell) and the assistant clerk was dismissed and replaced, only for his replacement to resign. Four attendants had been dismissed, and thirteen left to join the army. Six nurses resigned. Greenlees, feeling pressured to reduce staff turnover and thereby maintain the standard of care the Asylum aspired to, noted in the 1901 Annual Report that the matter of securing reliable staff would not be resolved until remaining in the Asylum's employment could be made as attractive as military service. He therefore suggested that wages for Asylum employees be raised, at least temporarily; further, he suggested, staff wages needed to be raised in general, as they were at that stage so low that married male attendants could not support their families on the current wages, especially because the cost of living had been increased by the war.¹⁴³ To make things worse, both Greenlees and Powell fell ill in 1902, putting both of the Asylum's medical practitioners out of action for nearly three months, during which time they were replaced by the returned Dr Purvis and a medical practitioner on loan from Valkenberg, Dr Cowper, who would later replace Greenlees as Medical Superintendent. The end of the South African War, however, settled matters and the Asylum's staff numbers eventually resumed equilibrium.

The asylum becomes the inmate's entire world; however much contact he or she may have with the outside world through communication with friends or relatives, it remains the fact that the great majority of his or her time is spent in one place, with one group of people, repeating the same routine every day with little enlivenment. Devising any kind of personal life in the asylum environment was tricky enough; it was presumably even more difficult to do so when those in power over you were a revolving cast of inept and inexperienced strangers, each of whom needed to be assessed, adjusted to, and accommodated. Quite apart from the difficulties in creating a cohesive Asylum project that Greenlees experienced as a result of constant wrangling with and over a high staff turnover, the patients bore the brunt of the Asylum's staffing problems.

¹⁴² T. Duncan Greenlees, "Part 3: Grahamstown Asylum 1900", pg. 81. This was attributed to the effects of the war.

¹⁴³ Greenlees, "Grahamstown Asylum 1901", pg. 97.

Inmates inside the institution had little control over who they come into contact with.¹⁴⁴ Outside the asylum, adult individuals have control – not always as much as they might like, but generally some measure – over who they interact with, but once inside the asylum this element of choice is removed. Outside, privacy is possible; inside the asylum, inmates often cannot choose who sees them unclothed, upset or ill,¹⁴⁵ and cannot avoid the possibility that witnesses to their discomfort might not be those with their best interests at heart. Furthermore, they cannot act with complete autonomy; breaking house rules in front of an attendant would lead to reprimand and possibly penalties.¹⁴⁶

The amount of power attendants wielded over inmates was considerable, and this was known to the Asylum's management structures, which, as we saw above, acknowledged that they were not always able to employ attendants to whom the care of other people came naturally. As a result, the Asylum management devised a set of rules, discussed below, to ensure that attendants understood the nature of their responsibilities.

Rules and Regulations for Staff in the Asylum

The admitted goal of providing careful care and a therapeutic environment in the Asylum meant that the staff, whose behaviour basically determined whether this goal became a reality, had to follow definite patterns in order to ensure that. To this end, two handbooks for Asylum staff were published in 1899: *Rules for the Management of Asylums*, and a similar text titled *Rules and Regulations for the Officers and Servants of the Graham's Town Asylum*. Both booklets deal with the duties and obligations of the various Asylum staff, and between them indicate that a certain set of values and goals informed the ways in which the Asylum operated. A major focus of these Asylum rule books was the moral obligation that staff held towards the patients in their care. Under the heading, "Rules and Regulations for Attendants, Nurses and Others", *Rules for the Management of Asylums* states,

It is expected that the attendants will assist in every way they can to promote the interest of the Asylum, and the comfort of its afflicted inmates... [They] should remember that their position is one of great trust and responsibility; they have the care of those who, through affliction,

¹⁴⁴ Goffman, *Asylums*, pg. 32.

¹⁴⁵ Goffman, *Asylums*, pg. 33.

¹⁴⁶ Goffman, *Asylums*, pg. 53.

cannot take care of themselves, and upon them the recovery, comfort, happiness and safety of the patients' in great measure depend.¹⁴⁷

Attendants were furthermore enjoined to be kind, tactful, firm, good-tempered, thoughtfully attentive to their duty, orderly and neat, and also to take a kindly interest in each patient.¹⁴⁸ This is a fairly formidable list of requirements for anybody to fulfil, even in a line of work where the satisfaction of working for the good of others was considered to be at least part of the reward.

Helpfully, a comprehensive guide to how to carry out these duties was provided in *Rules for the Management of Asylums*. This book suggested that attendants cultivate the "minor accomplishments which are popular in Asylums"¹⁴⁹ (possibly music, needlework, basketwork or something else mildly entertaining), and learn not to resent "intemperate or unruly behaviour directed at them", and "set examples for the patients in terms of attitudes, industry and proper moral conduct".¹⁵⁰

The rules were clear on the necessity of setting a good example and treating the patients kindly: "[Attendants] should always remember that the patients under their charges are afflicted and suffering beings, separated from home and relations...and that any cruelty towards them is of a peculiarly cowardly nature."¹⁵¹ Instant dismissal would result for any attendant who was found drunk or in possession of intoxicating liquor, or who swore, or who entered the opposite sex's quarters in the Asylum.¹⁵² Any cruelty to the patients likewise resulted in instant dismissal, as well as prosecution when possible.¹⁵³ Any attendant who witnessed the ill-treatment of a patient and failed to report it promptly would likewise be dismissed.¹⁵⁴

¹⁴⁷ *Rules*, pg. 4.

¹⁴⁸ *Ibid.*

¹⁴⁹ *Rules*, pg. 7.

¹⁵⁰ *Ibid.*

¹⁵¹ *Rules*, pg. 7.

¹⁵² *Rules*, pg. 5.

¹⁵³ *Ibid.*

¹⁵⁴ *Ibid.*

Safeguards against the risk that attendants might not willingly fulfil their mandate of kind treatment and infinite patience were therefore encoded into the rules governing their behaviour. Attendants were repeatedly warned, in their dealings with upset or dangerous patients, against becoming angry or aggressive in return. This was described as being simply counterproductive; the book insisted that dangerous patients were more easily controlled by kindness, tact and firmness than by force, and attendants were accordingly told to interfere as little as possible with patients unless they became violent.¹⁵⁵ The first concern, in that respect, was to avoid harming the patient rather than to avoid injury to the attendant.

The first instruction to be followed in the event of a patient becoming violent was to summon as many other attendants as could be mustered, in the hopes that a show of force would persuade the patient to abandon any proclivity towards violence. Attendants, specifically those new to the job, were requested to forego heroics and call for help, as struggling with patients usually only resulted in injury and resentment.¹⁵⁶ There was also an explicit request that attendants refrain from kneeling on patients' backs¹⁵⁷ or twisting their wrists when attempting to subdue them. These measures were evidently commonly used, or feared, enough that a specific request to avoid them was included in the handbook. Also rather emphatically stressed in the handbook was that troublesome patients were not being troublesome simply to annoy their attendants, but were rather unable to control their behaviour, which was a product of their disease;¹⁵⁸ becoming angry, therefore, was pointless, as well as unbecoming of professional personnel. There is an interesting disjuncture between this exhortation towards patience and forbearance towards unruly patients in this book, and the frustration directed at them in the Annual Reports. It is also interesting to note that while attendants were enjoined to treat all patients as though their behaviour was the result of their illness, black patients were usually perceived as being problematic due to racial characteristics.¹⁵⁹ Although the rule-books do not say so explicitly, the depth of discrimination evident everywhere else in Asylum practices suggests that it was more acceptable for attendants to take a hard line with black patients than it would have been for them to be aggressive or uncaring towards white, wealthy patients.

¹⁵⁵ *Ibid.*

¹⁵⁶ *Rules*, pg. 8.

¹⁵⁷ Kneeling on a person's back compresses the lungs and diaphragm and may cause positional asphyxia.

¹⁵⁸ *Rules*, pg. 8.

¹⁵⁹ As discussed earlier in this thesis.

Second to patience and compassion came vigilance: attendants were expected to keep a very close eye on their patients, to manage negative behaviour and maintain standards of comportment. “Wet and dirty” (incontinent) patients had to be given “regular and persevering attention to be encouraged to improve their habits” while epileptic patients – described as being of “great irritability and sudden impulses”¹⁶⁰ – were supposed to be given special attention for some days before and after their seizures,¹⁶¹ which would have translated to constant surveillance. This may not have entailed extra work; attendants were supposed to exercise constant supervision over their patients in any case. No wards could ever be left unsupervised, and attendants were expected to be *au fait* with the mental condition, health, and habits of every patient in their care, and be able to report on and describe any new developments or changes, and were also in charge of dispensing whatever medications the Medical Superintendent prescribed.¹⁶² The practical and emotional considerations undertaking the job of an asylum employee were considerable, and daunting.

The bigger part of the booklet under examination detailed the attendants’ duties regarding the Asylum’s various activities, meals, amusements, and work. The booklet does not outline daily schedules to which patients and staff had to adhere, but rather provides guidelines for the manner in which patients were to be handled. In the dining hall, for example, attendants were expected to keep track of which patients ate their meals without trouble, and which would or could not eat, as well as ensure that meals were neatly served.¹⁶³ During outdoor excursions attendants were required to prevent patients from wandering away, eating or handling anything potentially dangerous, and especially to make sure they did not bring anything back inside that could be used to harm themselves or others. In hot weather, they also had to prevent patients being overexposed to the sun.¹⁶⁴

In light of this, attendants acted primarily as minders, concerned with keeping patients safe and as happy as possible, but not with administering much therapeutic care or treatment. (For a broader discussion of this mode of treatment, see Chapter Two). If one goes by the guidelines issued to attendants in the asylums of the Cape Colony, patients in the asylums

¹⁶⁰ *Rules*, pg. 9.

¹⁶¹ *Ibid.*

¹⁶² *Rules*, pg. 10.

¹⁶³ *Rules*, pg. 11.

¹⁶⁴ *Rules*, pg. 12.

there were under care rather than incarceration – protective custody, so to speak. Rehabilitation was a goal, to be achieved through kindness, good treatment, and the diversion of patients from their insanity by amusements, work, and the good example set by Asylum attendants.

Defiance may also have resulted from the sheer number of rules which attendant had to follow to ensure the Asylum ran smoothly in all respects. As already mentioned, the Asylum was primarily divided into male and female quarters, and access to each was strictly controlled. Indeed, one of the most pervasive aspects of the Asylum's rules was the control and restriction of interaction between all individuals connected with the Asylum. On a fairly basic level, access to wards and dormitories was restricted. Neither male attendants nor patients were permitted into the female ward of the Asylum without a specific errand or other authorisation; the obverse also applied.¹⁶⁵ Also prominent in the rules was that no male attendant was allowed to possess a key to the female quarters of the Asylum without the written permission of the Medical Superintendent; no mention is made of the circumstances under which female staff might have obtained a key to the male quarters.¹⁶⁶

Evidently, then, the division of gender within the Asylum, among staff and patients alike, was fairly clear: male attendants engaged in activities, such as repairs, that took them to the female side of the asylum on occasion, but mostly they remained on the male wards and in shared areas. Furthermore, the rule against male staff entering the female wards indicates that males seem to have been perceived – and indeed probably did present – more of a threat to the women in the Asylum than vice versa.¹⁶⁷ The threat does seem to have been believed to be allayed by restricting of access. The circumstances under which male staff *could* access female quarters are outlined in the rule booklet, however; what might be deduced from this, then, is that while there were circumstances that would necessitate men entering the female wards, it was either much rarer or never that women would need to go over to the male wards.

¹⁶⁵ *Rules*, pg. 2.

¹⁶⁶ *Ibid.*

¹⁶⁷ In the other handbook, an annexure lists the penalties levied against staff for various infractions. Carnal knowledge by a male staff member of a female patient, with or without consent, carried a term of imprisonment. No penalty is mentioned for the obverse, and same-sex relationships are, unsurprisingly, not mentioned.

Sleeping arrangements were likewise rigidly prescribed. The *Rules for Management* booklet notes that in the male dormitories specifically, staff were to ensure that there were no more than three men to each dormitory and that each man slept alone in a single bed (the exceptions were men in single rooms, who would be one to a room and therefore one to a bed).¹⁶⁸ No such rule is laid down for the female dormitories. In each part of the Asylum, an attendant or nurse had to sleep in or near to the dormitory to which they were assigned. The Medical Superintendent and Assistant Medical Officer had to be accompanied by the Matron or a nurse on any night visits to the female wards.¹⁶⁹

The likelihood of inmates engaging in sexual relations, therefore, was evidently something of a concern; perhaps more so in the case of male patients than of female. Although the need for the Medical Superintendent to be accompanied by a female staff-member while visiting the female dormitories was most likely in the interests of observing propriety (at least part of which arose from Victorian anxiety around unsanctioned sex), the explicit reference to the need to ensure that male patients all slept separately is somewhat more opaque. It could be simply that, as there were more male patients generally, the risk of overcrowding was higher and therefore the practice of male patients sleeping two to a bed became more widespread. This may have been discouraged on the grounds of the spread of infections such as colds or influenza, or to cut back on the spread of lice. It is possible that the rule was put in place to prevent arguments about bedclothes, snoring or space from turning violent. Or, perhaps, the emphasis on making male patients sleep alone might have arisen from a fear, albeit one that went largely unarticulated in practically all Asylum notebooks and handbooks, that proximity might lead to homosexual behaviour. (The instance, mentioned in Chapter 6, in which the patient Frederick G. was discovered in bed with another male patient was evidently unusual and upsetting enough to warrant a special note in his files.)

The absence of a corresponding rule for governing sleeping arrangements on the female wards suggests that either sex and/or violence were not causes for concern on the female wards (regardless of their actual incidence, evidently; female patients were known to have injured one another fairly often, but no mention of sex ever made it into an Annual Report) or

¹⁶⁸ *Rules*, pg. 3.

¹⁶⁹ *Ibid.*

that there was enough space to accommodate female patients one to a bed. Distinct concerns about violence and/or sex are also evident in the short set of rules governing visiting hours and procedures surrounding visitors. No male, whether inmate, attendant or visitor, was allowed to be alone with a female, unless under the supervision of another attendant, a nurse or any other third party *except* another patient.¹⁷⁰ No person unconnected to the Asylum was allowed onto asylum premises (that is, nobody who was not staff, a patient, an official connected to the asylum, or a visitor connected to a specific patient) unless on the authority of the law, or with the permission of the Medical Superintendent, and then only if they were accompanied by one of the medical officers.¹⁷¹

Also informing both the sleeping and the visiting arrangements was the attention paid to the information regarding the Asylum that passed out into the world outside. As already mentioned, the Asylum staff were obliged to pass any complaints or communication with the government across the Medical Superintendent's desk, and they were not allowed to send any communications regarding the Asylum to outside parties except with the permission of the Medical Superintendent.¹⁷² While this does make sense if seen in terms of maintaining an institutional image and protecting sensitive information, it obviously proscribes much institutional transparency and, as already stated, gave the Medical Superintendent a considerable degree of control over the Asylum's image. The *Rules of Asylum Management* handbook also noted that the Medical Superintendent could prevent patients from being visited by anyone whose presence he deemed to be potentially "injurious to the patient or...otherwise inexpedient."¹⁷³

The same book also notes that all letters from patients had to cross the Superintendent's desk before being posted. This did not, however, mean that he read all – or even most – of them: he was obliged to forward unopened any letters that patients had addressed to their nearest relatives or sponsors, the Governor of the Colony, any Ministers of State, High Court Judges, Resident Magistrates, Official Visitors or the Under Colonial Secretary. This does seem to be fairly comprehensive list, but it left a number of letters that could potentially be opened, such as those to friends who were not their sponsors. It is patently clear therefore that one of the

¹⁷⁰ *Rules*, pg. 2

¹⁷¹ *Rules*, pg. 3.

¹⁷² *Rules*, pg. 2. One does wonder what staff *could* write about in letters.

¹⁷³ *Rules*, pg. 2.

primary concerns of the Asylum management at any Colonial asylum was the control and regulation of interaction between individuals inside the Asylum and between the Asylum and the rest of Colonial society, both close to home and further afield. The effectiveness of a total institution, particularly a closed one such as an asylum, depends on sealing the boundaries and creating, inside that seal, a particular culture with its own rules and hierarchies. That, in the case of the Grahamstown Asylum, this culture mimicked the one outside is unfortunate but entirely predictable.

Repeated enjoinders by the handbooks that attendants be patient, efficient and loyal to the Asylum – and penalties against anyone who failed to be these things – would have gone some way towards preserving the patients' safety, and were intended to create a therapeutic environment. Attendants were expected to "assist in every way they can [to] promote the interests of the Asylum, and the comfort of its afflicted inmates"; particularly in the case of work and amusements: "As a principle of treatment, endeavours should be continually made to occupy the minds of the patients to induce them to take exercise in the open air, and to promote cheerfulness and happiness among them."¹⁷⁴ This sentiment is repeated later in the booklet: "Occupation and amusement are invaluable means of treatment by diverting the mind from its insane notions and giving it a new and healthy direction."¹⁷⁵ In the case of work and amusements, attendants were requested to try and get as many patients as possible to participate. As discussed in Chapter Six, however, there were certain groups of patients who were excluded almost by default from recreational activities, and therefore it seems reasonable to say that these rules only applied to attendants when they were dealing with one of the more favoured categories of inmate.

Participation had, however, some drawbacks for the attendants. As most patients' actions were deemed to be out of their control (evidenced by several reminders to attendants to keep calm and take nothing personally) the entire onus on keeping them safe *and* under control fell to the attendants. Any misconduct by patients was likewise the responsibility of the attendants who had charge: for example, any failure to keep a walking party under control led

¹⁷⁴ *Ibid.*

¹⁷⁵ *Rules*, pg. 11.

to the suspension of all walking parties, and any attendant whose negligence allowed a patient to escape was held liable for any damages and costs incurred.¹⁷⁶

What might be considered fairly routine related work indoors at the Asylum was even more demanding. Attendants had to ensure that patients were neatly and completely dressed, that they bathed regularly, and that they did not deliberately break or waste anything.¹⁷⁷ In the case of bathing, the booklet noted that no patient had to be forced to bathe if they chose not to, and that the “greatest gentleness and propriety” had to be observed.¹⁷⁸ The section on bathing stipulates the frequency of baths, how many patients could be bathed at a time, and so on. The procedure for putting patients to bed was similarly detailed, requiring an attendant’s presence to ensure that all clothes and other objects were properly stored away. Unsurprisingly, the storage of dangerous objects was given great attention; in fact, a register existed to log lost objects, particularly potentially dangerous ones like knives and glass.¹⁷⁹ This mention of the possibility of suicide or violence jars in the context of the remainder of the booklet, which seldom alludes to the direct risks patients posed to themselves or others.

Asylum work, on the whole, certainly was not a particularly soft option – apart from the long hours and the nature of the work which could be both physically and mentally exhausting, there were also a great number of rules and regulations to which Asylum staff had to adhere in order to ensure that the Asylum ran smoothly and, beyond that, that patients benefited from their presence. Two handbooks published in 1899 deal with the duties and obligations of the various Asylum staff, and between them indicate that a certain set of values and goals informed the ways in which the Asylum operated.

In terms of the rules set out by this manual, Asylum staff members of all kinds were emphatically expected to consider their employment at the Asylum as more than merely a source of occupation and income. Apart from being expected to loyally co-operate with the Medical Superintendent in all respects, and to promote the “general welfare and harmony of

¹⁷⁶ *Rules*, pg. 13.

¹⁷⁷ *Ibid.*

¹⁷⁸ *Ibid.*

¹⁷⁹ *Rules*, pg. 15.

the establishment,”¹⁸⁰ they were barely allowed to leave the Asylum and when on duty were expected to submit to the Medical Superintendent in every particular.¹⁸¹ Even assuming that the Medical Superintendent was a reasonable person in charge, it is unsurprising that the Asylum battled to retain staff – comparatively low pay, combined with long hours and strenuous work under fairly restrictive conditions, would have meant that only certain individuals would have been temperamentally suited to the work, let alone competent to carry it out.

However, as people will generally opt not to get into trouble if they feel they can avoid it, it is likely that the abovementioned strictures – especially those about reporting things deemed improper, and making of complaints only to the Medical Superintendent – were not always observed. It is also likely that attendants occasionally covered up for one another. In some cases, such as that of Nurse Hickey described later in this chapter, they blatantly ignored the latter rule by bypassing the Superintendent completely. It is also possible that in some instances staff opted *not* to report. The high number of dismissals for drunkenness and missing curfew, mentioned above, suggests that a definite thread of defiance ran through the complement of attendants, and it may be naïve to assume that their misbehaviour did not extend to the treatment of patients. However, this cannot be verified.

In terms of implementing moral therapy, the rules and regulations that governed the behaviour and comportment of asylum attendants and nurses at the Grahamstown Asylum cannot be faulted. They each enjoin asylum staff to be kind, patient and reassuring towards patients, while creating an environment that was safe and peaceful. They are also notable for supporting the all-encompassing nature of the asylum as a total institution: they lay out, in detail, each procedure and protocol that is to be followed in regulating the daily life of the asylum. They also laid out the precise, small ways in which the closed nature of the asylum, and its internal hierarchy of patients, staff and management were maintained.

¹⁸⁰ *Rules*, pg. 1

¹⁸¹ *Ibid.*

Hints and Allegations: Nurse Hickey vs the Asylum

That managing this slew of requirements made for inevitable oversights – and that asylum work was not suited to everyone, and that not everyone appreciated the strictness of the hierarchy of the asylum – is well illustrated by a sequence of correspondence between the Under Colonial Secretary, the Inspector of Asylums, the Medical Superintendent of the Grahamstown Asylum, and a nurse formerly employed at that asylum, Miss Hickey.¹⁸² This exchange illuminates, albeit by the biased light of a disgruntled employee, the gaps that inevitably appeared between the Asylum's intentions of providing moral therapy, and the reality that prevailed there.

In November 1898, Miss Hickey wrote to the Under Colonial Secretary detailing the parlous state of affairs prevailing on the women's side of the Grahamstown Asylum. The original letter has not survived but her accusations were of sufficient severity that an investigation was mounted by the Inspector of Asylums in late 1898. The list of complaints made by Hickey was concerned the female wards of the Asylum, although two of the complaints did encompass the entire Asylum.¹⁸³ She complained about the state of a cupboard which was used for storing (clean) slop pails, opposite her bedroom door; the state of the lavatories; the unhygienic state of a *stoep* (a ground-floor veranda or porch, sometimes unroofed) on the ladies ward; the state of clothing and bedding on the black female ward; the presence of dogs in the Asylum; and the lack of exercise afforded to the patients. Furthermore, she complained about the "coming and going" of nurses in the Nurses' Home, a grievance that for some reason annoyed Greenlees.¹⁸⁴ Most severely, she made allegations of ill treatment concerning several patients.¹⁸⁵ This last is especially concerning, given that asylum reports usually

¹⁸² *Grahamstown Asylum: Management and Treatment of Patients, Volume 1*, Folio 128, CO 7320, Western Cape Archives and Records Repository, Cape Town. Miss Hickey's first name is not recorded.

¹⁸³ Those pertaining to the smell and noise caused by dogs on the Asylum grounds, and a complaint that patients did not get enough exercise.

¹⁸⁴ It is perhaps uncharitable to note that *some* complaint about the living quarters for staff was likely, both because they were not particularly good (as Greenlees acknowledged), and because Miss Hickey had not wanted to live there in the first place.

¹⁸⁵ It should be noted at this point that allegations of ill-treatment, sometimes fatal, of psychiatric patients in South African public and public-private partnership psychiatric institutions continue to this day (this author has no knowledge of ill-treatment allegations from private clinics). Since late 2016, the deaths of over a hundred patients at various unlicensed residential facilities in South Africa's Gauteng Province have drawn much attention in the South African media (<http://ewn.co.za/Topic/Life-Esidimeni>), while as of early- to mid-2018, allegations of patient mistreatment at Tower Hospital in Fort Beaufort and Grahamstown Asylum's new iteration of Fort England Hospital have also been uncovered.

described incidents involving attendants or nurses being aggressive or violent towards patients as “accidents” to avoid allegations of cruelty; this, as Swartz notes, effectively elides the potential some attendants or nurses undoubtedly had for cruelty or sadism.¹⁸⁶

Although the Inspector of Asylums, upon reading Miss Hickey’s letters of accusation, concluded that she had exaggerated and bore malice towards Greenlees¹⁸⁷ he concluded that her accusations were valid, and that the female half of the Grahamstown Asylum had been mismanaged.¹⁸⁸ However, Hickey *had* contravened some of the Asylum’s most important rules for employees: to wit, that they do nothing that was disloyal to the Medical Superintendent or the Asylum as a whole, and that they do nothing to interrupt the smooth running of the Asylum. By complaining directly to the Under Colonial Secretary, she had contravened the first of these: the rules for nurses and attendants clearly stated that no Asylum employee could contact the Government or any member thereof without the permission of the Medical Superintendent. She had contravened the second by making complaints. Disloyalty, or what was seen as disloyalty, to the Asylum was probably seen as the more severe of these, given that Dodds’ investigation revealed that there were in fact genuine shortcomings of the nature Hickey had suggested.¹⁸⁹

Later in 1899, Hickey sent a follow-up letter to the UCS, requesting further information on her earlier queries; evidently she had not seen Dodds’ report. Matters regarding the type and behaviour of staff preoccupied Miss Hickey, who had been employed as a seamstress nurse at the Grahamstown Asylum for a period of only one month;¹⁹⁰ the Asylum Superintendent believed that she was unsuitable for Asylum work, basing this largely on the form and content

Coverage of the Fort England and Tower Hospital cases can be found in the *Grocott’s Mail*, at www.grocotts.co.za.

¹⁸⁶ Swartz, “Psychiatric Knowledge in the Cape”, pg. 94.

¹⁸⁷ Letter, T Duncan Greenlees to the Under Colonial Secretary, 14 November 1898, *Grahamstown Asylum: Management and Treatment of Patients, Volume 1*, Folio 128, CO 7320, Western Cape Archives and Records Repository, Cape Town. It was this lack of respect for protocol that really irritated Greenlees, rather than the severity of the accusations Hickey was making.

¹⁸⁸ Letter, WJ Dodds to Under Colonial Secretary, 12 December 1898, *Grahamstown Asylum: Management and Treatment of Patients, Volume 1*, Folio 128, CO 7320, Western Cape Archives and Records Repository, Cape Town.

¹⁸⁹ It should be noted that Greenlees’ letter of the 14th of November 1898 pre-dated Dodds’ report. Greenlees says, in this letter, that Hickey had admitted to having failed to read the copy of the Asylum’s rules and regulations that had been supplied to her.

¹⁹⁰ Letter, T Duncan Greenlees to Under Colonial Secretary, 14 February 1899, *Grahamstown Asylum: Management and Treatment of Patients, Volume 1*, Folio 128, CO 7320, Western Cape Archives and Records Repository, Cape Town.

of her complaints.¹⁹¹ This was said despite the fact that it was true that the Matron at Grahamstown Asylum, Miss Robinson, had been managing the female wards poorly.¹⁹² Miss Robinson had been away from the Asylum on sick leave in the time between Miss Hickey's first accusation and the submission of Dr Dodds' report, and had consequently not been consulted about the allegations.¹⁹³ Upon her return, Miss Robinson was examined by Drs Greenlees and Cassidy as deemed physically unfit to continue in the demanding role of Matron. In the letter dealing with this matter, Greenlees stated that he had examined Miss Robinson previously and determined that a heart condition made her unfit for work, but that the UCS had insisted on obtaining second opinions from other physicians, all of which had disagreed with him. As a result Miss Robinson had continued as Matron, leading to the current state of affairs.

In a November 1898 letter to the Inspector of Asylums, Greenlees explained that Hickey had been employed while he was on leave from the Asylum, and was the only applicant for the position, despite the fact that it had been advertised in 12 different newspapers.¹⁹⁴ She had not subsequently proved to be a satisfactory employee: almost her first action upon being appointed to the job was to complain that she did not like the room in the Nurses Home that had been assigned to her).¹⁹⁵ Almost immediately, according to Greenlees, she began to make complaints about trifling matters, despite having expressed satisfaction with her terms of employment and duties and Greenlees concluded from this that she was not suited to work in a public asylum.¹⁹⁶ Miss Hickey left the employ of the Grahamstown Asylum, and although the matters she had brought to the Under Colonial Secretary's attention were resolved, it was now clear that staff who did not follow the authority of the Asylum medical staff, and show deference to their dictates and practices, would be met with little support.

¹⁹¹ Memorandum from Under Colonial Secretary to T Duncan Greenlees, 17 December 1898; *Grahamstown Asylum: Management and Treatment of Patients, Volume 1*, Folio 128, CO 7320, Western Cape Archives and Records Repository, Cape Town.

¹⁹² UCS to Greenlees, 17 December 1898, Folio 128, CO 7320.

¹⁹³ *Ibid.*

¹⁹⁴ Letter, T Duncan Greenlees to WJ Dodds, 14 November 1898; *Grahamstown Asylum: Management and Treatment of Patients, Volume 1*, Folio 128, CO 7320, Western Cape Archives and Records Repository, Cape Town.

¹⁹⁵ Letter, Greenlees to Dodds, 1 November 1898, Folio 128, CO 7320.

¹⁹⁶ *Ibid.*

In codifying the practices that attendants were to follow in their work with the inmates, the Grahamstown Asylum and others in the Cape asylum network made an attempt to ameliorate cruelty and avoid chaos inside the Asylum. This should not be understood as nothing but an altruistic attempt to make up for the deeply entrenched racism. While the rules did undoubtedly prevent grievous cruelty and promoted the provision of kind, careful therapy, they did not meliorate the aggressions and deprivations of the economic and racial hierarchy that controlled the everyday experience of patients within the Asylum.

Chapter 3: Understanding Mental Illness in the Nineteenth-Century Cape Colony: Causes and Categories

In 1875, the year the Grahamstown Asylum opened, Henry Wadsworth Longfellow published “The Masque of Pandora”, in which the character Prometheus speaks a line which has been quoted, misquoted and misattributed for the last 150 years: “Whom the gods would destroy, they first make mad.”¹⁹⁷ The origin of the phrase may be Latin, or Greek; it may have arisen, as the difficulty of tracing its origin suggests, as a colloquial phrase in daily use, with no clear origin. Whatever its source, the phrase seems to have encapsulated an idea common to Western society and those it drew inspiration from: madness could be a form of punishment, rather than something completely random. It is also something of an anachronism: by 1875, the medical establishment had long since discarded the idea that insanity was divine judgement or inexplicable.

The process of being committed to an asylum in the Cape Colony was a closely monitored and codified one governed by constables, magistrates, medical practitioners and Colonial governmental regulations as laid out in the Lunacy Acts of 1879, 1891 and 1897. The protocols put in place to ensure the smooth running of asylums and regulation of their patient bodies generated significant amounts of paperwork dedicated to recording the presumed reasons for the insanity of the individuals entering the asylum, and the behaviour that had led to their eventual committal. The specification of a diagnosis came relatively late in the committal process: diagnoses were recorded in the general patient registers but not in the committal documents, especially not the two medical practitioners’ reports that accompanied the Summary Reception Order that essentially authorised for the individual believed to be insane to be referred to an asylum. Even before the patient-to-be took up residence in the Asylum, the Medical Superintendent or Assistant Medical Officer recorded their histories and basic biographical information. In some cases, Asylum doctors believed, the affected individual’s

¹⁹⁷ Henry Wadsworth Longfellow, “VI: In the Garden”, *The Masque of Pandora*, accessed at http://www.hwlongfellow.org/poems_poem.php?pid=2088, 17 October 2016.

disorder had been triggered by something – in most cases, physical and emotional trauma, but often something hereditary.

The Cape Colony asylum system was designed to provide care for all lunatics who were vulnerable to ill-treatment outside or presented a potential threat to others. Although the quality of the care that patients in asylums received differed significantly according to race and class and the asylum to which they were admitted, the intention underlying the committal of lunatics to asylum custody was nevertheless broadly philanthropic. But the distribution of resources and the quality of care provided differed according to the race and class of the patient concerned, and this was undeniable, which meant that a way of justifying this difference had to be justified and practiced inside the asylum system itself.¹⁹⁸ Preconceptions and stereotypes relating to race and gender informed the attribution of causes of disorder, and Asylum staff had pre-existing biases based on gender, race or class informing their attitudes towards the people in their care. The kinds of underlying cause to which asylum authorities attributed insanity differed according to the gender and racial classification of the patient in question.

Universalism and Essentialism in Colonial Psychiatry

As Swanson notes,

Psychiatry derived its power and legitimacy to provide the best understanding of mental illness from...its claims to be empirically grounded in objective, scientific principles that were universally applicable. Strategically, this medical model helps position psychiatry within mainstream western medicine, legitimating and consolidating colonial doctors' professional claims to specific expertise and authority.¹⁹⁹

Once Western psychiatry had established itself as the pre-eminent system for interpreting and treating mental illness by asserting itself to be unbiased and factual, therefore, it extended its reach by claiming that its science was universally applicable. This does not mean that it understood all people the same way, only that it claimed to understand all people. This

¹⁹⁸ Sally Swartz, "The Black Insane in the Cape, 1891 – 1920", *Journal of Southern African Studies*, 21, 3, 1995, pg. 403.

¹⁹⁹ Felicity Swanson, "'Of Unsound Mind': A History of Three Eastern Cape Mental Institutions, 1875 – 1910", Unpublished MA Thesis, University of Cape Town, 1994, pg. 59.

declaration of authority meant that what psychiatrists asserted was true of certain groups was difficult to challenge. Disputing the legitimacy of Western psychiatry was perhaps especially difficult in the Cape Colonial context, although as Julie Parle explores in *States of Mind: Searching for Mental Health in Natal and Zululand, 1868 – 1918*, alternative systems of understanding and dealing with mental illness did exist in the region;²⁰⁰ Megan Vaughan has shown the same for other parts of Africa, particularly Malawi.²⁰¹ In the Cape, however, the authority of Western-style psychiatry in explaining insanity among the “native insane” served to further embed existing societal prejudices in mainstream society. Psychiatry was well and truly enmeshed in the colonial power relations.

Doctors in the Cape Colony – and other British colonies – sorted their patients into racial, gender and socioeconomic categories, and the preconceptions and misconceptions about the people within these categories informed the theories doctors constructed regarding them. In explaining insanity, the predetermined qualities of each biological sex or racial classification influenced the explanations which Colonial psychiatrists devised to explain the root causes of insanity in lunatics originating in each group. The dominant school of thought in Western psychiatry of the nineteenth century was both universalist and biologically essentialist, which allowed psychiatrists to assume that although the sociocultural context of insanity might differ across groups of individuals, the neurological origins of insanity meant that all of the affected were affected in uniform ways. This approach was implicitly racist and sexist, taking white maleness as the norm and constructing other groups as fundamentally different. This belief in the essential difference of those classified as female and/or black was used to justify the provision of different facilities and treatment within asylums. Because of the racism already ingrained in colonial society and the colonial project as a whole, in the case of those classified as black, this meant *inferior* treatment.²⁰² The validity of local knowledge and the fact that the colonial interlopers generally did not understand the sociocultural contexts of their black patients were not acknowledged, and whatever did not fit the imported Western structures within colonial society was elided. Erasure of the experience and expression of indigenous groups is, as Swartz points out, inchoate to colonial relationships and perhaps a necessary part

²⁰⁰ Julie Parle, *States of Mind: Searching for Mental Health in Natal and Zululand, 1868 – 1918* (Scottsville, 2007).

²⁰¹ Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Cambridge, 1991).

²⁰² Sally Swartz, “Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920”, Unpublished PhD thesis, University of Cape Town, 1996, pg. 8.

of colonisation's socioeconomic exploitation.²⁰³ To this I would add that such erasure is also vital to the creation of the white colonial sociocultural hegemony: as the abnormal, it is simply not spoken of, although transgressions are penalised. In terms of identifying and treating the insane, the creation of a racist, sexist system with strictly-patrolled boundaries serves to compartmentalise acceptable behaviour. In this system, men and women who did not adhere to specific set-out colonial societal gender roles could be considered insane; the same went for black men and women who did not stick to imposed racial roles.²⁰⁴ In fact, deviating from imposed roles could be interpreted as both a cause and a sign of insanity. The underlying causes of insanity were believed to affect the symptoms that patients manifested, and the various types of insanity carried different connotations for the understandings both Colonial psychiatrists and Colonial civil authorities had of the various groups under their purview.

However, it needs to be noted that uncovering the underlying cause of an individual's insanity was not something that doctors did for all lunatics. In some cases, as Parle notes, we simply cannot know *what* doctors found out about their patients: in her study of the Natal Government Asylum, Parle found that the destruction or loss of case records means that there is a silence that cannot be filled.²⁰⁵ Sometimes, also, doctors simply did not display any interest in whatever had caused a particular patient's insanity, and in other cases it was not in fact possible – due to language barriers, cultural barriers, or cultural unintelligibility – to take a patient's history and from it, deduce what the trigger for that inmate's insanity had been. In some cases there was no trigger, as far as could be established. Sometimes, if the lunatic could not give his or her own version of events, asylum doctors had to resort to asking their relatives or friends, if any of them were within easy reach. If nobody was available to provide the information, then the cause of the insanity went unrecorded. Even if friends or family members were prepared to answer questions on the subject, there was a chance that they might not know, might simply be mistaken, or might not be prepared to tell the unvarnished truth. (There is also the inescapable reality that much of the understanding of mental illness was then, and is now, incomplete or incorrect, or at least subject to change upon the reception of new information). The information provided by and about lunatics entering the asylum could not always be taken at face value.²⁰⁶ Nevertheless, the doctors and magistrates administering the committal procedures were willing to note down the various anecdotes of

²⁰³ Swartz, "Psychiatric Knowledge in the Cape", pg. 9.

²⁰⁴ Parle, *States of Mind*, pg. 19.

²⁰⁵ Parle, *States of Mind*, pg. 88.

²⁰⁶ Swanson, "Of Unsound Mind", pg. 74.

narratives presented by witnesses and family members, and so did the asylum doctors when they compiled their notes upon admitting the legally-adjudged lunatic into the asylum.

It needs to be noted at this point that Superintendent Greenlees, as Swanson outlines, held a particular set of views regarding the causes of insanity among the Colony's white population; these views were in concordance with the general beliefs held by Western psychiatry at the same, at least as evidenced by the discussion of causes of insanity in Bucknill and Tuke's *The Manual of Psychological Medicine*.²⁰⁷ He believed that intemperance, inbreeding and hereditary predisposition to insanity were the major causes of lunacy in the Cape.²⁰⁸ Mental instability, according to Greenlees, ran in the family and could lie dormant for years until triggered by some sort of trauma specific to the individual. Mainstream psychiatry, it is true, did embrace the idea that certain types of insanity could run in families. Of course, some mental illnesses are recognised as having a genetic component that may predispose an individual to them. But in the 19th-century Cape, this theory of inherited insanity had a particularly useful application: it allowed Colonial psychiatrists to explain why so many white patients left the asylum without being cured, although treatment had value in terms of ameliorating their suffering.

Causes of Insanity: Gender and Race in the Aetiology of Insanity

The pre-eminent psychiatric textbook of the day, used throughout the British Empire, was Bucknill and Tuke's *Manual of Psychological Medicine: Containing the Lunacy Laws, Nosology, Aetiology, Statistics, Description, Diagnosis, Pathology and Treatment of Insanity with an Appendix of Cases*, first published in 1859 and running to at least four editions. Within its almost 900 pages, the authors outline the various categories of mental disorder, their pathologies, etiologies, and prognoses, and their causes. Both Bucknill and Tuke believed that insanity had a physical cause – the text contains a comprehensive section on the histology of insanity, complete with plates – but that the development of an insane state occurred after a

²⁰⁷ John Charles Bucknill and Daniel Hack Tuke, *Manual of Psychological Medicine: Containing the Lunacy Laws, Nosology, Aetiology, Statistics, Description, Diagnosis, Pathology and Treatment of Insanity with an Appendix of Cases*. (London, 1879).

²⁰⁸ Swanson, "Of Unsound Mind", pg. 69.

physical or moral trigger. These triggers were divided into “exciting” and “predisposing” causes, which the authors explained thus:

“For example, a man may be in an exceedingly feeble condition of health, in which the death of a friend, or other domestic trial, may induce an attack of Insanity, from which he would not have suffered had he been in the enjoyment of sound health at the time of the event. In such a case, the predisposing cause of the patient’s Insanity was ill health, the exciting cause, domestic grief.”²⁰⁹

Exciting causes, which could be either physical or moral, included injuries to the brain, intemperance (meaning overindulgence in alcohol, drugs or sex), or disappointment in love. Predisposing causes, which were usually physical but could be moral,²¹⁰ included a hereditary disposition, a “delicate mental organisation” or simply an “unbalanced mind.”²¹¹ Hereditary predisposition to insanity was believed to be a major factor in the development of certain disorders, such as mania, idiocy and melancholia. Bucknill and Tuke noted that,

“It may be said that no cause or combination of causes is so powerful as the natural constitution of mind. If a man has a weak point somewhere in his head, it is like a weak link in his watch-chain, which, on the occasion of a very slight strain, gives way, and the watch is lost. It is the defect in the chain which is the really important factor in its breakage, not the little accident which corresponds to the exciting cause.”

They noted that both Esquirol and Jacques-Joseph Moreau²¹² believed that if a direct relative, i.e. a parent, experienced insanity, the chances were high that their children would as well.²¹³ Puberty, menopause and childbirth were believed particularly high-risk periods for the “outbreak” of hereditary forms of insanity.

From this, it is evident that in the nineteenth century, women were regarded to be slightly more likely to experience insanity. In fact, rates of admittance to asylums – and insanity – were rising across the Western world at the time: Edward Shorter argues that disease, social problems, changes in family and community structure, and increased *knowledge* of institutionalisation as an option for treatment all caused increases in the number of people classified as insane.²¹⁴ Despite this, and despite contemporary researchers pointing out that it

²⁰⁹ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 54.

²¹⁰ Moral, here, denotes something that is behavioural or experienced, as opposed to deriving from a physical cause.

²¹¹ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 54.

²¹² Jacques-Joseph Moreau, also known as Moreau of Tours, was one of the first psychiatrists to research the effects of psychoactive drugs, particularly hashish, on mental illness.

²¹³ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 68.

²¹⁴ Parle, *States of Mind*, pg. 51.

was not the case that more women than men became insane,²¹⁵ many psychiatrists placed particular emphasis on the susceptibility of women to insanity. This was particularly the case in the colonial context, where white women were believed to be doubly at risk because they were female and white in a colonial space, while black women were constructed as hypersexual and simpleminded.²¹⁶ Writing about presumably white women in the metropole, Bucknill and Tuke remarked that,

“On the whole, it is clearly proved that in general fewer women...become insane than men, although it is difficult to establish that the female sex is intrinsically less susceptible to the causes of Insanity than the male, since the former is less exposed to those causes than the latter.”²¹⁷

This can be contrasted with Sally Swartz’s contention that, in the colonies,

“..fear of insane women’s unruly, reproducing, bleeding or lactating bodies [were] closely associated with anxiety about racial borders and racial purity. Insane white women were regarded as likely to produce insane or feeble-minded children, endangering the health of the total white population. They were also perceived as having insufficient moral strength to avoid sexual contact across racial borders.”²¹⁸

Apparently, then, while white women in the United Kingdom could be expected to simply not encounter intemperance, grief or physical injury, white women in the colonies were both at risk of insanity and themselves posed risks. Black and white women were believed to have the susceptibility for irrational, extreme behaviour.²¹⁹

It is possible to, so to speak, reverse-engineer the mores and values which Colonial society applied to the men and women within its sphere: by examining the disassembled product, we can understand what the assembled product should look like. Therefore, by looking at what was deemed to have gone wrong with male lunatics in the Colony, we can deduce what men in the Colony were ‘supposed’ to be like. The same reverse-engineering of socially dominant forms of femininity can be done for female lunatics.

²¹⁵ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 72. They contend that although there were more women in asylums, this was due to more women surviving for longer in asylums or simply staying for longer, while more men came in but were either discharged or died.

²¹⁶ Parle, *States of Mind*, pg. 57.

²¹⁷ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 74.

²¹⁸ Swartz, “Psychiatric Knowledge at the Cape”, pg. 101.

²¹⁹ Parle, *States of Mind*, pg. 57.

The first and most obvious factor to take into account is that, as Swanson noted²²⁰ and as is indeed made likely by his familiarity with the work of, among others, Bucknill and Tuke, Greenlees definitely believed that hereditary factors played a major role in the susceptibility of white lunatics to insanity. Just under half of the white men and white women admitted to the Asylum with causes recorded were thought to have hereditary insanity, while almost two thirds of white men and a third of white women had, further, congenital forms of insanity as well. However, it seemed that Greenlees did not find that hereditary or congenital insanity were often factors in the insanity of the Asylum's black patients; while this indicates that Greenlees understood black insanity as having quite a different aetiology to white insanity, it also suggests that Greenlees and his staff simply could not – or did not make much of an effort to – extract family histories from black patients. It is also likely that the tendency of colonial psychiatrists to regard black patients as members of a homogenous society with little differentiated individualism played a role in this belief: if someone was only a member of a group and not a monad, it stood to reason that individual antecedents were not relevant or were at least forgotten or thought irrelevant.²²¹ It is also likely that the causes of insanity among black men and women admitted to the asylum were believed to be simpler, in keeping with the simpler forms of mental illness colonial psychiatrists believed affected that group (of which more below). This can be compared with Swartz's observation that while Valkenberg Asylum's returns for causes of insanity (among white patients) recorded 39 potential causes of insanity between 1891 and 1909, that for the Tower Hospital in Fort Beaufort recorded only eight.²²² By contrast, again, the 1879 edition of Bucknill and Tuke's text gives figures for 1877 from the *Rapport sur le Seine des Miénés du Department de la Seine*, which analysed over 2068 admissions to that asylum. They found the principal causes of admission for lunatics there to be very similar to those found in the Cape asylums: intemperance, followed by age, domestic grief, fright or shock, "female diseases", epilepsy, and religious excitement. Overall, that report listed eight physical and eight moral causes, and noted that 152 patients had an insane parent, indicating that hereditary factors were also considered important.²²³

The primary "exciting"²²⁴ causes of insanity among white men admitted to the Grahamstown Asylum were sexual intemperance, venereal disease, self-abuse, over-exertion, sunstroke, and

²²⁰ Swanson, "Of Unsound Mind," pg. 85.

²²¹ Swartz, "Psychiatric Knowledge at the Cape", pg. 108.

²²² Swartz, "Psychiatric Knowledge at the Cape", pp. 107-108.

²²³ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 92.

²²⁴ "Excite," here, is used in the sense of "instigate" or "incite."

accident or injury. In contrast to men, not many white women had mental illnesses caused by sexual intemperance and only very few were admitted with disorders thought to be caused by self-abuse, over-exertion, or sunstroke. Instead, white women were thought to go mad if exposed to religious excitement, love affairs, fright and nervous shock, pregnancy, lactation, childbirth, disorders of the uterus and ovaries, puberty and the change of life. This fairly clearly indicates that what could go seriously wrong with women was primarily linked to the functioning of their bodies and emotions, whereas men were more likely to go insane on account of sex, alcohol and physical activity outdoors. At Valkenberg in the period 1891-1909, the leading causes of insanity among men admitted there were previous attacks, intemperate in drink, hereditary factors, disease, old age, anxiety, and puberty. Among women, the leading causes were previous attacks, hereditary factors, childbirth, old age, domestic trouble, intemperance in drink, mental anxiety, and puberty. As at the Grahamstown Asylum, many men and women were believed to have experienced sunstroke, fever, disease, accidents and epilepsy that triggered mental illness. Less than 25% of Valkenberg patients were admitted with insanity that followed stressful life events, while men were admitted more often than women with the recorded cause of “adverse circumstances” (which Swartz notes could include both financial losses and military service) and more women than men were admitted with the listed cause of “domestic trouble”, which included anything from widowhood to a troubled marriage.²²⁵

That white women were not generally to be found with mental disorders caused by physical exertion or substance abuse problems does not suggest that women were believed to be more robust or could better hold their alcohol. Rather, it shows that women were simply not spending much time outdoors in the sun, or drinking excess amounts of strong liquor, or having much sex outside the marital bed (in this way, this fits with Bucknill and Tuke’s assertion that women simply did not encounter the exciting causes as often as men did.) In fact it seems to have been sex within the marital bed that was problematic for women, as the vast majority of white female lunatics appear to have been badly affected by the ramifications of childbirth and motherhood, which appears – based on these statistics - to have been their sole occupation, for religious observance and love affairs. White women, if we read into the causes of their insanity as outlined here, seemed mostly to be troubled by men. Men, on the other hand, seemed to have troubled themselves.

²²⁵ Swartz, “Psychiatric Knowledge in the Cape”, pg. 108.

As Helen Dampier notes, settlers on the Eastern Frontier were usually constructed as “brave and determined pioneers,” which complicates the image of settler women, especially given that under the norms of the time, women were supposed to be “timid, reticent and fragile.”²²⁶ The “brave and determined pioneer” and the “timid, reticent and fragile” aspects do not cancel one another out; they contain elements of one another.²²⁷ On the Frontier, and in the relatively less hardscrabble environment of Albany in the late 1800s, the potential that white women had for entrenching the gender and class norms of the era was harnessed to uphold the white Colonial culture that was dominant at the time.²²⁸ This culture was characterised by an insistence on maintaining respectability and keeping up appearances; the lives of women and men were often circumscribed by the very specific gender roles each group was expected to play.²²⁹ There was not always a great deal of room to manoeuvre in these roles without running the risk of becoming socially unacceptable. Men, under this system, engaged in the public sphere, with business, money and politics. Women, on the other hand, were pretty much confined to wifedom and motherhood, the private rather than the public – that is, the service of men in the shape of husbands, sons and fathers, and the maintenance of the home sphere.²³⁰ In this system, mental disorder among men could be triggered by stresses from outside the home, consequences of stressful male engagement with larger societal mechanisms; among women, however, mental disorder could usually only result from their interactions with men and families in the confines of the home. In the eastern Cape Colony in the late 1800s, as will be outlined, not all white women in the participated only in private home spheres – possibly because they were unmarried or engaged in professions that removed them from the home, such as prostitution, education, farm-work or business. The Grahamstown region was one that required women to depart from their stereotyped roles as mothers and helpmeets. Moreover, in thinking about black individuals suffering from insanity, Colonial psychiatrists did not often consider the details of individual home environments – in the surviving Grahamstown Asylum records, there is seldom mention of private-sphere stress in discussions of black patients.

²²⁶ Helen Dampier, “Settler Women’s Experiences of Fear, Illness and Isolation, with Particular Reference to the Eastern Cape Frontier, 1820 – 1890”, unpublished MA thesis, Rhodes University, 2000, pg. 17.

²²⁷ Dampier, “Fear, Illness and Isolation”, pg. 17

²²⁸ Dampier, “Settler Women”, pg. 41.

²²⁹ Dampier, “Settler Women”, pg. 43.

²³⁰ *Ibid.*

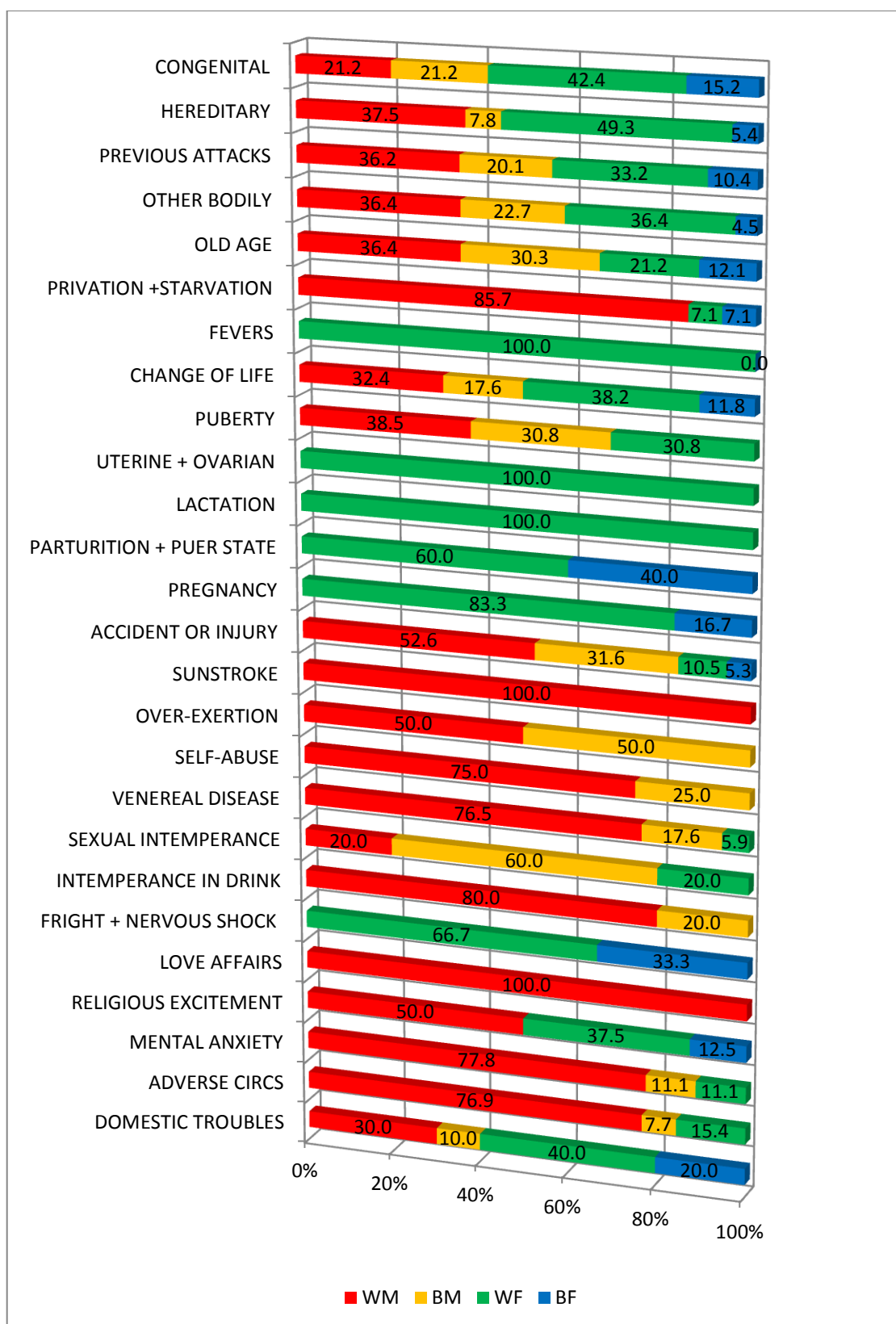


Figure 4: Exciting Causes of Insanity among Grahamstown Asylum Patients, 1875 - 1905, by percentage.

Over half of the black men who were admitted at Grahamstown were allegedly alcoholics (56.7%), or had fallen victim to hard conditions such as privation and starvation (33.3%; this high rate may have been associated with homelessness or economic migrancy), or the categories of 'previous attacks' and 'other causes'.²³¹ Black women, for their part, seemed to be believed to be subject to much the same privations and physiological problems as white women were: old age, childbirth, pregnancy and domestic trouble predominated as the causes. Asylum authorities believed underlay their mental illness. With the exception of domestic trouble which is, as mentioned above, a broad category, these were physical rather than moral causes, suggesting that black insanity was largely explained in physical, rather than emotional or environmental, terms.

Among the factors believed to predispose individuals to insanity, clear gender divisions were visible. The majority of patients believed to have been driven mad by mental anxiety, religious excitement, alcoholism, STIs, masturbation, accident, injury and the imprecise description "adverse circumstances" were white men. These records show that sexual intemperance was the most commonly recorded cause of disorder among black men. Domestic troubles, fright and nervous shock, pregnancy and childbirth-related causes were usually found among women; the small number of black women in the asylum did not, in many cases, have their supposed causes of disorder recorded. It is notable that, as indicated above, normal female physiology and sexuality were seen as potential triggers for nervous disorders among women.²³² The link asylum authorities drew between female physiology and madness was bogus; instead, it can definitely be said that the stressful events that were believed to land women in the asylum derived from the role their gender placed them in within Colonial 19th-century society.

It was all very well to notice that, say, a son was perhaps taking too much liquor, but if he was not bothering anybody and still managed to handle his daily affairs adequately, this was embarrassing rather than harmful. There was relatively little pressure for the families or friends of lunatics to commit them *unless* they had become difficult to handle. Families or

²³¹ Please see Appendix 2, Figures 1 and 2. The issue with these statistics is quite prosaic: at some point, in order to fit the tables onto one page, editors excised one or more categories from the statistical tables to render them narrow enough.

²³² Bassuk, Ellen L. "The Rest Cure: Repetition of Resolution of Victorian Women's Conflicts", *Poetics Today*, 6, ½, 1985, pg. 251.

friends, or the authorities, often decided to commit a lunatic only when their behaviour became dangerous, or simply strange. That the asylum was considered as a potential way for a family and friends, in the case of those who were not committed via the law courts, to handle this for both black and white insane persons speaks to the prominence of the Western psychiatric tradition in the Cape Colony. As already intimated, however, this tradition barely understood many of the people over whom it took control.

Preconceptions and Repercussions: Trends in Diagnosis in the Grahamstown Asylum

Being diagnosed as “mad” was only part of the total experience of being removed from the mainstream of society for the men and women entering the Grahamstown Asylum in the late 19th and early 20th centuries. The asylum doctors did not apply a diagnosis to an incoming patient at random, and the assignment of a diagnosis was not the beginning or the end of the total committal process. To a degree, the primary role of doctors was to verify the conclusion a lunatic’s family or friends and the magistrates’ courts had already arrived at – that the man or woman in question was, in fact, of unsound mind and needed to be sent to the asylum - by assigning a medical/psychiatric term to the condition.²³³ Furthermore, any individual lunatic’s diagnosis was not derived solely from the symptoms and behaviour manifested by the individual facing admission.

Instead, the process of applying a diagnosis was made up of at least four strands of information. The patients themselves provided one strand of information; their friends and/or family, and/or civil authorities concerned with bringing them to the attention of the Asylum provided another. A third strand was derived from the experiences, preconceptions and professional education of the Asylum authorities.²³⁴ All of these were embedded in the last, deriving from the existing stereotypes and prejudices informing the consciousness of the colonial society in which all of these people operated and lived, as will be discussed shortly.

²³³ Patricia E. Prestwich “Family Strategies and Medical Power: ‘Voluntary’ Committal in a Parisian Asylum, 1876 – 1914” in Roy Porter and David Wright *The Confinement of the Insane: International Perspectives, 1800 – 1965* (Cambridge, 2003), pg. 7.

²³⁴ Catharine Coleborne, “‘His Brain was Wrong, His Mind Astray’: Families and the Language of Insanity in New South Wales, Queensland, and New Zealand, 1880 – 1910”, *Journal of Family History*, 31, 45, 2006, pg. 48.

As Vaughan has argued,²³⁵ the colonial world saw no Great Confinement *a la* Foucault's conception of asylums as a mechanism of control and repression in Europe.²³⁶ (In African colonialism, black individuals were already controlled and repression by other means, economic, legal and social.) However, the reification of madness and the formalisation of an individual's categorisation as a member of an insane minority was nevertheless a process future asylum inmates underwent in the colonial sphere. Doctors, in determining that an individual was not of sound mind and later in attaching a diagnosis were in many cases only confirming a conclusion already reached by the lunatic's family and associates.²³⁷ Lunacy is both a social and a legislative category, and those believed to be lunatics by those around them (whatever they themselves thought) were transplanted, by this re-categorisation, from mainstream society into the world of the asylum.

In the absence of specific drug or psychotherapy regimes, asylum doctors and attendants of the Cape Colonial asylum system did not do much except modify treatment according to whether a patient was violent, subject to fits, excitable, suicidal, and so on. Also, Cape asylums – and particularly the Grahamstown Asylum under Greenlees – were internally segregated; gender, race and class, rather than diagnosis, were the major dividing factors.²³⁸ But psychiatrists made diagnoses, and kept records of which diagnoses they had assigned to whom; this allowed them to invent theories, and these theories – embedded in the prejudices and preconceptions of Colonial society and psychiatry both – systematically devalued the experience of some patients, and consequently the sectors of society to which they belonged, while over-privileging that of others.

The Grahamstown Asylum may not have been a site of social control in the way that asylums in Britain or elsewhere in Europe were,²³⁹ but it was a place at which deep-seated ideas about social hierarchies and order came to the fore, and these ideas certainly influenced the types of diagnosis meted out to incoming patients. During the period 1875 to 1905, trends appeared

²³⁵ Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Cambridge, 1991), pg. 101.

²³⁶ Megan Vaughan, *Curing Their Ills*, pg. 101.

²³⁷ Prestwich, "Family Strategies", pg. 79.

²³⁸ Swartz, "Psychiatric Knowledge at the Cape", pg. 124.

²³⁹ Megan Vaughan, *Curing Their Ills*, pg. 8.

among these diagnoses, and were connected directly to the existing social and cultural order of the Colony.

The two main sociocultural factors that influenced the type of disorder with which an individual was diagnosed were gender and racial classification. Suspicion that an individual had gone mad could not arise in a vacuum; there had to be some evidence to suggest that that was what was affecting the person's behaviour. To be categorised as "insane", an individual had to display symptoms of insanity. Exactly what constituted this proof of insanity depended, to a large degree, on where that individual fell in the gender and racial hierarchies. Doctors, civil authorities and the lunatic's social connections assumed the various behaviours that accompanied a presumed lunatic's committal – violence, incoherence, unreasonable behaviour or suicidal tendencies – to be in some way emblematic or typical of that individual's race and, to a lesser degree, gender (as has already been shown). A similar praxis was at work when Asylum doctors determined, from the information available and visible symptoms, the disorder from which an individual was suffering. A lunatic's race and gender, being both freighted with social and cultural baggage, fed into the decisions Colonial asylum doctors made about the type of disorder from which they were suffering.

In colonial societies, the mechanism of power exercised by colonial authorities often relied on complex classification systems.²⁴⁰ The major layer of classification, more influential than gender or socioeconomic class, was race. In Europe, the mad were 'othered' by their madness; in colonies, the 'other' was already present in the form of the colonial subject.²⁴¹ Colonial subjects were much more 'othered' by their race than by almost any other thing about them: in a system where the (artificial) black/white binary was paramount in deciding where an individual fell on the social scale, black colonial subjects were already considered to be the other, and the requirement to further distance them was not very stringent.²⁴² Because of this, colonial authorities, particularly in the British Empire's African colonies, did not have an urgent need to impress more types of otherness upon them.²⁴³

²⁴⁰ Vaughan, *Curing Their Ills*, pg. 8.

²⁴¹ Vaughan, *Curing Their Ills*, pg. 101.

²⁴² Vaughan, *Curing Their Ills*, pg. 10.

²⁴³ *Ibid.*

Asylums situated in colonies, their actual usefulness as sites of care and cure aside, were in effect monuments to the perceived social and scientific superiority of the colonisers' systems of medicine and law, not the ascendancy of the sane over the mad.²⁴⁴ Establishing asylums, furthermore, was generally not the foremost concern of nascent colonial administrations, and as a result they were not established immediately after colonisation, or while colonisers experienced resistance from indigenous peoples; instead, asylums generally appeared only once colonial power had been consolidated.²⁴⁵ This may be because of the physical networks of resources, transport, expertise and supplies needed to establish and maintain an asylum rather than any manifestation of civil responsibility. This consolidation of colonial power usually, and in the case of Cape as well as the future Union and Republic of South Africa, did involve the codification and formalisation of difference based on racial classification and cultural difference,²⁴⁶ and in this process, the role of medicine, the medical establishment and medical professionals, including psychiatrists, was crucial. Medicine and psychiatry in the Cape Colony formed a key part of the so-called "civilising mission" of colonialism by creating an image of the black population as very different and separate from the white population, with a mirror set of attributes: where white society and individuals were complex, adult, measured in behaviour, and rooted in history, black society and individuals were simple, childish, uncontrolled and existing in an eternal present.²⁴⁷ This supposed primitive state was believed to make them not only fit subjects for colonial conquer, but also *in need* of such control.²⁴⁸ In doing this, colonial psychiatrists elided the complexity, humanity and unpredictability of colonial subjects.

In the 1890 Annual Report for the Grahamstown Asylum, T Duncan Greenlees, the asylum's newly-appointed Medical Superintendent wrote,

The native insane get well sooner than the Europeans of this Colony, and this is undoubtedly due to the simpler forms of insanity found in the natives as compared with the more serious forms which it assumes when it occurs in persons of higher mental development, the fall from sanity to insanity being greater. While our means of treating the native insane is quite adequate much must be done before we can say the same of Europeans.²⁴⁹

²⁴⁴ Richard Keller, "Madness and Colonisation: Psychiatry in the British and French Empires, 1800 – 1962", *Journal of Social History*, 35, 2, 2001, pg. 301.

²⁴⁵ Keller, "Madness and Colonisation", pg. 305.

²⁴⁶ Vaughan, *Curing Their Ills*, pg. 8.

²⁴⁷ Swartz, "Psychiatric Knowledge in the Cape", pg. 99.

²⁴⁸ Swartz, "Psychiatric Knowledge in the Cape", pg. 8.

²⁴⁹ Greenlees, *Annual Report*, 1890.

What Greenlees is suggesting here is that “native” insanity was of a shorter duration and less complex than insanity found among white individuals in the Colony. He bases this supposition on the claim that black Africans were inferior in terms of mental development when compared to the European immigrants and their descendants that were socioeconomically dominant in the Colony. The crux of this belief is simple: Greenlees believed that Europeans were more mentally intricate, and therefore had “further to fall” to become insane; when they did become insane, the insanity was complicated to understand and treat. Conversely, he asserts, “native insanity” was simple, resulting as it did from simple minds. This was an attitude current in the psychiatry of the time, which subscribed to the idea of an hierarchy of mental complexity:

“...the liability to Insanity is infinitely less among savages than among civilised nations; less, for example, among the North American Indians than the French or English; and less, it may be added, among a people presenting a peculiar and stationary form of civilisation like the Chinese than among Europeans....The liability to Insanity among the lowest – the most ignorant and degraded – class of a civilised people is greater than among the higher and educated classes. The mistake has been made of regarding as identical the condition of the savage and the English pauper, simply because both are ignorant.”²⁵⁰

Greenlees believed that white insanity, having more convoluted roots, was harder to ameliorate or cure required a deeper understanding of the individual’s mentality. Consequently, he devoted more energy to understanding and curing white insanity. This had negative ramifications for Greenlees’ treatment of black patients at the Grahamstown Asylum – the “adequate” means of treatment he refers to involved little beyond the custody of black patients, who were then put to work. Because he believed that the insanity of black individuals was simple and short-lived – and because he already believed that he understood the subject - he did not put great effort into understanding the black insane as multifaceted individuals whose insanity may have resulted from any number of interlocking life experiences and hereditary predispositions.

²⁵⁰ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 85.

A few years later, in 1895, he expanded on his idea that black insanity was simple by stating that the “native brain has its analogue in the European child’s cerebrum,”²⁵¹ at one stroke downgrading fully half of his asylum’s patients to the status of children. Saul Dubow’s examination of Colonial understandings of the ‘native mind’ states that one theory Colonial doctors had was that the African mind existed in a state of arrested development, and that consequently all blacks in the Colony were basically overgrown children. This theory carried the assumptions that as such Africans were, firstly, illogical in a way that Europeans were not, and secondly implicitly suggested that they were in all ways intellectually inferior to their white Colonial overlords.²⁵² By holding the opinion that *all* black people, sane and insane, within the Colony were effectively children – illogical, unpredictable and thus likely to benefit from Colonial control as they might from the attention of a stern, wise parent – psychiatrists provided a validation and rationale for the imperial project of extending British control and culture over the Colony. Special treatment to restore sanity was therefore not believed to be needed, even if it would do any good.

In short, individual black lunatics were not believed to be mad because something had gone awry with them in particular – an illness, a stressful event, even a hereditary predisposition – but rather because they were black. White patients, on the other hand, were examined and understood with their idiosyncratic complexity taken for granted – even if they often ended up being deemed to be victims of their own inherent traits (as discussed in the previous section), the roots and compulsions of their lunacy was still evidently of much more interest to Asylum doctors than those of their black counterparts. As Parle observes, colonial psychiatry was as concerned with the white mind as it was with the black mind.²⁵³ In a way, the madness of white people was much more of a threat to the Colonial project than the madness of black people was: the supremacy of the numerically disadvantaged white Colonial population rested on the assumed superiority of their health, wealth and education, as well as the weight of their imported Western sociocultural system.²⁵⁴ The loss of that supremacy on an individual basis was believed, if allowed to go unchecked, to be immensely threatening. The reasons behind white insanity had to be unlocked, understood, and, if possible, dealt with. The reasons behind black insanity were believed to be perpetual, built into the very fabric of the race. A cure was therefore of secondary importance to custody.

²⁵¹ Saul Dubow, *Scientific Racism in Modern South Africa* (Cambridge, 1995), pg. 201.

²⁵² Dubow, *Scientific Racism*, pg 200.

²⁵³ Parle, *States of Mind*, pg. 119.

²⁵⁴ Swanson, “Of Unsound Mind”, pg. 65.

Diagnostic Patterns in the Grahamstown Asylum, 1875 – 1905

In the early years of the Grahamstown Asylum, the range of diagnoses applied to the individuals being committed was relatively small. Indeed, all patients within the Asylum between 1875 and 1879 were assigned one of only eight possible diagnoses, in keeping with the British Medico-Psychological Association's categories: mania, melancholia and dementia (the functional psychoses), and General Paralysis of the Insane (GPI), epilepsy, idiocy, imbecility, and imbecility with epilepsy.²⁵⁵ It is immediately apparent that the determination of diagnoses depended to some degree on the race and gender of the individual in question; while a white patient might be assigned any of the eight aforementioned diagnoses, the range of diagnoses applied to black patients was somewhat smaller, only one of a maximum of four disorders.²⁵⁶

One of the primary texts used by psychiatrists in Britain and British colonies was *The Manual of Psychological Medicine: Containing the Lunacy Laws, Nosology, Aetiology, Statistics, Description, Diagnosis, Pathology and Treatment of Insanity with an Appendix of Cases*, by British psychiatrists John Charles Bucknill and Daniel Hack Tuke, first published in 1858.²⁵⁷ John Charles Bucknill, a British psychiatrist, was an ardent supporter of the work of British asylum inspector John Conolly, who had phased out the use of restraints – physical and otherwise – at Hanwell Asylum in Middlesex, England. Although Conolly was not the only person to advocate for the elimination of restraints in asylums (this had already been done at York Retreat under the Tuke family, and at Lincoln Asylum), but he was among the most prominent, and as such his ideas carried significant weight. Bucknill, accordingly, eschewed any punitive understanding of insanity, instead adopting the approach of moral therapy. He did, however, believe that insanity was the result of brain disease, and was therefore possible to treat with medication. Daniel Hack Tuke was the great-grandson of William Tuke and grandson of Samuel Tuke, co-founders of the York Retreat. He thus came from several

²⁵⁵ PR360-1, Grahamstown Asylum General Register of Patients, 1875-1896, Cory Library, Grahamstown.

²⁵⁶ PR360-1, Grahamstown Asylum General Register of Patients, 1875-1896, Cory Library, Grahamstown

²⁵⁷ John Charles Bucknill and Daniel Hack Tuke, *The Manual of Psychological Medicine: The Manual of Psychological Medicine: Containing the Lunacy Laws, Nosology, Aetiology, Statistics, Description, Diagnosis, Pathology and Treatment of Insanity with an Appendix of Cases*. (London, 1879).

generations' tradition of moral treatment.²⁵⁸ The *Manual of Psychological Medicine* became the standard work on "lunacy" and remained so for many years. It is very likely that Greenlees, Hullah, Dodds and most other British-trained psychiatrists in the Cape Colony would have been very familiar with the text. It is likely that the definitions and symptoms of the various forms of insanity as described in this text would have been influential in their diagnostic practices.

The major two strands of diagnoses in the Asylum's earliest years were mania and dementia. Mania and dementia formed the two major strands of disorder as understood by the Asylum's medical authorities, following their profession's precepts; melancholia was a third such diagnosis.

Mania

Mania indicated a state of disorder characterised by disorganised actions and thoughts, and could include irritability or elevated mood; it was a broad diagnosis often separated into subtypes.²⁵⁹ Psychiatrists believed it to be reversible in most cases.²⁶⁰ Various subtypes – *mania-a-potu*, homicidal mania, etcetera – were named for whatever characteristic of the mania was most apparent: mania linked to alcoholism, mania that included homicidal actions, and so on. Mania could be chronic, recurrent or acute.

Bucknill and Tuke defined this broad disorder of mania as,

A term understood in various senses, and it doubtless includes many cases presenting very different symptoms; but in its primary sense, that of Raving Madness, it may be properly regarded as passion arising from disease and more prolonged in its operation.²⁶¹

Symptoms of mania included excitement, delusions, illusions, violent actions, destructive actions, "dirty habits", incoherence and abusive language.²⁶² In terms of facial expression,

²⁵⁸ Edward Shorter, *A Historical Dictionary of Psychiatry* (Oxford, 2005), pg. 293.

²⁵⁹ G.E Berrios, "Dementia: Historical Overview" in Alistair Burns and Raymond Levy (eds.), *Dementia* (London, 1994), pg. 6.

²⁶⁰ Bala Mahendra, *Dementia: A Survey of the Syndrome of Dementia, Second Edition* (Dordrecht, 1987), pg. 2.

²⁶¹ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 294.

²⁶² Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 295-6.

those with mania were described as showing “a knitted brow, ferocious aspect, [and] expressions of strong emotional force.”²⁶³

Obviously, the diagnosis of “mania” could be applied to diverse symptoms of mood or cognitive disorders, as well as to a large number of behaviours deemed to be problematic without being actual psychopathologies.

Dementia and dementia praecox

For much of the early history of psychiatry as a medical specialisation, the condition of dementia indicated, following Jean Esquirol’s formulation, “a cerebral affection . . . characterised by a weakening of the sensibility, understanding, and will.”²⁶⁴ Causing widespread changes in the brain, dementia was characterised primarily by memory and cognitive impairment, but included apathy, deterioration in social behaviour, aggression, delusions and hallucinations.²⁶⁵ Many disorders of the mind were believed to terminate in a demented state, in which the mental life of the affected person dwindled away.²⁶⁶ Senile dementia was one of the most familiar forms, but as psychiatric nosologies and taxonomies diversified, other forms of dementia-related disorders began to proliferate. Foremost among these from the mid-1800s onward was dementia praecox.

French psychiatrist Bénédict-Augustin Morel, writing in the mid-1800s, described a form of insanity that affected younger people, and led to state of dementia long before they reached middle-age. In the 1860s, Karl Ludwig Kahlbaum, a Prussian psychiatrist, described two forms of insanity that “ran downhill” into dementia. One of these has retrospectively been identified as neurosyphilis, a variant of tertiary syphilis, which can indeed lead to considerable neurological damage. The other, which Kahlbaum termed *vesania typica*, affected the person’s mental faculties, which dwindled, degenerating into dementia.²⁶⁷

²⁶³ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 418.

²⁶⁴ A.S. Henderson and A.F. Jorm, “Definition and Epidemiology of Dementia: a Review”, in Mario Maj and Norman Sartorius, *Dementia, Second Edition* (Chichester, 2002), pg. 1.

²⁶⁵ Henderson and Jorm, “Definition and Epidemiology”, pg. 1.

²⁶⁶ Shorter, *Historical Dictionary*, pg. 267.

²⁶⁷ Shorter, *Historical Dictionary*, pg. 152.

In the writings of Morel and Kahlbaum, this dementia changes were *not* associated with advanced age; when they occurred in younger people, they were believed to be premature. German psychiatrist Emil Kraepelin, working with such cases in Germany and the Russian Empire the 1880s and 1890s, devised the diagnostic category of dementia praecox, a term which literally means “premature dementia”, i.e. that which has developed earlier in life. This became a broad diagnosis usually divided into subtypes, all characterised by a familiar set of symptoms and a predictable deterioration of cognition.²⁶⁸ Hebephrenia and catatonia were subsumed into this diagnostic class. As a diagnostic group, dementia praecox was renamed schizophrenia by prominent Swiss psychiatrist Eugen Bleuler in 1908.

According to Bucknill and Tuke, those suffering from dementia had

[L]ost [the faculties of understanding and sensibility] to a very considerable degree...The conversation and manners of the insensate bear the impress of their former state. There exists, therefore, a form of mental alienation which is very distinct – in which the disorder of the ideas, affections and determinations, is characterised by feebleness, and by the abolition, more or less marked, of all the sensitive, intellectual and voluntary faculties.²⁶⁹

Bucknill and Tuke loosely group dementia with idiocy and imbecility, but warn that the three disorders should not be confused. People affected by dementia, according to Bucknill and Tuke, experienced great confusion of thought, and although they could often read or write in the earlier stages, they soon lost the thread of their thoughts and were unable to express themselves.

Physically, those with dementia often wore perplexed expressions, were listless and aimless, and often fidgeted and muttered to themselves. Incoherence and using bad language were also included as potential symptoms of dementia, as were fits of excitement, “dirty habits” and incontinence.²⁷⁰

Bucknill and Tuke believed that dementia could sometimes arise on its own, but was more often the result of another disease of the mind, for example melancholia or mania – which is to day, dementia was often thought to be secondary rather than primary.

²⁶⁸ Shorter, *Historical Dictionary*, pg. 268.

²⁶⁹ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 177.

²⁷⁰ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 181

Melancholia

As a diagnosis or descriptor of a mental disorder, melancholia dates back to Ancient Greece. Into the modern era, two broad definitions of the term existed. In one sense, melancholia referred to “all mental afflictions in which mood, drive and intellectual function were somehow down.”²⁷¹ In this, it was the opposite of mania. In the other sense, it indicated madness that involved fixed delusions, and contrasted with mania, which involved hallucinations or false perceptions.²⁷² There is no evidence that this second meaning was that used in the Grahamstown Asylum, and depression began to replace melancholia as a diagnosis in the later nineteenth century.

Bucknill and Tuke firmly adhered to the first sense of the word. In their formulation, melancholia, while of complex aetiology, was a disorder in which the affected person lost their “relish for life”, wished to be alone, preferred to stay home rather than go out, and became quiet, cheerless, moody and taciturn. Furthermore, Bucknill and Tuke described people with melancholia as being may quick to cry, despondent, fearful or despairing, and either depressed and silent or restless and active. Many suffered from insomnia and bad dreams, anxiety, and, in men, a lack of interest in sex was common.²⁷³ (Whether women with melancholia had lost their interest in sex is not mentioned, possibly as Bucknill and Tuke probably believed, like most nineteenth-century medical specialists, that women were not supposed to be interested in sex to begin with.)

Diagnoses within the Grahamstown Asylum

Between 1875 and 1879, the distribution of dementia diagnoses across the groups indicates that it was a diagnosis more commonly attached to black patients: 31.6% of black males were diagnosed with dementia, as were just under 40% of black female patients.²⁷⁴ Conversely, doctors deemed only 22.1% of white males to be suffering from dementia, and only 16.7% of white females.²⁷⁵ Asylum doctors seem to have given diagnoses of melancholia more

²⁷¹ Shorter, *Historical Dictionary*, pg. 174.

²⁷² *Ibid.*

²⁷³ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 218.

²⁷⁴ PR360-1, Grahamstown Asylum General Register of Patients, 1875-1896, Cory Library, Grahamstown.

²⁷⁵ *Ibid.*

commonly to women than to men: 3.8% of black women and 13.4% of white women were so diagnosed, but only 3% of white men and no black men were diagnosed with melancholia.²⁷⁶

Indeed, very few of the black patients that ever entered Grahamstown Asylum were diagnosed with melancholia; Colonial psychiatrists did not think it could affect the simple, childlike black psyche. In reality, this low return was more likely to be an effect of the different paths of committal. White individuals displaying the symptoms of melancholia, if they were not violent or suicidal (and generally they were not), usually came to the Asylum's notice via the efforts of friends of family. But most black patients, as mentioned elsewhere in this thesis, came to the Asylum via the intervention of the police and the courts - law-enforcement organs which only noticed them once they had been noticed and subsequently apprehended after displaying so-called unruly behaviour in public. Obviously this is no indication of whether or not black patients within the Asylum experienced melancholia or depression, but it is a strong sign that, if they did, it usually went unnoticed.

By the mid-1880s, the types of diagnoses Asylum doctors assigned to the patients in their care were changing, and a long-term trend became apparent, namely that mania and dementia were the diagnoses most commonly given by Asylum medical staff. Mania accounted for 52.9% of white men, 38.3% of white women, 28.9% of black men, and 39.1% of black women. Dementia, on the other hand, was diagnosed among 22.4% of black men and 30.4% of black women, but only 14.3% of white men and 20% of white women. Asylum doctors also diagnosed proportionately more black patients with imbecility and idiocy. Mania was the most common diagnosis across the Asylum's patient population as a whole in the mid-1880s, which on its own would suggest only that it was a broad catch-all disorder,²⁷⁷ which is consistent with the broad set of signs and symptoms outlined in Bucknill and Tuke's *Manual*. Disorders manifesting in lethargic or passive behaviour were commonly assigned to white patients. Melancholia, in the 1870s and early 1880s, was a disorder most commonly found among white women, in whom was believed to repose the qualities of kindness, gentleness and passivity, which was countered or complemented by masculine dynamism and assertiveness.

²⁷⁶ PR360-1, Grahamstown Asylum General Register of Patients, 1875-1896, Cory Library, Grahamstown.

²⁷⁷ *Ibid.*

In the period 1885 to 1889, for example, 10% of white men and 3% of black men were diagnosed with melancholia, but 15% of white women were so assigned.²⁷⁸

The range of diagnoses that Asylum authorities assigned to the patients committed to the Grahamstown Asylum between 1875 and 1889 was small, and corresponded to racial and gender divisions among the patients in the Asylum. Dementia was most often diagnosed among black women; imbecility accounted for a good number of diagnoses among black men, while white men were thought more likely to suffer from mania, and women from melancholia. By the 1890s, dementia came to be employed as a diagnosis less often, possibly as a result of changes in the psychiatric community's understanding of the disorder. However, melancholia became a more common diagnosis and mania remained the predominant form of mental disorder encountered by the Grahamstown Asylum's medical practitioners.²⁷⁹ Epilepsy-related disorders, congenital or inherited mental disorders, and General Paralysis of the Insane (also then known as paralytic dementia, and now identified as neurosyphilis, an organic mental disorder found in late-stage tertiary syphilis), entered the lexicon as major categories in addition to mania, dementia and melancholia. The consolidation of diagnoses into fewer, more codified groups in the 1880s led to the range of diagnoses found among the Asylum shrinking: three main varieties of mania (acute, chronic and recurrent), as well as group-specific subtypes such as puerperal mania and mania-a-potu. Melancholia was divided into acute, chronic and recurrent varieties, while dementia was divided into primary, secondary, senile and organic types. This is in keeping with the systems laid out by Bucknill and Tuke.

With the arrival of Dr T Duncan Greenlees in 1890, following Dr Richard Hullah's death, the pattern of assigning different diagnoses to men and women according to race intensified. Greenlees, almost alone among the Cape's growing contingent of psychiatrists, believed that "native" patients could only suffer from simple forms of insanity.²⁸⁰ This was, he believed, the

²⁷⁸ PR360-1, Grahamstown Asylum General Register of Patients, 1875-1896, Cory Library, Grahamstown.

²⁷⁹ PR360-1, Grahamstown Asylum General Register of Patients, 1875-1896, Cory Library, Grahamstown.

²⁸⁰ Shula Marks, "'Every Facility that Modern Science and Enlightened Humanity Have Devised': Race and Progress in a Colonial Hospital, Valkenberg Mental Asylum, Cape Colony, 1894 – 1910", in Joseph Melling and Bill Forsythe (eds.), *Insanity, Institutions, and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London, 1999), pg. 283; R. Duncan Greenlees, "Part 6:

result of their relatively simple brains, as referred to in an earlier quote.²⁸¹ Greenlees believed that the increasingly 'civilised' nature of the Cape accounted for the increase in insanity, and consequently in committal to the Asylum, among black individuals resident in the Colony.²⁸² In 1892, Greenlees complained that the forms of insanity he encountered among the black patients committed to the Asylum were so different from those he observed among white patients that he could not understand them.²⁸³ It may be that he simply chose not to. It is indubitable, however, that the Western psychiatry practiced in the Cape Colony was being practiced very far from home. Julie Parle writes that,

“As biomedical practitioners fanned out through the world, some consciously as part of the ‘civilising mission’, other propelled by professional prospects, Western psychiatry was practiced in places far from its genesis. In Africa, as in Asia and elsewhere, its aetiological and nosological categorisations, its secular and materialist explanations, and later, its treatments, would be applied to people who had very different ways of understanding the origins and meanings of madness.”²⁸⁴

The difficulties Greenlees and other asylum medical officers faced was partly due to language barriers (in which case the simplest and surely most obvious solution would have been to hire staff that spoke isiXhosa, isiZulu or Sesotho) and partly because “habits common to the native sane” could appear, to white Asylum doctors unfamiliar with such habits, to indicate insanity in the individual manifesting them.²⁸⁵ Whatever Greenlees’ particular understanding of the causes of black insanity was, the patterns of diagnoses among incoming Asylum patients remained similar to those already established prior to his arrival. Mania diagnoses were still the most commonly encountered, accounting for half of the white patient intake and more than two thirds of the black patient intake. Dementia was most often diagnosed among male patients, usually black, while most cases of melancholia were found among female patients.

Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1890, part VI: Grahamstown Asylum and Chronic Sick Hospital*, CCP1/2/1/79, G37-'91, Western Cape Archives and Records Service, Cape Town, pg. 42.

²⁸¹ Greenlees, “Grahamstown Asylum 1890”, pg. 42.

²⁸² Butchart, Alexander, *The Anatomy of Power: European Constructions of the African Body* (New York, 1998), pg. 112.

²⁸³ T. Duncan Greenlees, “Part 6: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1892*, CCP1/2/1/84, G17-'93, Western Cape Archives and Records Service, Cape Town, pg. 21.

²⁸⁴ Parle, *States of Mind*, pg. 59.

²⁸⁵ Greenlees, “Grahamstown Asylum 1892”, pg. 21.

Mania-type disorders predominated among incoming Grahamstown Asylum inmates in the 1890s; more than half of all the lunatics admitted to the Asylum were diagnosed as manic. Melancholia, imbecility and dementia are the only other diagnoses that were assigned among all groups, however. Doctors seemed more likely to be able to discern some disorders in some groups rather than others. In the case of black patients, they ‘saw’ mania. In the case of white patients, it is as if the spectrum of available diagnoses was widened: in the early 1890s, idiocy and GPI were only diagnosed among white men and women, while hysterical insanity was only diagnosed among black women, and “moral insanity”²⁸⁶ was only diagnosed among white women.²⁸⁷ Melancholia was especially prevalent among black women and white women, while imbecility was also more prevalent among white women than any other group. Black males saw the highest rates of dementia, which were also higher among white males than among either group of females.²⁸⁸

In the mania category, slight differences are visible between groups. All groups show noticeable majorities of acute mania, but the smaller categories in this group do not show a similar consistency. Among women, puerperal mania shows a sizeable presence, accounting for more black female admissions (9.9% of the total intake) than white female (3.8%). By the same token, mania-a-potu has much higher incidences among men, particularly white men (11.8%; black men show a rate of 11%), then women (black women in this intake had no cases of mania-a-potu among them, while white women showed a rate of only 3.8%). Chronic mania showed a higher incidence among black individuals, 11% of women and 5.8% of men, than white, where only 5.8% of women and 3.5% of men received the diagnoses.²⁸⁹

²⁸⁶ “Moral insanity” was an accepted diagnosis throughout Western psychiatry in the later nineteenth and early twentieth century. It was understood as a form of madness in which individuals manifested abnormal emotions and behaviours, but no delusions, hallucinations, or melancholia. The “moral” here refers to emotions rather than ethics.

²⁸⁷ PR 360-3, Grahamstown Asylum General Register of Patients, 1896 – 1918, Cory Library, Grahamstown.

²⁸⁸ *Ibid.*

²⁸⁹ Greenlees, “Grahamstown Asylum 1890”, pg. 54; T. Duncan Greenlees, “Part 6: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1891, part VI: Grahamstown Asylum and Chronic Sick Hospital*, CCP1/2/1/82, G36-’92, Western Cape Archives and Records Service, Cape Town, pg. 52; Greenlees, “Grahamstown Asylum 1892”, pg. 33; T. Duncan Greenlees, “Part 6: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1893, part VI: Grahamstown Asylum*, CCP1/2/1/89, G24-’94, Western Cape Archives and Records Service, Cape Town, pg. 65; T. Duncan Greenlees, “Part 14: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the*

Among the melancholia diagnoses between 1890 and 1894, white individuals predominate – 17.3% of white women and 16.7% of white men had melancholia diagnoses, compared to 14.9% of black men and 11% of black females. The gender divisions here, taken overall, do not appear to be significant; the racial division, however, is clearer. The most commonly encountered melancholia diagnoses were that of the disease's acute form: 11.8% of white males, 9.6% of white females, 8.4% of black males, and 7.7% of black females received this diagnoses. Chronic melancholia is similar, if less prevalent, in its distribution: 4.2% of white men and 4.8% of white women, compared to only 3.2% of black men and no black women.²⁹⁰

In the first four years of Greenlees' administration of the Grahamstown Asylum, the patterns Swanson notes are already in place: Asylum doctors did indeed assign diagnoses of mania, dementia and melancholia differently across the various racial groups, thereby entrenching the idea that black lunatics were admitted to the Asylum for reasons different to those of whites, but had different types of madness, justifying the different kinds of treatment, care and custody they received. For white lunatics, the experience was quite different – the ramifications of their madness were dissimilar; their insanity was thought to be more complex, more indicative of the pressures each individual suffered, and – Greenlees hoped – more amenable to efforts at cure.

In the late 1890s, mania-type disorders predominated; in all groups except white females, acute mania was the most commonly-encountered diagnosis, occurring among 16.8% of white males, 13.5% of white females, 32.9% of black males, and 31% of black females. Rates of mania overall were even higher, accounting for almost two-thirds of all black diagnoses – 65.8% of black males and 69% of black females – and lower, but still very significant, levels of white individuals: 38.9% of white males and 44.8% of white females. The subtype of mania, other than acute mania, most prevalent among each group does differ: 15.5% of black females were diagnosed with chronic mania, and 13.9% of black males were diagnosed with recurrent

Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1894, part VI: Grahamstown Asylum, CCP1/2/1/92, G16-'95, Western Cape Archives and Records Service, Cape Town, pg. 78.

²⁹⁰ Greenlees, "Grahamstown Asylum 1890", pg. 54; Greenlees, "Grahamstown Asylum 1891", pg. 52; Greenlees, "Grahamstown Asylum 1892", pg. 33; Greenlees, "Grahamstown Asylum 1893", pg. 65; Greenlees, "Grahamstown Asylum 1894", pg. 78.

mania, as were 12.5% of white females and 9.7% of white males, making recurrent mania the next-most prevalent form of mania after acute mania. Senile and puerperal mania seem, in this group, to have been found mostly among females, with somewhat higher rates among black females (3.1% of white females were diagnosed with puerperal mania, but double that number of black females - 7%; senile mania saw a rate of 4.6% among white females and 5.6% among black females). Mania-a-potu, by contrast, was mostly a male disorder, 6.2% of white men and 7.6% of black men received the diagnosis, and only 3.1% of white females, but no black females.²⁹¹

The attribution of melancholia, however, showed a clear racial bias: it was considerably more prevalent among white individuals; it was rather rare among black males, in particular. Acute melancholia, for example, was showed its lowest prevalence among black males, only 4.4%; the rate among black females was 7%, among white males 8.8% and white females 10.4% (a higher prevalence among women vis-à-vis men is therefore evident). Chronic and recurrent melancholia were also much more prevalent among white individuals, as was senile melancholia.²⁹²

Dementia, conversely, was more commonly assigned by the doctors involved as a diagnosis among black individuals entering the Asylum; rates across the board are low overall, but with a surprisingly high proportion of such diagnoses among black males – 11.4% compared to

²⁹¹ T. Duncan Greenlees, "Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1896, part VI: Grahamstown Asylum*, CCP1/2/1/101, G20-'87, Western Cape Archives and Records Service, Cape Town, pg. 37; Greenlees, T. Duncan Greenlees, "Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1895, part VI: Grahamstown Asylum*, CCP1/2/1/101, G20-'87, Western Cape Archives and Records Service, Cape Town, pg. 19; T. Duncan Greenlees, "Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1898, part VI: Grahamstown Asylum*, CCP1/2/1/108, G21-'99, Western Cape Archives and Records Service, Cape Town, pg. 21; T. Duncan Greenlees, "Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1899, part VI: Grahamstown Asylum*, CCP1/2/1/112, G25-'00, Western Cape Archives and Records Service, Cape Town, pg. 18.

²⁹² Greenlees, "Grahamstown Asylum 1895", pg. 37; Greenlees, "Grahamstown Asylum 1896", pg. 19; Greenlees, "Grahamstown Asylum 1898", pg. 21; Greenlees, "Grahamstown Asylum 1899", pg. 18.

5.3% of white men, 4.2% of black women, and 3.1% of white women.²⁹³ The prevalence of black men in this appears to be the result of an 8.2% rate of secondary dementia diagnoses among that group, while senile and organic dementia were more often found among white men.²⁹⁴

In this intake, then, white men were more likely to have assigned diagnoses in the mania or congenital-disorder categories than they were to be diagnosed as melancholic or demented. Among black men, mania accounted for by far the highest number of diagnoses, with dementia, congenital disorders, and melancholia accounting for sequentially smaller groups of individuals. White females, like all groups, saw a majority of mania diagnoses, but there were equal proportions of congenital disorders, and a very small proportion of dementia diagnoses. Black females also showed a very low rate of dementia diagnoses, and a similarly small number of congenital-disorder cases; melancholia diagnoses and mania diagnoses were the most prevalent.

The diagnoses assigned to individuals entering the Asylum in the early 1900s were, as before, mostly on the mania spectrum, but the incidence of melancholia increased to the point where it became the second most commonly identified disorder; the third most common disorder diagnosed in the early 1900s was dementia. Mania was, as before, more typically encountered among male patients, melancholia among female patients. These divisions remained intact when viewed across racial lines: melancholia was diagnosed more often among white patients, and dementia more often among black patients.

The final period under discussion showed, like all those previously, a predominance of mania diagnoses across all groups (except, in this case, black males, who show a startling albeit slight majority of melancholia diagnoses). Melancholia, overall, was the second most-commonly encountered type of disorder; dementia, congenital disorders, and GPI also show considerable presences.

²⁹³ Greenlees, "Grahamstown Asylum 1895", pg. 37; Greenlees, "Grahamstown Asylum 1896", pg. 19; Greenlees, "Grahamstown Asylum 1898", pg. 21; Greenlees, "Grahamstown Asylum 1899", pg. 18.

²⁹⁴ *Ibid.*

The mania diagnoses for the first few years of the 1900s showed that more black patients than white patients were diagnosed as manic by doctors: 54.2% of black females, and 53.3% of black males, compared to 37.8% of white males and 30.2% of white females. It is the most commonly-encountered diagnostic category among white men, black men, and black women.²⁹⁵ Among white women, the most commonly-encountered diagnostic category was that of melancholia – 31.4% of white women, compared to 23.6% of white men, only 9.3% of black men, and 12.9% of black females. Dementia was more common than melancholia among black men, and almost as prevalent as melancholia among black women. 9.9% of white men were diagnosed with dementia-type disorders, 12% of white men, 15.9% of black men, and 12.1% of black females.²⁹⁶ Congenital disorders were far more common among white females than any other group: 17.1% of white women were diagnosed with these disorders, which could include epilepsy. It was also present among white men, black men, and black females – 6.3%, 7.6% and 7.1% respectively. By contrast, acquired epilepsy, not connected to congenital disorders, was most common among black men – 6.2% of these patients, compared to 3.6% of white men, 4.7% of white females, and 3.3% of black females. GPI was much more

²⁹⁵ T. Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1900, part VI: Grahamstown Asylum*, CCP1/2/1/115, G41-'01, Western Cape Archives and Records Service, Cape Town, pg. 93; T. Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1901, part VI: Grahamstown Asylum*, CCP1/2/1/115, G41-'01, Western Cape Archives and Records Service, Cape Town, pg. 117; T. Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and of the Inspector of Asylums for 1902*, CCP1/2/1/123, G60-'03, Western Cape Archives and Records Service, Cape Town, pg. 88; T. Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and of the Inspector of Asylums for 1903*, CCP1/2/1/123, G60-'03, Western Cape Archives and Records Service, Cape Town, pg. 124; T. Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and of the Inspector of Asylums for 1904*, CCP1/2/1/123, G60-'03, Western Cape Archives and Records Service, Cape Town, pg. 88; T. Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and of the Inspector of Asylums for 1905*, CCP1/2/1/137, G32-'06, Western Cape Archives and Records Service, Cape Town, pg. 85.

²⁹⁶ Greenlees, "Part 3: Grahamstown Asylum, 1900", pg. 93; Greenlees, "Grahamstown Asylum 1901", pg. 117; Greenlees, "Grahamstown Asylum 1902", pg. 88; Greenlees, "Grahamstown Asylum 1903", pg. 124; Greenlees, "Grahamstown Asylum 1904", pg. 88; Greenlees, "Grahamstown Asylum, 1905", pg. 85.

prevalent among white men than any other group, found in 10.6% of white men, but only 1.2% of white women, 1.1% of black men, and no black women.²⁹⁷

The rise in melancholia – a diagnosis seldom encountered among black patients, relative to white ones – suggests that although the number of black patients committed to the Grahamstown Asylum remained high, a number of white patients who displayed no dangerous or unacceptable behaviour were admitted to the Asylum. Melancholia, as Swanson notes, was a passive disorder, a nonviolent affliction that could often be dealt with for years in the home; melancholics did not often come to the attention of the police or criminal authorities, and were presumably therefore usually brought to the Asylum by friends or family. It was also a disorder believed to be found almost solely among white men and women, as Swartz notes, due to the “superior intellectual development” of white people.²⁹⁸ An increasing number of melancholics in the Asylum would therefore indicate a higher number of patients who had come there under Urgency Order or Summary Reception Order, rather than through the criminal courts. This would indicate that Greenlees’ vision of the Grahamstown Asylum as more of a private sanatorium was coming to fruition.

At Valkenberg, acute mania accounted for a majority of diagnoses among men and women (39% and 32.3% respectively), followed by acute melancholia (21.3% and 23.2% respectively), and secondary dementia, i.e. dementia following another disorder (3.2% and 5.1% respectively). General Paralysis of the Insane was rare among women but affected about 8.5% of the men admitted, while chronic mania, puerperal melancholia, and acquired epilepsy affected more women than men.²⁹⁹ These figures and the patterns they indicate are largely consistent with those seen at the Grahamstown Asylum.

There existed, in colonial and metropolitan psychiatry, an intractable fear of the wildness and danger posed by the “other”.³⁰⁰ This is illustrated by the previous section’s conclusion that black patients admitted to the Grahamstown Asylum were believed to be manifesting violent

²⁹⁷ Greenlees, “Part 3: Grahamstown Asylum, 1900”, pg. 93; Greenlees, “Grahamstown Asylum 1901”, pg. 117; Greenlees, “Grahamstown Asylum 1902”, pg. 88; Greenlees, “Grahamstown Asylum 1903”, pg. 124; Greenlees, “Grahamstown Asylum 1904”, pg. 88; Greenlees, “Grahamstown Asylum, 1905”, pg. 85.

²⁹⁸ Swartz, “Psychiatric Knowledge in the Cape”, pg. 103.

²⁹⁹ Swartz, “Psychiatric Knowledge at the Cape”, pg. 104.

³⁰⁰ Sander Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race and Madness*, pg. 139.

behaviour far more often than white patients were. This tied into existing misconceptions of the innate inferiority of blacks when compared to whites: believed by metropolitan scientists, such as Francis Galton, to be less individually distinct than whites,³⁰¹ they were thought to be less adaptable and less sophisticated, almost childlike, in comparison to Europeans,³⁰² both traits which rendered them vulnerable to the vagaries of fast-changing colonial society.³⁰³ The more civilisation advanced, many European scientists argued, the more indigenous peoples were at risk of insanity.³⁰⁴ (James Hyslop of the Natal Government Asylum believed that “the more civilised a community, and the more stress to be borne, the more mental breakdowns may be expected.”)³⁰⁵ Furthermore, the perceived (but non-existent) differences between black and white groups meant that blacks and whites were believed to be prone to different sets of mental disorders.³⁰⁶ White patients, being more mentally sophisticated, were thought to be more prone to disorders of mood, such as mania, while black patients, believed to be less sensitive, were more prone to disorders of the mind, such as dementia.

The most common diagnosis among black patients was mania, which was believed to be especially prevalent in brains that were underdeveloped; the relative under-sophistication of the black brain was believed, by doctors, to render black individuals unable to handle the complexities of the Western civilisation that colonisation had brought them into contact with.³⁰⁷ This was a typically sleight-of-hand way to blame the victim: civilisation, as the doctors understood the world, was good. Being unable to adapt to it, as black individuals seemed to be, merely meant that they were inferior to white people, who evidently could handle it. However, mania was also the most commonly-diagnosed disorder among white patients at the Grahamstown Asylum.

Gender did not have as deep-seated an effect on the determination of diagnosis as race did; it was not the primary signifier of difference in colonial settings.³⁰⁸ Although the colonial and medical establishments were obsessed with the minutiae of difference among the people who

³⁰¹ Graham Richards, *'Race', Racism and Psychology: Towards a Reflexive History* (London, 1997), pg. 16.

³⁰² Butchart, *The Anatomy of Power*, pg. 112.

³⁰³ Richards, *'Race', Racism and Psychology*, pg. 18.

³⁰⁴ Waltraud Ernst, *Mad Tales from the Raj: Colonial Psychiatry in South Asia, 1800 – 1858*, (London, 2010), pg. 119.

³⁰⁵ Parle, *States of Mind*, pg. 99.

³⁰⁶ Sally Swartz “The Black Insane in the Cape”, pg. 409.

³⁰⁷ Swanson, “Of Unsound Mind”, pg. 43.

³⁰⁸ Vaughan, *Curing Their Ills*, pg. 23.

entered their asylums, in the case of African colonies, of which the Cape was one despite its relatively large white population, the medical discourse was more focussed on race.³⁰⁹ Gender differentiation was somewhat secondary in this system.³¹⁰ In particular, African women were practically invisible.³¹¹ In the case of the Grahamstown Asylum, it is certainly true that race was somewhat more influential than gender in swaying the physicians' decisions about which diagnosis was the most appropriate to the case before them. Indeed, the ideas authorities' held about gender seemed to be more influential when it came to interpreting the causes of insanity than when deciding what kind of insanity it was they suffered from. This is not to say that gender had no effect in the way physicians arrived at a diagnosis. In fact, it influenced diagnosis in much the same way race did on a slightly higher level: the belief that women more emotional creatures than men meant that their diagnoses were more often of more emotional disorders, such as melancholia, and less often disorders of the mind or thinking, such as mania.³¹²

In addition to illustrating the ways in which underlying preconceptions surrounding race and gender influenced the patterns of diagnoses of insanity in colonial asylums, the patterns of diagnoses at the Grahamstown Asylum are evidence of the particular system of discrimination at work in that institution. On the one hand, T Duncan Greenlees and Robert Hullah before him, employed a broader range of diagnoses than were usually found in the medical repertoires of colonial asylums. Most asylums divided diagnoses into cases of mania or dementia, with the former far outnumbering the latter.³¹³ The Grahamstown Asylum divided incoming patients into more groups, even before the arrival of T Duncan Greenlees in 1890. The more detailed separation of patients into various categories only confirmed what authorities thought they knew: that insanity was not an equal-opportunity state of being. Greenlees, much more so than Hullah, believed that the "native mind" had special properties.³¹⁴ The trends of diagnoses in the Asylum admissions between 1875 and 1905 may have been separated from the ways in which patients experienced the rest of their time in the Asylum, but the same set of prejudices that affected the allocation of resources during their

³⁰⁹ Vaughan, *Curing Their Ills*, pg. 13.

³¹⁰ Vaughan, *Curing Their Ills*, pg. 22.

³¹¹ *Ibid.*

³¹² Constance M. McGovern, "The Myths of Social Control and Custodial Oppression: Patterns of Psychiatric Medicine in Late Nineteenth-Century Institutions", *Journal of Social History*, 20, 1, 1986, pg. 11.

³¹³ Vaughan, *Curing Their Ills*, pg. 120.

³¹⁴ Marks, "Modern Science and Enlightened Humanity", pg. 283.

time there worked backwards through time to the earliest days of their committal. In this way, the path an individual's life took once inside the Asylum was decided upon even before they were assigned a room and bed. The types of behaviour they were thought to manifest upon admission, and the diagnoses they received shortly thereafter, were subject to prevailing currents of prejudice that determined everything else in their Asylum experience.

Being admitted into the Grahamstown Asylum – at least initially - was more or less a given for anyone adjudged to be a lunatic in the Eastern Districts of the Cape Colony. That is, it was a given that when their time came to be sent to an asylum, it would be Grahamstown Asylum to which they were sent. But as we have seen, quite often lunatics spent most of their lives outside the purview of Colonial authorities, let alone the Asylum, until changing behaviour brought them to the attention of the authorities. Commitment to the Asylum followed one or other course: arriving via the efforts of friends and families seeking better care for their afflicted loved one, or being institutionalised by law enforcement, often experiencing a spell in gaol or a locked hospital ward in the interim. In both cases, alleged lunatics were brought before a sequence of civil authorities who judged them as insane or not according to stipulations laid out in legislation that was designed, often by asylum doctors, to treat all lunatics equally. However, this very legislation had encoded inequalities into the Lunacy Acts by implicitly allowing some patients more respect than others, and established differential, unequal modes of care and treatment long before anyone even saw the inside of an Asylum dormitory. Greenlees was involved in the formulation of these laws, and his reach was long, even affecting those lunatics who did not come under his portfolio.

This chapter is concerned with discourse of the emerging psychiatric profession in defining madness or lunacy. Further, it discusses with how the profession's assumptions fed off prevalent ideas about the social order, including prejudices. Among other things, this chapter sought to make the point that there was no way for anyone in the Cape Colonial asylum system, or the sphere of influence of the Grahamstown Asylum, to have escaped the overarching prejudices and stereotypes prevalent in the Colony's socially-dominant culture. Colonial insiders could avoid neither being shaped by it nor perpetuating it. Asylum doctors in the Colony understood their profession and patients through a lens of science and medicine, but subscribed – at least partly – to existing underlying prejudices around sex and gender classifications. Outsiders in the Colony could not avoid being judged by the values of that

area's homogeneous dominant culture, and in the case of lunatics admitted to asylums they found themselves, to varying degrees, engaging with that culture's dominant norms and values. Upon entering the Cape's legislative machinery and asylums, all lunatics of whatever description in the Cape were fitted into ready-made moulds that determined not only how they would be treated by the Colony's legislative officers – police officers, lawyers, and magistrates – but also how the asylum doctors would interpret their symptoms once they came to enter an Asylum. The case of the Grahamstown Asylum is particular, both because of the peculiar opinions and beliefs of Medical Superintendent Greenlees, and because it was a place that housed patients of various economic statuses and racial classifications.

Chapter 4: The Cape Colony's Lunacy Acts and Institutional Committal

Lunacy is a category invented by the psychiatric profession in conjunction with lawmakers. No lunatic is born a lunatic and nor, indeed, are they deemed to be lunatics later in life when the symptoms of mental disorder begin to affect their behaviour and interactions. Instead, lunacy is recognised as a condition or state when madness is understood as a problem requiring control and resolution; individuals become lunatics at the point where their condition is diagnosed/determined by medical and legislative bodies concerned with these matters. Being a lunatic is perhaps more the result of having been made to undergo a process of social redefinition than it is of any innate individual attribute. In the 19th and early 20th centuries, anyone who became an inmate of an asylum in the Cape Colony had to be certified as a lunatic before they could be committed. The progression was clear: first an unremarkable member of mainstream society, then a somewhat unusual member, possibly a misfit, and potentially then a threat, and then only a lunatic, and finally an inmate (or, depending on how you look at it, patient¹) in an asylum. This process was not necessarily so neatly defined, or so sequential, but one could not become an inmate without first being found to be a lunatic in the legal sense.

This chapter seeks to examine the ways in which and reasons why this process of redefinition happened to the individuals who ended up committed to the asylum as lunatics. It examines the development and evolution of the Colony's Lunacy Acts, and the role that violent behaviour and the potential for violence played the way in which these Acts were applied to mentally disordered individuals. It goes on to examine the ways in which the Acts' various subcategories of lunatic complemented the Asylum authorities' selectivity as to who was allowed to enter the Asylum, and the role this had in making the Grahamstown Asylum into the discriminatory institution it became.

As Julie Parle notes in the introduction to *States of Mind*, recognition of mental health as a subcategory of the entire health of a person is a fairly recent development, and is,

¹ Please see the Notes on Terminology section of the Introduction for an explanation of the terminology used here.

furthermore, a broad subcategory.² And although health and ill-health are concepts found across all cultures globally, no two understand these concepts exactly the same way (in fact, as Gail Hornstein explores in the excellent *Agnes's Jacket: A Psychologist's Search for the Meanings of Madness*, different understandings of what insanity is and what it means develop and proliferate almost daily).³ Mental health, especially, is a concept so broad that it is able to accommodate almost any constructs or set of understandings around sanity and insanity. Generally, however, mental health is understood as something more complex than simply the absence of mental distress,⁴ and the expression of a definition(s) of psychological distress differ across cultures and locations, as well as across time.⁵ Parle's suggestion that mental health and mental illness are best regarded as a continuum is useful in the examination of the history of the Grahamstown Asylum, which was enmeshed in the laws and sociocultural mores of the late 19th-century Cape Colony. According to Parle, this continuum has, at one end, the clearly-named and widely-recognised forms of mental illness and, at the other, distressed or disturbed states of mind that – while perhaps unpleasant to experience – do not require drastic measures to alleviate.⁶ In many ways, however, the legal structures dealing with insanity, particularly committal procedures, reify and concretise boundaries between sanity and insanity.⁷

In the 20th-century Cape, resorting to psychiatry as a way to get relief from mental illness meant seeking out the care or custody of an asylum, and this quest was usually undertaken by the family or friends of the lunatic rather than the lunatic him/herself. In cases where the lunatic evidently was not situated in a social network, s/he usually found him/herself directed to the asylum via the offices of some or other arm of the Colonial state. But insanity is not quite the same as physical illness; for one, it is less tangible and generally follows a less predictable course of infection and recovery than something physical, such as measles, does. For another, it carries stigma in the way that most physical illnesses do not, and consequently the families and friends of lunatics, and often the lunatics themselves, preferred to engage

² Julie Parle, *States of Mind: Searching for Mental Health in Natal and Zululand, 1868 – 1918* (Scottsville, 2007), pg. 8

³ Gail A Hornstein, *Agnes's Jacket: A Psychologist's Search for the Meanings of Madness*. (New York, 2009).

⁴ Parle, *States of Mind*, pg. 9.

⁵ *Ibid.*

⁶ *Ibid.*

⁷ Sally Swartz, "Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920", Unpublished PhD thesis, University of Cape Town, 1996, pg. 70.

with the formal structures of the psychiatric profession only as a last resort.⁸ Not only did resorting to the Asylum mean admitting that distress was present and could not be addressed without asking for help, but also because in many ways it meant effectively handing over responsibility for – and also control over – the lunatic to authorities situated outside the family. Even the families of lunatics who were comfortable with Western biomedicine and psychiatry often preferred to try to care for or at least contain their lunatic loved ones at home before admitting them to an asylum, usually following changes in circumstances that often involved behavioural changes for the worse.⁹ These behavioural changes usually made continued care at home impractical or risky – violent outbursts, threats to harm others, and either threats of or attempt to commit suicide.

The location of the asylum within the societal network of the Colony is important; it was an option, but seldom one that a lunatic would choose for him- or herself; in fact there was no provision in the 1876, 1891 or 1897 Lunacy Acts for an individual to voluntarily admit themselves without the involvement of friends or family. Families and friends, likewise, often had reservations about the asylum – it was often far away from home, and a closed institution, was not necessarily somewhere which most laypersons would have an accurate mental image even if they lived in close proximity – but nevertheless accepted it as a viable alternative to increasingly onerous responsibility of providing care at home.¹⁰

The development of methods for admitting disturbed individual into the care and/or custody of an asylum was fairly slow in the Cape, and grew from two intertwined imperatives. The first of these was the entrenchment of the Cape Colony's governmental system and concerns with establishing and maintaining law and order. The second was the solidification of the Western medical profession's position as the primary healthcare provider in the Cape Colony. In 1872, three years before the Grahamstown Asylum was established, the Cape Colony was granted Responsible Government, and effectively became semi-autonomous from Britain.¹¹ In the following years the Cape Cabinet passed a number of laws specific to the Cape, tailored to that environment (at least as far as the lawmakers thought was necessary). In the case of

⁸ Parle, *States of Mind*, pg. 11.

⁹ *Ibid.*

¹⁰ Parle, *States of Mind*, pg. 20.

¹¹ Sally Swartz, "'Work of Mercy and Necessity: British Rule and Psychiatric Practice in the Cape Colony, 1891 – 1910", *International Journal of Mental Health*, 28, 2, 1999, pg. 72.

legislation dealing with the control of insane individuals, the Colonial acts were modelled on legislation already in operation in Britain. Between 1879 and 1899, the Cape government passed three Lunacy Acts,¹² which reflected a concern with the reform of care for lunatics and the establishment of proper places of care - or for custody masquerading as care.¹³ This was, as Parle notes, a direct result of the spreading concern for the custody and treatment of lunatics, and the establishment of lunatic asylums, and hospital reform throughout the British Empire in the 1860s and 1870s.¹⁴

The psychiatric profession and psychiatric practice in the Cape Colony were strongly linked to that in the United Kingdom,¹⁵ which was where most of the Cape's asylum doctors came from. Most were Scottish-trained doctors, graduates of the medical school at Edinburgh University; all had immigrated to the Cape as adults, rather than being locally born and raised, and as such they brought with them strong ideas on the role of doctors in the colonial project as well as the sociocultural values and beliefs of white, Westernised 19th-century British society. Colonial and metropolitan beliefs around gender and racial classification influenced the ways in which the Colonial psychiatric profession identified and classified insanity, and subsequently dealt with those so identified and classified. As Parle neatly summarises the position:

...the history of colonial psychiatry cannot be divorced from the milieu in which it occurred where the violent subjugation, economic undermining and political marginalisation of indigenous peoples were often underway, as well as the shaping of societies in ways that were fractured along lines of race, class and gender.¹⁶

Colonial psychiatrists and their putative patients lived – temporarily or permanently – in a society deeply and stratified along constructed lines of gender and racial classification, not to mention socioeconomic divisions that were arguably more deeply entrenched in colonial society. The Colony's mental health services reflected, in organisation and therapeutic practice, these divisions and this was reflected in the Colony's Lunacy Acts.

¹² Parle, *States of Mind*, pg. 40.

¹³ Institutions that provided mere custody rather than therapeutic care were Port Alfred Asylum (opened in 1889, for white chronically insane patients (Swartz, "Work of Mercy", pg. 76), Fort Beaufort Asylum (opened in 1894, for black patients (Swartz, "Work of Mercy", pg. 76), and Robben Island.

¹⁴ Parle, *States of Mind*, pg. 31.

¹⁵ Parle, *States of Mind*, pg. 45.

¹⁶ Parle, *States of Mind*, pg. 42.

As Felicity Swanson observes, some historians of Colonial psychiatry, Harriet Deacon among them, have noted that although Colonial psychiatric theory and practice were both racialised, the Acts themselves were not.¹⁷ In fact, the Acts were primarily concerned with separating the insane from the sane, and indirectly with providing those hoping to identify insanity with a set of descriptors with which to detect and delineate insanity. These descriptors were intended to help create what Swartz calls a “common definition of insanity,” shared by all bodies involved with identifying and managing it, and believed to be fair and objective.¹⁸ On the other hand, though, these Acts still allowed for discrimination – although the terminology of the Acts was neutral and nominally treated all alleged lunatics equally, in practice it still allowed some lunatics to receive inferior care, not least by failing to stipulate basic facilities and standards of care for all asylums in the Colony. Those defined as ‘lunatics’ under the law were hypothetically promised equal treatment, but in practice this was seldom the case. The quality of care they received was dependent on their racial classification. The removal of lunatics to asylums placed them squarely in the care of government authorities outside the family, whose power was vested in them by both the legislative authority of the Cape government and the position of Western biomedicine as the Colony’s socio-politically dominant framework for dealing with health and illness of all kinds, even those it did not recognise and could not understand.¹⁹

Unacceptable Behaviour and the Appearance of Insanity

The behaviour a lunatic or suspected lunatic displayed sometimes functioned as the main deciding factor in their committal process, and sometimes also prompted that process. The decision to seek admittance lay primarily with those friends or family members who had been the potential lunatic’s primary caregivers, although once said lunatic came to public attention by wandering at large or acting strangely in public – essentially being deemed to be a public nuisance²⁰ – more power shifted into the hands of police constables, magistrates, and medical practitioners.

¹⁷ Felicity Swanson, “‘Of Unsound Mind’: A History of Three Eastern Cape Mental Institutions, 1975 – 1910”, Unpublished MA Thesis, University of Cape Town, 1994, pg. 101.

¹⁸ Swartz, “Psychiatric Knowledge in the Cape”, pg. 69.

¹⁹ *Ibid.*

²⁰ Section 23 of Act No. 35 – 1891, Act to Amend the Law relating to Lunatics, in Statutes of the Cape of Good Hope passed by the Eighth Parliament during the Sessions 1889 – 1893, pg. 322.

The authorities involved in committing an individual to the care or custody of the asylum were influenced by several factors. They believed that if an individual exhibited behaviour generally out of context and inappropriate to the situation, he or she might be insane. Of course, in some cases this was the case. At the same time, the fact that strange behaviour was (and indeed still is) considered such concrete proof of insanity suggests that the societal norms that could be transgressed were narrow, and easily overstepped. Judging whether or not an individual was insane was (and still is) a process that relies on particular geopolitical and temporal context and was therefore far more subjective than objective. The basis of that subjectivity was, and is, determined by the norms and standard practices that dominated the culture in which they occurred.

There were, in the period 1875 to 1905, several main factors influencing the means by which stakeholders in the committal process identified potential lunatics. Violence that posed a danger to the individual or others, played a part in the process. In addition, an individual's incoherence, strange behaviour and delusions – all of which could be departures from the social requirements of being coherent and sensible, behaving appropriately across a spectrum of domestic, professional and social situations, and fully subscribing and adhering to a consensual version of reality – played a role. The committal process for lunatics took into account the testimony of various combinations of members of the public, medical practitioners, law enforcement officers, judges, friends and relatives – and all of these various people attested before a magistrate as to the individual's conduct, prior to being examined by the representative of the courts. If their version of events, description of the alleged lunatic, or testimony that the lunatic had been behaving in an untoward manner were deemed convincing, the lunatic – who did not testify for him/herself, but spoke only to the examining physicians – was committed, and sent to an asylum. Medical consensus governed what was considered a sign of insanity and what was not; Bucknill and Tuke's *Manual of Psychological Medicine*, for example, provides not only descriptions of the physical signs of the various forms of insanity but also sketches thereof.

The ways in which 19th century asylum authorities defined or determined an individual's insanity in many ways merely ratified a legal definition articulated in the Lunacy Acts by

buttressing it with a medical sanction.²¹ Classifying the insane – in terms of whether they were insane, as well as what kind of insanity it was, centred on behavioural signs,²² specifically behaviours that did not fit well with what was socially accepted. However, despite the safeguards intended to prevent the individual being incorrectly committed to an asylum (see the preceding chapter), the sections of the document intended to record the facts proving the individual's unsoundness of mind were quite brief. Overwriting and notes in the margins on the original records show that the physicians had considerable trouble restricting their comments to the number of lines provided on the pre-printed form. They relied in part on hearsay: there was, in fact, a specific subheading "Facts communicated to me by others", and physicians often noted that a certain person, usually named, had told them about the alleged lunatic's behaviour.

The first section, "Facts indicating insanity or idiocy observed by myself" (i.e. the physician) was intended to record the affect and behaviour of the individual at the time of examination, and the second section, "Facts indicating Insanity or Idiocy communicated to me by others", included reported behaviour. The forms did provide some guidelines as to what information needed to be included on the forms in order to confirm that the person under examination was in fact insane. The first section, it is specified, needed to include the physician's observations of the individual's appearance, conduct and conversation. The second section was rather less structured, with the only stipulation being that the name of the informant was recorded. The type and intensity of behaviours and appearances listed as "facts indicating insanity" was quite varied, but show a number of commonalities, especially in terms of the appearance and conversation observed by the physicians. As the men examined here did not share physicians, and did not all have the same diagnosis, it might be assumed that there were a number of commonly accepted types of behaviours that were believed to indicate insanity. Bucknill and Tuke remind medical practitioners of the correct way to ascertain whether the affected person is insane:

"When a medical man is called to see a patient whose conduct has excited suspicions of insanity, before he proceeds to personal interrogation and

²¹ Harriet Deacon, "Insanity, Institutions and Society: the Case of Robben Island Lunatic Asylum, 1846 – 1910" in Roy Porter and David Wright, *The Confinement of the Insane: International Perspectives, 1800 – 1965* (Cambridge, 2003), pg. 33.

²² Deacon, "Insanity, Institutions", pg. 33.

examination, he will act wisely in making himself as thoroughly acquainted as he can attain to be, with the antecedents and history of the patient.”²³

This included finding out about previous attacks, any insane ancestors, and whether the affected person’s habits, disposition, and demeanour had changed. If their places of abode, or their bedrooms, were unusual – over or under-furnished, untidy or too tidy, unusually bare or full of collections of objects – insanity might be present. Gestures, too, could become suspicious: “...the insane man, removed from the restraints placed upon him by so-called civilisation, returns to the state of the child or the savage, and expresses his desires and his feelings by the sign-language of nature.”²⁴ While Bucknill and Tuke were writing about lunatics in Britain, this attitude was carried over into the colonial context.

One of the major signs of insanity, as far as the examining physicians and constables were concerned, was an unusual appearance. Individuals who were slovenly, addled or dazed, or simply seemed out of the ordinary could be suspected of insanity, and indeed, when they were assessed as alleged lunatics, all of these signs were taken into account by the doctors. Being strangely dressed, inappropriately dressed, or undressed was also considered a sign of insanity.²⁵ Departing from the apparent norms was evidently enough to indicate that an individual – in the case of the following examples, all white males – had also diverged from the behavioural norm. Of course, behaviour considered inappropriate to the situation is an indicator of mental illness in many cases, but at the same time even this suggests that human behaviour is only considered appropriate within fairly narrow limits. It should be stated here that all of the men under examination (indeed, all of the individuals examined here) were certainly deemed insane.

However, it is of course also possible to appear dishevelled, agitated, impatient and/or in poor spirits without being insane. Likewise, disjointed conversation or inappropriate conduct does not on its own indicate insanity. The coincidence of inappropriate behaviour and insensible conversation was believed to be a strong indication that an individual was insane. Obviously

²³ John Charles Bucknill and Daniel Hack Tuke, *The Manual of Psychological Medicine: The Manual of Psychological Medicine: Containing the Lunacy Laws, Nosology, Aetiology, Statistics, Description, Diagnosis, Pathology and Treatment of Insanity with an Appendix of Cases*. (London, 1879), pg. 404.

²⁴ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 412.

²⁵ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 416.

this quite strongly suggests that judging whether or not someone was insane relied – and indeed still relies – upon context, and the overall tenor of that context is further determined by the norms and standard practices in operation within the dominant culture. In the case of the Grahamstown Asylum, this culture was a variant of the British or Dutch-speaking Westernised culture that placed a premium on neatness and articulacy. Therefore, the range of behaviours deemed to be indicative of an individual's madness themselves point towards what was considered normal by the sociocultural milieu in which they were found. Put differently, "the mad" were what "the sane" were not: out of place, inappropriately equipped for public interaction, and impolite. Good appearance, proper behaviour, and a good grasp of expectations and the ability to fulfil them were obvious requirements for inclusion in "sane" society. Failure to tick these boxes indicated, at best, social ineptitude and, at worst, insanity. The above are all directly related to the overall failure of the insane to meet sociocultural norms to the satisfaction of those around them.

There were several main ways by which an individual was admitted to the group labelled "insane", according to the Colony's committal papers. One was to exhibit incoherence, uncooperativeness, or delusions in conversation. Another was to behave strangely and/or inappropriately. This last, but usually the first noted because of its position at the front and centre of human interaction, was appearance; moreover, appearance and conduct often dovetailed with one another. Unusual appearance was noted in the intake documents of a great number of white men admitted before 1905; this appearance did not show a uniform kind of oddness, but rather divided into three main manifestations that were connected to insanity: wild behaviour, apathetic or listless behaviour, and foolishness.

These categories of insanity appear to persist over the entire periods for which records were examined – 1882 to 1905 – the type of behaviour deemed unusual or unacceptable remained constant because the sociocultural milieu remained broadly the same. Behaving with undue aggression while partly undressed in public was deemed an unacceptable behaviour in at least five instances: in 1890 when Henry G,²⁶ in 1895 when Charles W,²⁷ in 1896 when John E,²⁸

²⁶ "Medical Certificate that a Person is a Lunatic A", ME 03, Patient File of Henry G. PR 10 360, Cory Library, Rhodes University, Grahamstown.

²⁷ "Medical Certificate that a Person is a Lunatic A", ME 12, Patient File of Charles W, PR 10 360, Cory Library, Rhodes University, Grahamstown.

1900 when Juan C²⁹ and in 1905 when Benjamin S did so.³⁰ Each of these men were described as “destructive” or “wild” on their intake certificates, with further details usually elaborating on this description. For example, Henry G was also said to tear his clothes and destroy property; Charles W wandered around at night slamming doors, while Juan C, an insomniac, sang and shouted constantly and undressed himself, often shredding his clothes and dropping them into the latrine pit. Benjamin S was “wild-looking” and “nervous”, “dirty in his habits,” and incoherent. Men who were judged to be of unsound mind partly on the grounds of having a wild appearance commonly also exhibited behaviour that could be described in similar terms. Conversation, often, was evidently considered the most important indicator of the patient’s departure from the norm, and often provided the most illuminating evidence of why the individual had come to the attention of physicians who considered having them committed to the asylum: if one’s words did not make sense, presumably neither did one’s thoughts, and therefore one must be mad (see Chapter Three for a description of the symptoms of dementia, mania and melancholia).

The case of Petrus G, admitted in 1882,³¹ is typical of that of the men described as wild in appearance: the first examining physicians described his condition as “wild and frenzied in appearance...difficult to control...had wandered around *rambling* about religion” [my italics]. The second examining physician elaborated on this, albeit more expressly. He wrote that Petrus had been prone to “uncontrollable” violence and that religious “exhortation” formed almost all his verbal output, as he tended to reply to all remarks with religious ramblings and “unfounded accusations of the worst sins against everyone.” David D, admitted in 1890,³² was “restless and wild in appearance, also violent, especially towards his relations” – at the same time, as one examining physician described him as “restless and wild” the other, merely described his facial expression as “simple”.

²⁸ “Medical Certificate that a Person is a Lunatic A”, ME 17, Patient File of John Thomas E., PR 10 360, Cory Library, Rhodes University, Grahamstown.

²⁹ “Medical Certificate that a Person is a Lunatic A”, ME 36, Patient File of Juan C., PR 10 360, Cory Library, Rhodes University, Grahamstown.

³⁰ “Medical Certificate that a Person is a Lunatic A”, ME 64, Patient File of Benjamin S., PR 10 360, Cory Library, Rhodes University, Grahamstown.

³¹ “Medical Certificate that a Person is a Lunatic”, ME 01, Patient File of Petrus G., PR 10 360, Cory Library, Rhodes University, Grahamstown.

³² “Medical Certificate that a Person is a Lunatic A”, ME 04, Patient File of David D., PR 10 360, Cory Library, Rhodes University, Grahamstown.

Although there is, of course, some behaviour that is incontrovertible proof of suffering from mental illness (talking to people who are not visible to anyone else appears to be a generally agreed-upon sign, for example), it is possible that some changing behaviours became important only because of the threat and/or inconvenience it posed to others. A distinction must be drawn between some unusual behaviour mentioned as being proof of insanity in itself, and some that was seen as proof of insanity because it was dangerous to others. For example, George C, admitted in 1891, is noted as having made a number of attempts to break into the mortuary of the hospital in Kimberley, where he was being held.³³ This was macabre, certainly, but not harmful. Arthur H, held in prison before being admitted to the Grahamstown Asylum in 1892, apparently went around the prison yard “shaking hands with the native prisoners.”³⁴ In neither case did these behaviours pose any threat to those around them. They were distinctly out of the ordinary, and broke social rules, in the first case by repeatedly attempting to enter a place strongly associated with death and protected from intrusion by the taboos around it, and in the second case by voluntarily associating with a group of people generally considered, at the time, not to be social equals.

By considerable contrast, John Thomas E’s voluminous³⁵ intake documents and the affidavits therein all make lengthy mention of exactly what kind of behaviours led to his admission to the Grahamstown Asylum in 1896. The first physician’s report noted that John Thomas E was violent and “unrestrainable, irrational, and nonsensical, with ‘wandering habits’,” twitching, and a evidencing a tendency to struggle “maniacally”.³⁶ He was furthermore apparently given to running around naked, in which state, according to a witness affidavit accompanied the medical certificates and was presented to the resident magistrate of the district, “he [desired] to make love to any children he...came across.” This was considered to be repellent, as well as potentially criminal.

³³ “Medical Certificate that a Person is a Lunatic A”, ME 05, Patient File of George C., PR 10 360, Cory Library, Rhodes University, Grahamstown.

³⁴ “Medical Certificate that a Person is a Lunatic A”, ME 08, Patient File of Arthur H, PR 10 360 Cory Library, Rhodes University, Grahamstown.

³⁵ Not all patients came in with the same set of or amount of documents. Obviously, at a distance of a century or so, some documents were lost, discarded or destroyed. Others may not have been there to begin with. All lunatics would have been admitted using the same set of documents, as that was the administrative requirement, but they have not all reached me.

³⁶ “Medical Certificate that a Person is a Lunatic A”, ME 17, Patient File of John Thomas E., PR 10 360, Cory Library, Rhodes University, Grahamstown.

Other than violence, another form of behaviour apparently deemed indicative enough of mental disorder to warrant an examination and consequent admission was an inability to give proper answers when questioned by physicians. Incoherence of speech and/or thought was considered a symptom of various mental disorders, although this inability was not always accompanied by much outward sign of eccentricity. Martin O³⁷ could not hold a conversation, would not answer questions, and began to pray and stare around when addressed by the examining physician. Ernest E-S, admitted in 1894, had a look of “feeble intelligence” and was judged to be “not only insane but dangerous to others.” Isaac L and James M, both admitted in 1896, were restless and insomniac and, most significantly, anxious. Isaac’s brother-in-law said that he had threatened to kill his landlady, was given to muttering to himself and would not eat.³⁸ James M had “grovelled” on the floor and “pulled the furniture about” the room.³⁹ None of this behaviour had translated to actual aggression; Isaac L’s threat to his landlady’s life was apparently verbal.

Willem D.K., admitted in 1900, was an extreme example of non-aggressive unacceptable behaviour: his medical certificates describe him as “extremely indolent, [of] placid appearance” or “smil[ing] vacuously [and answering] monosyllabically”, while Frederick F⁴⁰ was morose and vacant”, Karl F⁴¹ had a “vacant expression and wandered around aimlessly”, and William L⁴² wore a “vacant, stolid expression”, although his second examining physician described him as “ill, haggard, insane *and wild*” [my italics], which suggests considerable overlap between the various forms of untoward behaviour.⁴³

Obviously, a relatively placid or vacant expression did not negate the possibility of violent behaviour. Aggression and unusually intense passivity are repeatedly remarked upon as proof

³⁷ “Medical Certificate that a Person is a Lunatic A”, ME 10A, Patient File of Martin O, PR 10 360, Cory Library, Rhodes University, Grahamstown.

³⁸ “Medical Certificate that a Person is a Lunatic A”, ME 14, Patient File of Isaac L, PR 10 360, Cory Library, Rhodes University, Grahamstown.

³⁹ “Medical Certificate that a Person is a Lunatic A”, ME 13, Patient File of James M, PR 10 360, Cory Library, Rhodes University, Grahamstown.

⁴⁰ “Medical Certificate that a Person is a Lunatic A”, ME 27, Patient File of Frederick F, PR 10 360, Cory Library, Rhodes University, Grahamstown.

⁴¹ “Medical Certificate that a Person is a Lunatic A”, ME 34, Patient File of Karl F., PR 10 360, Cory Library, Rhodes University, Grahamstown.

⁴² “Medical Certificate that a Person is a Lunatic A”, ME 32, Patient File of William L., PR 10 360 Cory Library, Rhodes University, Grahamstown.

⁴³ It also seems rather unfair that someone being assessed for insanity should have insanity levelled as a fact indicating insanity, but this seems to have passed, if not unremarked, then at least uncorrected.

of insanity, which indicates that they were considered abnormal in the extreme. Aimlessness, also, attracted almost as much comment as aggression did, unwillingness to remain clothed, unclean habits, and unsanctioned expressions of sexuality were also danger signals.⁴⁴ All of these things – undue violence or violence deemed inappropriate to the situation, undue passivity, and unwillingness to follow social proscriptions around privacy – were departures from the masculine norms as well as the norms of the overall social milieu. These norms required men to be active and strong but also gentlemanly, as far as possible; all adults were required to be clothed, to carry out ablutions in private, and to express sexuality only in narrow and specific situations.

Dirtiness and dishevelled outward appearance often registered in physicians' examinations. Isaac L, admitted issuing threats against his landlady, was "unshaven and unwashed"; William Y⁴⁵ who was unrestrainable, and thought to have been an alcoholic, was "haggard" as well as being "filthy in his habits", and would not remain clothed, while James O⁴⁶ was "untidy, wild and excitable" and Samuel M⁴⁷ was described as dirty and slovenly, as well as being dirty in habits. This man's outward appearance was so offensive to those around him that he had to be cleaned by force: two men had to be hired for the purpose. It does not seem, then, that anything more than a lack of acceptable personal hygiene was required to act as proof of mental disorder.

It is admitted that this section makes mention almost solely of white patients when particular cases are cited. It needs to be noted here that there was often quite possibly an element of resistance and perhaps also of artificiality in the characteristics shown by men and women who were about to be or being admitted to the Asylum. Patients were not passive receivers of the admissions process or the committal proceedings, particularly the latter. The admission procedures in the Asylum involved physical measurements, undressing and re-dressing, and being photographed. It is likely that much of the violence and distress described in the

⁴⁴ See Nancy Theriot, "Diagnosing Unnatural Motherhood: Nineteenth-Century Physicians and Puerperal Insanity", *American Studies*, 30, 2, 1989.

⁴⁵ "Medical Certificate that a Person is a Lunatic A", ME 18, Patient File of William Y, PR 10 360, Cory Library, Rhodes University, Grahamstown.

⁴⁶ "Medical Certificate that a Person is a Lunatic A", ME 21, Patient File of James O, PR 10 360, Cory Library, Rhodes University, Grahamstown.

⁴⁷ "Medical Certificate that a Person is a Lunatic A", ME 43, Patient File of Samuel M, PR 10 360, Cory Library, Rhodes University, Grahamstown.

committal documents was a reasonable reaction to the stressful process. Furthermore, as Du Plessis notes,⁴⁸ many black patients resisted what was probably a noticeable difference in attitude towards them during the admission process, as well as the process itself, and were therefore on occasion, quite possibly, forced to present certain attitudes in order to meet the attendants' requirements. There is also the possibility that, because photographs can be staged, that some patients ended up *artificially* displaying the characteristics of madness: averted gaze, distress, unkempt appearance, etcetera. This staging, where it took place, would presumably have taken place at the behest of the Asylum's authorities. For both black and white patients (Du Plessis only speaks of black patients), being made to look more characteristically mad in photograph taken at the time they entered the Asylum may have related to the Asylum authorities' need for patients to "look the part" upon admission, perhaps the better to appear improved later. In the case of black patients, also, looking worse off than they were may have played an important part in the construction of black insanity current at the Asylum.

Both physicians and the companions of suspected lunatics considered a wide range of behaviours to be offensive. This continuum extended from the vague unkemptness of Isaac L to the more severely "unclean" habits of David D, William Y, William J,⁴⁹ Ruben G ("exceedingly dirty"),⁵⁰ Marks O, and Luigi R.⁵¹ The latter group are those among whom behaviour was the major indicator of insanity. In the case of Benjamin S, for example, both examining physicians and two of the three affidavits from gaolers that accompanied his committal documents mentioned repeated fouling of his jail cell. Juan C, by comparison, was noted by his examining physician to have "put his drawers down the closet",⁵² while Benjamin S and Samuel M both refused to use the latrine as instructed. Refusal to wash or to keep clean immediate surroundings was as much as a sign of insanity as a refusal to remain fully clothed. Luigi R ran around undressed; Henry G would not remain clothed (suggesting that he was, at some point, dressed, and then undressed himself).

⁴⁸ Du Plessis, Rory, "Photographs from the Grahamstown Lunatic Asylum, South Africa, 1890–1907," *Social Dynamics*, 40, 1, 2014. As Du Plessis does not discuss white patients or provide admissions photographs of them in this article, it is not possible to comment on that aspect based on this material.

⁴⁹ "Medical Certificate that a Person is a Lunatic A", ME 19, Patient File of William J, PR 10 360, Cory Library, Rhodes University, Grahamstown.

⁵⁰ "Medical Certificate that a Person is a Lunatic A", ME 27, Patient File of Ruben G, PR 10 360 Cory Library, Rhodes University, Grahamstown.

⁵¹ "Medical Certificate that a Person is a Lunatic A", ME 68, Patient File of Luigi R, PR 10 360, Cory Library, Rhodes University, Grahamstown.

⁵² Presumably "closet" here denotes a toilet, while "drawers" are underwear.

Most alarming to the physicians who examined candidates, and to those who had been carers for these people, was the exhibition of unregulated sexual desire or behaviour. Unacceptable sexual behaviour is a feature often noted in physician's examinations, often found in conjunction with other strange behaviour, mostly wildness and aggression. John Thomas E's public displays of sexual desire for children (as well as for the examining physician) was merely the most spectacular example of the role played in proving unsoundness of mind by expressions of sexuality outside acceptable norms. Many men already mentioned here were described as having "unclean habits", the exact nature of which was usually left delicately vague, as well as a tendency to defecate or urinate on the floor, or smear food on the walls. Arthur H⁵³ was recorded as having "masturbated and laughed while so occupied" on both of his medical certificates, as was Henry M,⁵⁴ who was also noted to be given to being "outrageous" in behaviour. Direct references to masturbation are in fact rare in the record, however, possibly due to reticence on the part of recording authorities, owing to 19th-century sensibilities.

Also noted as proof of insanity was inappropriately familiar behaviour towards woman (again, the exception is John Thomas E, who instead approached men and children). Franz F had on more than one occasion left the house "to run after girls and women",⁵⁵ while William C was said to believe that "all women and girls were in love with him", and Heinrich H – a married man – one more than one occasion was said to have "[jumped] up with erotic intent" and approached his wife "with erotic intent", also "attempting self-abuse" in her presence. All of this behaviour was deemed inappropriate, even though Heinrich H was married, suggesting that even within marriage expressions of over-enthusiastic sexual arousal were deemed unusual and inappropriate enough to be used as a proof of unsound mind. Although the Victorians were not as straitlaced as they are popularly thought to be, research suggests that Victorian wives could be reticent about sex,⁵⁶ while sexual "continence" was expected of

⁵³ "Medical Certificate that a Person is a Lunatic A", ME 8, Patient File of Arthur H, PR 10 360, Cory Library, Rhodes University, Grahamstown.

⁵⁴ "Medical Certificate that a Person is a Lunatic A", ME 39, Patient File of Henry M, PR 10 360, Cory Library, Rhodes University, Grahamstown.

⁵⁵ "Medical Certificate that a Person is a Lunatic A", Patient File of Franz E.F.

⁵⁶ Francis M.L. Thompson, *The Rise of Respectable Society: A Social History of Victorian Britain, 1830 – 1900* (Cambridge, Mass, 1988), pg. 73.

husbands.⁵⁷ It should be noted that although much Victorian literature emphasizes self-discipline, self-control, hard work and asceticism for men and women,⁵⁸ private behaviour is obviously not easy to regulate. However Heinrich H and his wife may have behaved in private, it was socially necessary for Heinrich H's wife to disapprove of her husband's overtly sexual behaviour. She may also, of course, have been genuinely disapproving, and at any rate seems to have been alarmed. Franz F and William C, on the other hand, by unwantedly approaching women from outside their households, were clearly behaving unacceptably by any Victorian standards.

The Lunacy Act 20 of 1879 made provision for the safe custody of and prevention of crimes being committed by lunatics, as well as those who were not considered dangerously insane.⁵⁹ The Act of 1879 also attempted to emplace measures to ensure the safety of those around lunatics should they be released before they were considered cured: in cases where a lunatic was released into the custody of a friend or family member, that person was held responsible for their behaviour.⁶⁰ If problems did arise, the lunatic would be returned to custody, whether gaol or the asylum.⁶¹ Similarly, the Lunacy Act of 1891 also made specific provision for the removal of alleged lunatics by constables "for the public welfare".⁶² The emphasis the 1891 Act places on what to do with lunatics believed to be dangerous and/or criminal is evidenced by the fact that an entire section of the Act was devoted to the procedures around their apprehension, hospitalisation, and potential exit from the Asylum. The 1897 Lunacy Act⁶³ is similarly concerned with the protection of the public in cases of dangerous lunatics roaming at large.

⁵⁷ Peter T. Cominos, "Late-Victorian Sexual Respectability and the Social System", *International Review of Social History*, 8, 2, 1963, pg. 217.

⁵⁸ Cominos, "Sexual Respectability", pg. 217.

⁵⁹ Preamble, Act No 20 of 1879, An Act to Provide for the Safe Custody of Persons Dangerously Insane, and for the Care and Custody of Persons of Unsound Mind, in *Statutes of the Cape of Good Hope 1879 – 1883*, pg. 42.

⁶⁰ Section X of the 1879 Act to Provide Safe Custody of Persons Dangerously Insane, pg. 47.

⁶¹ *Ibid.*

⁶² Section 5 of the Lunacy Act 1891.

⁶³ Act No 1 of 1897, Act to Amend and add to the Law relating to Lunatics, in E.M. Jackson, *Statutes of the Cape of Good Hope 1652 – 1905, being a revised reprint of the authorised editions issued in 1895 by H. Tennant and E.M. Jackson to which have been added the acts of Parliament passed in the Sessions held during the period 1896 – 1905, Volume III, 1894 – 1905.*

Relatively few lunatics were violent, whether suicidal or dangerous.⁶⁴ Those admitted to the Grahamstown Asylum usually did not present any threat towards themselves or others. However, an analysis of the data regarding threat of violence and risk of suicide does reveal that certain behaviours were more commonly reported among some groups than others. The divisions in this set of reported behaviours lay along racial rather than gender lines.

Among white women, the majority were judged to be neither dangerous nor suicidal; the same was true of white men who entered the asylum. Among black men and women, however, the asylum authorities believed the risk of violence against others to be higher than the risk of suicide; proportionately more white men and women were thought to be at risk of suicide.⁶⁵ The trend is clear: Asylum authorities were much more prone to labelling black individuals entering the Asylum as dangerous or criminal and thus in need of control, and white patients as in need care. Asylum authorities and the civil authorities they dealt with routinely perceived black patients as being more violent than their white counterparts,⁶⁶ posing a threat to others rather than themselves.

On the whole there is a clear correlation between an individual's race and the type of danger they were supposed to pose. (The imagined black propensity towards violence would resurface time and again; the incidents of violence among black patients on the wards would preoccupy Greenlees' during his time as Medical Superintendent, as will be discussed more fully in a later chapter.) It cannot be stressed enough, however, that the great majority of the adults and teenagers entering the Asylum did so not because they were dangerous to others but because they were in need of care. The career of William J Dodds as Inspector of Asylums and Superintendent of Valkenberg spans the careers of both Hullah and Greenlees, beginning in 1889 and ending in 1913. Dodds, a Scottish-trained MB ChM MD DSc, had worked in various Scottish asylums before arriving in the Cape, and brought to the colony a firm grasp of and passion for not only moral treatment and therapeutic psychiatry but also a determination to bring colonial psychiatry into line with the most up-to-date practices in Britain.⁶⁷ The Lunacy Acts of 1891 and 1897 were drawn up with his guidance, and he was very instrumental in

⁶⁴ PR 10 360-1. Grahamstown Asylum General Register of Patients, 1875-1896, Cory Library, Grahamstown.

⁶⁵ *Ibid.*

⁶⁶ *Ibid.*

⁶⁷ Swartz, "Psychiatric Knowledge in the Cape", pg. 36.

setting out the organisation of policy and funding for the Cape asylums. Unfortunately, Dodds did not have much experience in having black patients under his care, and his efforts were – despite his disapproval of some of Greenlees’ actions – mostly concentrated on improving the lot of white asylum patients, and the various medical superintendents under his advisement extended and deepened discriminatory practices within their asylums.⁶⁸

The 1879 Lunacy Act

Before the Colony’s first Lunacy Act was passed in 1879, commitment procedures were unregulated and lunatics generally received care in the home unless they exhibited dangerous behaviour, in which case permission to confine them in a prison or private house was obtained by application to a court of law.⁶⁹ In 1864, the Secretary of State for Colonies tabled the plan of establishing a network of asylums in the British colonies, but pointed out that the government would have to fund these from public coffers; in Britain, many had instead been funded by philanthropists.⁷⁰ Only in 1866 did the Colonial Office instruct magistrates to authorise, by providing lunacy certificates, the detention of lunatics in asylums or hospitals.⁷¹ In 1868, the neighbouring colony of Natal introduced the Custody of Lunatics Act, which became the blueprint for the Cape’s 1879 Act. In 1875, Cape regulations changed: only the Colonial Secretary could authorise a lunatic’s detention; this decision was not readily accepted by the Eastern Districts Court (which had jurisdiction over the eastern districts of the Cape Colony, including that within which Grahamstown fell), who believed that the discretion should be theirs.⁷² Robert Hullah, the first Medical Superintendent of the Grahamstown Asylum, was bedevilled by the uncertainty that these regulations caused: he could not easily keep lunatics in the Asylum if they wanted to leave, and magistrates who found themselves required to adjudge committals battled to apply what few regulations there were correctly.⁷³

⁶⁸ Swartz, “Psychiatric Knowledge in the Cape”, pg. 37. For Dodds’ career at the Valkenberg Asylum, see Swartz’s thesis.

⁶⁹ Swanson, “Of Unsound Mind”, pg. 106.

⁷⁰ Parle, *States of Mind*, pg. 33.

⁷¹ Parle, *States of Mind*, pg. 39.

⁷² Swanson, “Of Unsound Mind”, pg. 107.

⁷³ Swanson, “Of Unsound Mind”, pg. 108.

The major preoccupation of all the rules governing the committal of lunatics to an asylum was the removal from public circulation of alleged lunatics who exhibited violent behaviour. The 1879 Lunacy Act made separate provision for both ordinary and dangerous lunatics. To commit an ordinary lunatic to an asylum required permission from the Colonial Secretary, and two medical practitioners had to examine him or her and issue two medical certificates. To commit a dangerous lunatic, according to Section 1 of the 1879 Act, only the two medical certificates were needed.⁷⁴ Unfortunately, the 1879 Act did not distinguish between lunatics who were violent but non-criminal, and those who had committed crimes involving violence. The examining medical doctors decided whether a patient was categorised as 'dangerous', or whether their behaviour was distressing and unpleasant but not dangerous; this decision was based on their personal observations, and information that they obtained from the patient's family and/or friends, and recorded in the abovementioned certificates.

In the absence of asylum space, many violent ended up spending some time confined in gaol, whether or not they were criminal. This complicated the procedures the authorities had to follow to release them from gaol, because permission to do so could only be granted by the order of the court or Governor's Warrant. These generally could not be obtained immediately, given the time it took to send and receive correspondence. Also, because two medical officers had to examine the alleged lunatic before s/he could be sent to an asylum, the committal could be slow to arrange and effect, delaying the start of treatment, or at least prolonging the time the lunatic spent in a damaging environment such as gaol.

The 1891 and 1897 Lunacy Acts

This problem was partially solved by the 1891 Lunacy Act, which repealed the 1879 Act and drew distinctions between dangerous lunatics, criminal lunatics, and ordinary lunatics.⁷⁵ The 1891 Act defined a lunatic as "any idiot or person of unsound mind incapable of managing himself or his own affairs", while a criminal lunatic was defined as "any person for whose safe custody during the Governor's Pleasure, the Governor is authorised to give order, and any prisoner whom the Governor has in pursuance of this or any other law directed to be removed

⁷⁴ Lunacy Act 1879, *Statutes of the Cape of Good Hope 1879 – 1883*, pg. 42.

⁷⁵ Lunacy Act 1891, *Statutes of the Cape of Good Hope Passed by the Eighth Parliament during the Sessions 1889 – 1893*, pg. 318.

to an asylum or other place for the reception of insane persons.”⁷⁶ The main difference between the two major categories seems therefore to have been in how the lunatic was dealt with, rather than what s/he had done to warrant confinement.

Dangerous lunatics, for their part, were those who acted violently or were deemed to have done so. Even with this definition, the committal process was slow and somewhat cumbersome. Furthermore, according to the Summary Reception Order, a lunatic could only be detained in an asylum or other place for a month, on the strength of a reception order issued by a district magistrate. When this order lapsed, the lunatic would be discharged unless an order extending his or her committal was given, and for *that* to happen, numerous documents had to be obtained. This was a slow process, requiring two medical certificates, an affidavit from a friend or relative testifying to the insanity of the alleged lunatic, a report and summary reception order from the magistrate, and a report from the asylum’s medical superintendent. All of these had to be sent to the Supreme Court. The accompanying scrutiny of the alleged lunatic’s life, and the limbo of waiting for orders to proceed, could be excruciating.⁷⁷

Antisocial behaviour was at the core of the first two of the Colony’s Lunacy Acts. The 1879 Act considered all lunatics to be legally criminal or dangerous, and the 1891 Act established categories of lunatic based on how and what kind of danger they presented.⁷⁸ Concerns around violence, dangerousness and criminal behaviour were at the core of the 1879 and 1891 Lunacy Acts. But before the nexus between lunacy, violence and committal is examined here, the issue of voluntary committal should be addressed. The major problem – from the point of view of the Colony’s psychiatric professionals – with the 1879 and 1891 Lunacy Acts was that lunatics had to be manoeuvred through the various channels of the legal system before they could gain entry to the asylum, and still others to leave.

Delays in admission, according to Greenlees, at least, adversely affected lunatics’ chances of recovery. To speed up their admission and thereby improve their chances of recovery by beginning treatment before the disorder was intractable, Greenlees believed that lunatics

⁷⁶ Lunacy Act 1891, pg. 318.

⁷⁷ Swanson, “Of Unsound Mind”, pg. 111.

⁷⁸ Swanson, “Of Unsound Mind”, pg. 117.

would be best served by the introduction of some means of effecting rapid admission. Greenlees and Dodds persuaded the medical members of the Cape Cabinet to introduce a revised version of the 1891 Act - the 1897 Lunacy Act⁷⁹ - in order to get the Emergency Reception Order passed into law. This Order allowed for the voluntary admission of a lunatic into the asylum for a period of seven days, during which time the resident magistrate had to proceed as though for an ordinary lunatic. To effect this admission two medical certificates and a Certificate of Urgency were needed, and once the alleged lunatic was safely assigned to the asylum, within reach of whatever treatment was offered, the legal machinery could proceed at its own pace.⁸⁰ (See Figures 5, 6 and 7 below for examples of these documents.)

⁷⁹ Swanson, "Of Unsound Mind", pg. 112.

⁸⁰ Swanson, "Of Unsound Mind", pg. 113.

A 9483, 0000, 12, 97.

[LUNACY FORM No. 1.]

MEDICAL CERTIFICATE THAT A PERSON IS A LUNATIC.

[Lunacy Act 1897: Sections 4, 9, 19 and 23.]

I, the undersigned, a...

a. Name in full.

being a duly licensed Medical Practitioner† in this Colony, hereby certify

that I, on the Twenty-fifth day of July, 1897,

at Labouca

b. Town or place.

in Labouca

c. District, &c.

separately from any other Medical Practitioner, personally examined

of

d. Residence.

a Labourer

e. Occupation.

and that the said

is a person of unsound mind and a proper person to be

taken charge of and detained under care and treatment, and that I have

f. Insert whether "an idiot" or "a person of unsound mind."

formed this opinion upon the following grounds,†† viz. :-

1st Facts indicating Insanity or Idiocy observed by myself.

In appearance there is nothing to indicate insanity. In conversation he lives for several years with Queen Victoria on a farm in this district. Said he was 20 years of age, while he is quite 30. Said he lived in this village until quite recently, whereas he has not lived here within last 10 years. Repeatedly avowed he was wealthy, whereas he is destitute. Told us he dug cattle & sheep out of the ground when he was removed by force.

g. 1. Appearance
2. Conduct.
3. Conversation.

2nd. Facts indicating Insanity or Idiocy communicated to me by others

Informed by keeper of Lock-up that he has turned up at a neighbouring farm, claiming the cultivated lands as his own, & refused to leave and when he was removed by force.

h. State the information, and from whom.

Dated at Labouca this 25th day of July, 1897

i. Signature of Medical Practitioner.

NOTE.—† In terms of Section 61 of the Lunacy Act, 1897, no Medical Certificate granted by a Practitioner who is related within the fourth degree of consanguinity or affinity to the person certified can be received or acted upon, and the Certificate of the partner or assistant of such a Medical Practitioner is similarly invalidated; and further, a second Medical Certificate cannot be signed by a Medical Practitioner who is related within the above degree to, or is the partner or assistant of the Medical Practitioner who has signed the first Certificate; and further, in terms of Section 10, a Magistrate is precluded from accepting under Section 9 the Certificate of any Asylum Medical Officer or private Medical Practitioner, to whose charge he proposes to commit the alleged lunatic by a Summary Reception Order, or who has any interest in the payments to be made on account of such lunatic.

†† These Certificates should be as complete as possible, and should contain all information obtainable in regard to the patient's malady; and the certifying Medical Practitioner should state the facts on which his opinion has been formed; e.g., delusions (specifying the nature of the delusions), incoherence, imbecility, fatuity, alteration of conduct and affections, dirty habits, &c. In this connection it should be noted that in terms of Section 59 no Order can be made upon a Certificate founded only upon facts communicated by others.

[FOR SPECIAL URGENCY CERTIFICATE AND ORDER, SEE OVERLEAF.]

Figure 5: Example of a "Medical Certificate That A Person is a Lunatic"

A4456.3000.2.1901.

[LUNACY FORM No. 1.]
MEDICAL CERTIFICATE THAT A PERSON IS A LUNATIC
 [Lunacy Act, 1897: Sections 4, 9, 19, and 23.]

I, the undersigned,* [REDACTED] D Name in full
 being a duly licensed Medical Practitioner† in this Colony, hereby certify
 that I, on the..... day of..... 1904,
 at^b.....
 in^c..... b. Town or place.
 separately from any other Medical Practitioner, personally examined.....
 of^a..... c. District, &c.
 a^e..... *Painter*..... d. Residence.
 and that the said..... e. Occupation.
 is^f..... *Unsound mind*..... and a proper person to be
 taken charge of and detained under care and treatment, and that I have
 formed this opinion upon the following grounds,†† viz.:—
 1st. Facts indicating Insanity or Idiocy observed by myself.* f. Insert whether
"an idiot" or
"a person of
unsound mind."
*Is dirty in his habits... defecating
about the floor of Cell... with a looking
+ nervous, scribbles + draws figures
on the walls with his nails and imagines
these things represent extraordinary beings.
Conversation incoherent & erratic*
 2nd. Facts indicating Insanity or Idiocy communicated to me by others.^h g. 1. Appearance.
2. Conduct.
3. Conversa-
tion.
*The man who looks after him... named...
is stated that he has taken
his excrement in his hand + thrown it
about. Sometimes when he pinches him for he throws
it away saying it is poisonous*
 Dated at,..... this..... day of..... 1904. h. State the in-
formation,
and from
whom.
 Signature of Medical Practitioner. *[Signature]*

NOTE.—† In terms of Section 61 of the Lunacy Act, 1897, no Medical Certificate granted by a Prac-
 titioner who is related within the fourth degree of consanguinity or affinity to the person certified can be
 received or acted upon, and the certificate of the partner or assistant of such a Medical Practitioner is
 similarly invalidated; and further, a second Medical Certificate cannot be signed by a Medical Practitioner
 who is related within the above degree to, or is the partner or assistant of the Medical Practitioner who has
 signed the first Certificate; and further, in terms of Section 10, a Magistrate is precluded from accepting under
 Section 9 the Certificate of any Asylum Medical Officer or private Medical Practitioner, to whose charge he
 proposes to commit the alleged lunatic by a Summary Reception Order, or who has any interest in the pay-
 ments to be made on account of such lunatic.

†† These Certificates should be as complete as possible, and should contain all information obtainable in
 regard to the patient's malady; and the certifying Medical Practitioner should state the facts on which his
 opinion has been formed; e.g., delusions (specifying the nature of the delusions), incoherence, imbecility,
 fatuity, alteration of conduct and affections, dirty habits, &c. In this connection it should be noted that in
 terms of Section 59 no Order can be made upon a Certificate founded only upon facts communicated by
 others.

[FOR SPECIAL URGENCY CERTIFICATES]

Figure 6: Example of a "Medical Certificate That A Person is a Lunatic"

[LUNACY FORM No. 4.]

SUMMARY RECEPTION ORDER.

[Lunacy Act, 1897 : Section 10.]

WHEREAS it has been made to appear to me ⁽¹⁾ ^{(1) Insert name of Magistrate.} Assistant

Resident Magistrate of the district of.

by information on oath, that ⁽²⁾ ^{(2) Insert name of lunatic.}

of ^{(3) Insert names of medical practitioners, or practitioner (Section 9)}

is deemed to be a lunatic, and whereas ⁽³⁾ Dr.

Additional District Surgeon at

and ⁽³⁾ medical practitioners, have examined

the said ⁽²⁾ and furnished me with certificates† as to ⁽⁴⁾ his mental state : and whereas ^{(4) Insert "his" or "her."}

upon consideration of the certificates of the said medical practitioners, and after due enquiry I am satisfied that the said ⁽²⁾ is a lunatic, and

* (a) is not under proper care, treatment, and control, and is a proper person to be taken charge of and detained under care and treatment

* (b) is cruelly treated and neglected by ⁽⁵⁾ ^{(5) Insert name of person in charge of lunatic.}

who has care or charge of ⁽⁶⁾ ^{(6) Insert "him" or "her."}

and is a proper person to be taken charge of and detained under care and treatment

* (c) whereas ⁽⁵⁾ who has care, treatment, or control of ⁽⁶⁾ consents to the issue of the order hereby given.

I do hereby direct you ^{(7)††} the Medical Superintendent of the Grahamstown Lunatic Asylum ^{(7) Insert designation if any or otherwise name of person to whom lunatic is to be delivered.}

to receive the said ⁽²⁾ and to detain ⁽⁶⁾ him in ⁽⁸⁾ the Grahamstown Asylum ^{(8) Insert name of asylum or other place of detention.}

for a period not exceeding one month, subject to such further order as may be made in regard to ⁽⁶⁾ him.

Given under my hand at 1904 18

this day of Assistant Resident Magistrate.

† In terms of Section 10 no Medical Certificate can be accepted for the purposes of this Order, unless the certifying Medical man has personally examined the alleged lunatic not more than fourteen clear days before the date of the Order.

†† Should it be intended with the concurrence of the certifying Medical Practitioners to commit the lunatic to some place other than an Asylum or Gaol, the Medical Practitioners should be requested to add the following clause on their Certificates :— "I further certify this case to be a suitable one for committal to the charge of [specify name and address of proposed custodian]."

Figure 7: Example of a "Summary Reception Order"

Although the Grahamstown Asylum was not atypical of the other asylums in the Cape network, it was distinctive in various ways. Unlike Robben Island, it was relatively well-resourced, and not cut off by 10 kilometres of the unfriendly Atlantic. Unlike the Fort Beaufort Asylum, it was not chronically overcrowded and reserved for black patients only; unlike Valkenberg Asylum, it was not purpose-built for paying patients and reserved only for white patients. And unlike Port Alfred Asylum, the Grahamstown Asylum did not focus solely on long-term custody rather than cure. Grahamstown Asylum, particularly once Greenlees had become Medical Superintendent provided care for wealthier patients and custody for poorer ones. As the asylum's chief paradigm was that of moral treatment, all patients nominally received kind, restorative care. But has been shown, Greenlees wished to make the Grahamstown Asylum an asylum for better-class white patients, and furthermore ones who were able to pay towards their expenses.⁸¹ And, although segregation was *de facto* rather than encoded in law until the Asylum finally became a whites-only institution in 1908, shortly before Greenlees left, he wanted to keep the number of black patients to a minimum. This meant both challenging the law that required him to accommodate patients of all races, and implementing some fairly strict measures in the Asylum. To attract paying patients, Greenlees had, firstly, to create space by removing incurable and involuntarily-committed patients from the Asylum, which had limited space and no real ability to expand rapidly, and, secondly, to attract some voluntary patients. As such, he was generally frustrated by the presence of black patients – almost all of which were involuntary patients, as will be discussed below – at Grahamstown Asylum.

Black men were the largest group admitted to the Grahamstown Asylum, and likewise black male patients were the ones mostly likely to be transferred from the Asylum to other asylums, usually Fort Beaufort Asylum. This was not coincidental, or any indication that black men were prone to exhibit symptoms of mental illness any more often than anyone else did, but rather that the provisions of the Lunacy Acts – though nominally designed to treat all lunatics equally – in fact contributed to upholding the race-based discrimination that was becoming entrenched in Colonial society. Although the Acts stated that every alleged lunatic should be assessed the same way, they allowed for various different routes to assessment, and this is where the main pre-hospitalisation modes of discrimination came into play.

⁸¹ Swanson, "Of Unsound Mind", pg. 113.

Race-based discrimination began early in the lunatic's experience of committal and asylum life. There were two categories of commitment - those that took place with the co-operation of the alleged lunatic's friends and family, and those in which lunatics reached the asylum through the offices of the Colony's criminal justice system. This distinction became especially stark when the 1897 Lunacy Act was passed because that Act allowed for voluntary committal that bypassed the criminal justice system and indeed the courts as a whole. In fact, the entire committal system, as formulated in 1891 and revised in 1897, favoured lunatics with families or at least friends who could co-operate in their certification as insane.⁸² On the other hand, lunatics who were sent to the asylum via the gaols and law courts did not have the benefit of a relative or friend assisting them. More than half of the lunatics committed to the Colony's asylums followed a process that saw them admitted via the gaols, police and courts rather than the family-led civil route.⁸³ At the same time, most of the admissions in the eastern regions of the Cape were black men. When a lunatic came through the criminal justice system, often their journey began with being arrested by a constable for some sort of illegal act. This category included "wandering at large," which included homelessness and engaging in unacceptable or erratic public. Once arrested, lunatics were then gaoled or detained in a general hospital until the legal committal process had run its course. Often, even once the certification process was complete, there was no space in the available asylums, and so black lunatics often ended up detained in gaols or hospitals for an indeterminate period of time.

The concern of the 1891 and 1897 Acts with violent behaviour displayed by lunatics led to these Acts encoding police involvement into their very fabric. Section 5 of the 1891 Act states unequivocally that

If a constable [or field cornet] is satisfied that it is necessary for the public safety or the welfare of an alleged lunatic...that the alleged lunatic should...be placed under care and control, the constable may apprehend and convey the alleged lunatic to a prison or hospital.⁸⁴

Section 6 states that,

When any person shall be discovered under circumstances indicating derangement of mind, and a purpose of committing suicide, or some crime or offence for which such person would be liable to be prosecuted, any

⁸² Swanson, "Of Unsound Mind", pg. 116.

⁸³ *Ibid.*

⁸⁴ Lunacy Act 1891, pg. 319

Magistrate before whom such person shall be brought, may call to his assistance any two medical practitioners and any other witnesses upon oath...

...while the apprehended lunatic was detained in a jail cell or hospital ward.⁸⁵ Section 8 of the 1891 Act extended the circumstances under which lunatics could be collared:

Any Magistrate or Justice of the Peace, upon its being made to appear to him on oath, that any person wandering at large is deemed to be a dangerous lunatic, may, by order under his hand, require any constable to apprehend and bring such person before any Magistrate having jurisdiction.⁸⁶

Sections 5 and 8 were both in Part I of the 1891 Act, subtitled “Proceedings for Restraining Dangerous Lunatics”. Part III, “Provisions Relating to Lunatics not being Dangerous or Criminal”, had three sections – Sections 23, 24 and 25 of the Act - dealing with lunatics wandering around in public unsupervised, and they shared wording. They state that:

(23) Any Magistrate, upon the information on oath of any person that a person wandering at large is deemed to be a lunatic, may by order require a constable to apprehend the alleged lunatic and bring him before the Magistrate making the order, or before any Magistrate having jurisdiction where the alleged lunatic is.

(24) When, under this Act notice has been given to, or an information on oath laid before a Magistrate, that a person wandering at large is deemed to be a lunatic, such Magistrate may examine the alleged lunatic at his own house, or elsewhere, and may proceed in all respects as if the alleged lunatic had been brought before him.

(25) Every constable who has knowledge that any person not wandering at large is deemed to be a lunatic and is not under care or control, or is cruelly treated, or neglected by any relative or other person having the care or charge of him shall without delay given information thereof on oath before the nearest magistrate.⁸⁷

In both Parts I and III of the Act, police involvement was central, and the Act placed emphasis on getting Magistrates involved as soon as possible. However, there is a distinct difference in the ways in which police were required to act. In Part III of the 1891 Act, the constables and magistrates were more or less only concerned with identifying the lunatic and bringing him or her to safety. In Part I of the Act, however, their primary concern was not the safety of the

⁸⁵ Lunacy Act 1891, pg. 319

⁸⁶ *Ibid.*

⁸⁷ Lunacy Act 1891, pg. 322.

lunatic but rather of the public. Under Sections 5 and 8 of the 1891 Act, the police had almost *carte blanche* to apprehend anyone who behaved in a threatening manner, or even simply oddly, in public. Of course, the scope for abuse of this power was wide, and it possible that many black lunatics were arrested for being obviously unemployed.

The 1897 Lunacy Act contained very much the same provisions regarding lunatics found wandering at large. Sections 5, 6 and 7 of Part I of the 1897 Act,⁸⁸ “Provisions relating to Lunatics who are neither Governor’s Pleasure nor Criminal Lunatics”, were virtually identical to Sections 5 and 6 of the 189a Act. In 1897, the sections on dangerous and non-dangerous (or “ordinary”) lunatics were conflated, but the category of criminal lunatics was left in place – evidently it was accepted that lunatics could be dangerous and ordinary. Or perhaps that dangerousness *was* ordinary, for lunatics.

The truth of the matter regarding dangerous and criminal lunatics at Grahamstown Asylum was that, put simply, Greenlees did not want them. Neither Greenlees or indeed any asylum superintendent in the Cape had total control over who was admitted to their institution: until formal segregation was implemented at Grahamstown Asylum in 1908, all individuals certified insane in the eastern Cape were admitted there, to Greenlees’ ill-concealed irritation.⁸⁹ These lunatics were assessed there, stabilised and then, if at all possible, discharged or transferred.⁹⁰ In the case of many black lunatics, often this was a life-sentence. Greenlees got to decide who remained at Grahamstown Asylum, and, according to Swanson,⁹¹ used this discretionary power to the maximum. Most patients ended up at Grahamstown Asylum for anything between a few weeks and more than a year, while some – especially voluntary patients – became long-stay patients.⁹² Greenlees could not discharge patients whom other authorities had classified as dangerous or criminal; this could only be done by a Governor’s Warrant – not at the request of their relatives, and nor at the behest of Greenlees. Moreover, Greenlees’ ongoing quest to improve the facilities at Grahamstown Asylum meant that in the eastern districts of the Colony only Grahamstown Asylum had the space and the staff to deal with

⁸⁸ Lunacy Act 1897, *Statutes of the Cape of Good Hope 1652 – 1905, Volume III: 1894 – 1905*, pg. 3687.

⁸⁹ Swanson, “Of Unsound Mind”, pg. 118.

⁹⁰ *Ibid.*

⁹¹ *Ibid.*

⁹² Please see Chapter Five.

dangerous patients or even those who from time to time became difficult to manage.⁹³ Violent patients would require different types of care, occasionally needed more time and attention from staff, and also – at least every now and then – posed a threat to staff and other patients, and occasionally themselves.

Unable to transfer these dangerous lunatics and unwilling to accommodate them at Grahamstown Asylum, Greenlees seemed to become intensely frustrated and, by 1896, used his influence with Dodds, who in turn used his influence with the medical members of the Cape Cabinet to get the 1897 Lunacy Act passed into law. This Act, as already mentioned, conflated the category of “dangerous lunatic” into that of “ordinary lunatic”, thus giving Greenlees the chance to open up space by transferring dangerous lunatics – at least, non-paying dangerous lunatics – to other asylums.⁹⁴ It was also, coincidentally, the more humane option: not all dangerous lunatics were dangerous all the time, or remained dangerous once admitted to the asylum, or had ever considered committing a crime or been arrested on suspicion of having committed one. Even so, patients who were not dangerous by classification could still exhibit dangerous behaviour and, as Parle notes, this behaviour played a central role in the decision that the families or friends of lunatics made to commit them to the care of an asylum. There was sometimes an urgent practical need to admit someone to an asylum, and obtaining various Orders and certificates took time.⁹⁵ The civil commitment system favoured those who had family networks – or rather, *functioning* family networks. Relatives who were too far away, estranged or simply disinclined to help were obviously of limited use. Lunatics who were estranged or for some other reason, such as migrancy, disconnected from their families and/or social networks more usually came to the asylum after being arrested or via the criminal law system.

Greenlees did not want the Grahamstown Asylum to fill up with chronic cases, or criminal cases and dangerous patients, whom he could not transfer and who caused extra work.⁹⁶ Furthermore, Greenlees held that criminal patients could not be safely held at Grahamstown Asylum because neither the wards nor the grounds were secure enough, and they therefore

⁹³ Swanson, “Of Unsound Mind”, pg. 119.

⁹⁴ Swanson, “Of Unsound Mind”, pg. 126.

⁹⁵ Swartz, “Psychiatric Knowledge at the Cape”, pg. 71.

⁹⁶ Swanson, “Of Unsound Mind”, pg. 120.

posed a risk to the public as well as the rest of the Asylum's population.⁹⁷ It is true that Greenlees did not display much concern over the welfare of criminal lunatics – in 1894, he applied to the Colonial Office to transfer a number of criminal lunatics to Fort Beaufort Asylum, a place where conditions were considerably worse than they were at Grahamstown. All of these lunatics, who Greenlees described as harmless, were committed under the 1879 Act (and had therefore been languishing at Grahamstown Asylum for between four and 14 years without improvement) and were all black men who had been committed as unconvicted criminal lunatics, remaining in the Asylum after their sentences had expired.⁹⁸ Neither the 1891 nor 1897 Lunacy Acts made the construction of new asylums compulsory,⁹⁹ so Greenlees had to find another method of shifting unwanted patients out of the Grahamstown Asylum. He achieved this at last in 1897, with the 1897 Lunacy Act that did away with the category of dangerous lunatic and thereby facilitated the movement of patients previously confined to the Asylum – and usually into other asylums, where they were no longer Greenlees' problem or responsibility.

Indeed, an examination of the Sections of the 1897 Act under which lunatics became patients at the Grahamstown Asylum shows a distinct lack of criminal lunatics and indicates that the majority of lunatics admitted to the Asylum were not criminal. Between 1898 and 1905, the majority of patients admitted to the Asylum were committed under Section 10 of the 1897 Lunacy Act. Sections 4, 11 and 18 made up the largest parts of the remainder, with a handful of patients admitted under Section 22, as Governor's Pleasure lunatics.¹⁰⁰ (See graphs between pages 193 and 198).

⁹⁷ Swanson, "Of Unsound Mind", pg. 120.

⁹⁸ *Ibid.*

⁹⁹ Swanson, "Of Unsound Mind", pg. 128

¹⁰⁰ Lunacy Act 1897, pg. 3691.

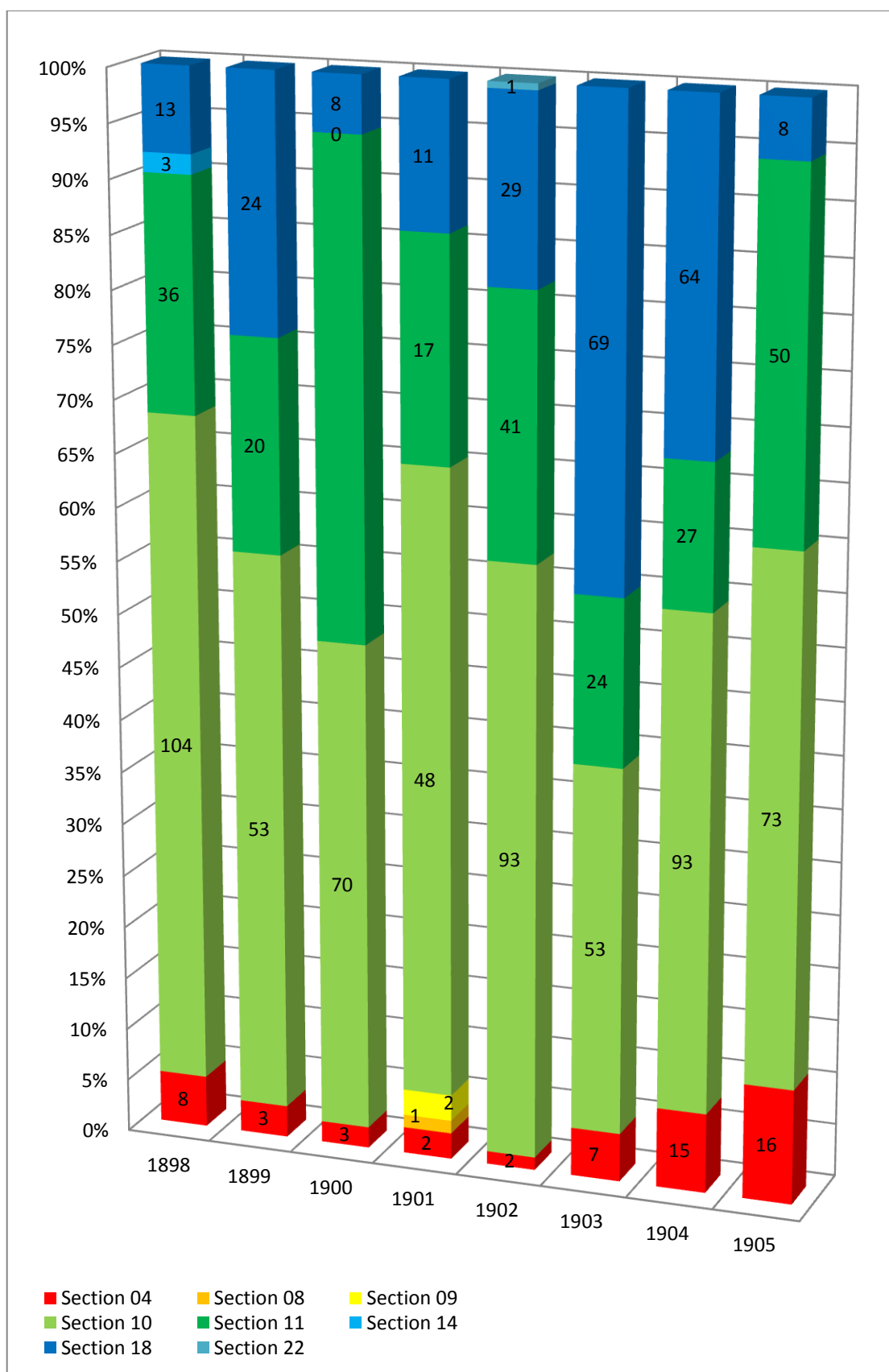


Figure 8: Admissions by Section of 1897 Lunacy Act, 1898 - 1905

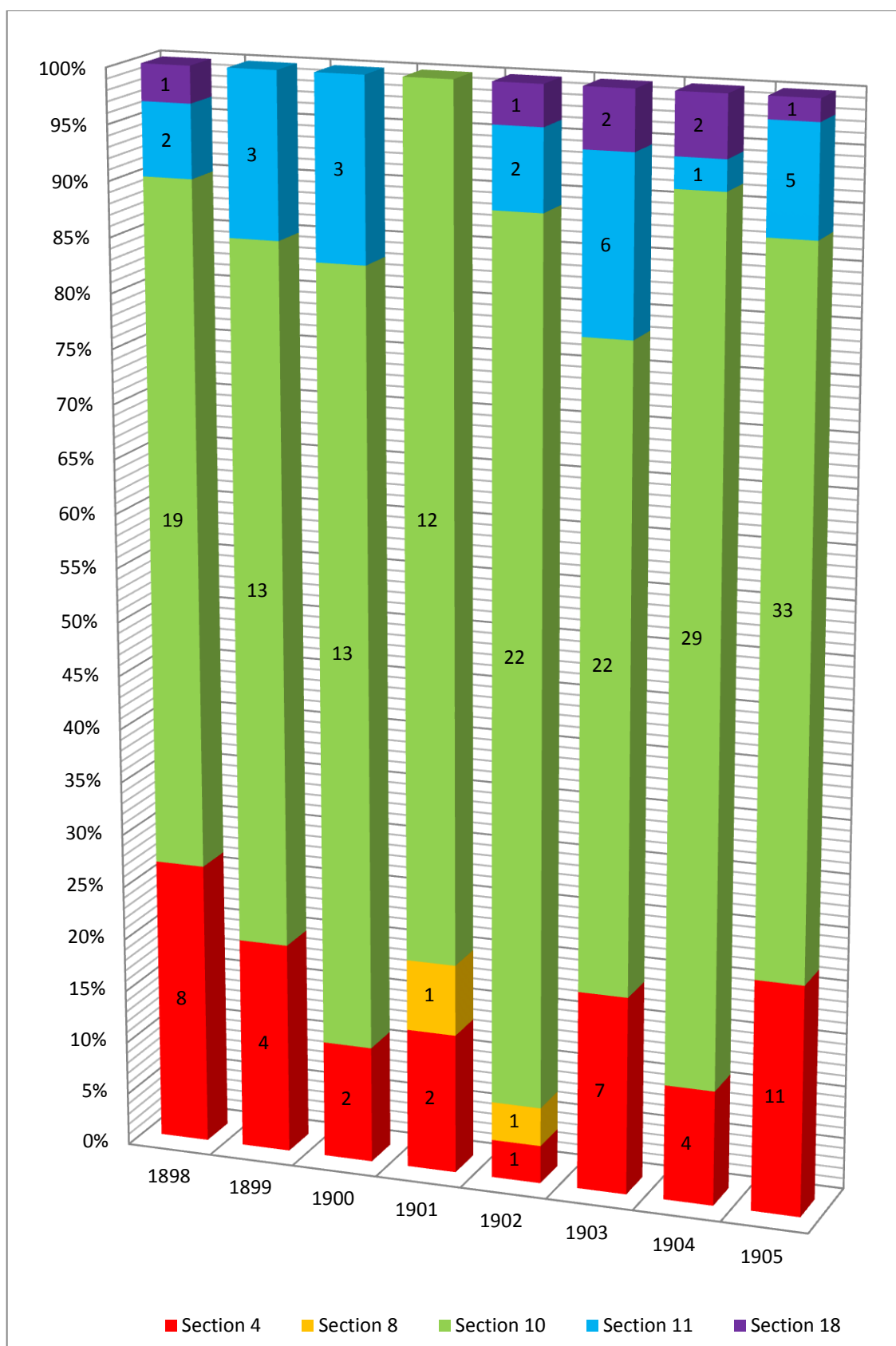


Figure 9: paying patients, by Section of 1897 Lunacy Act under which admitted

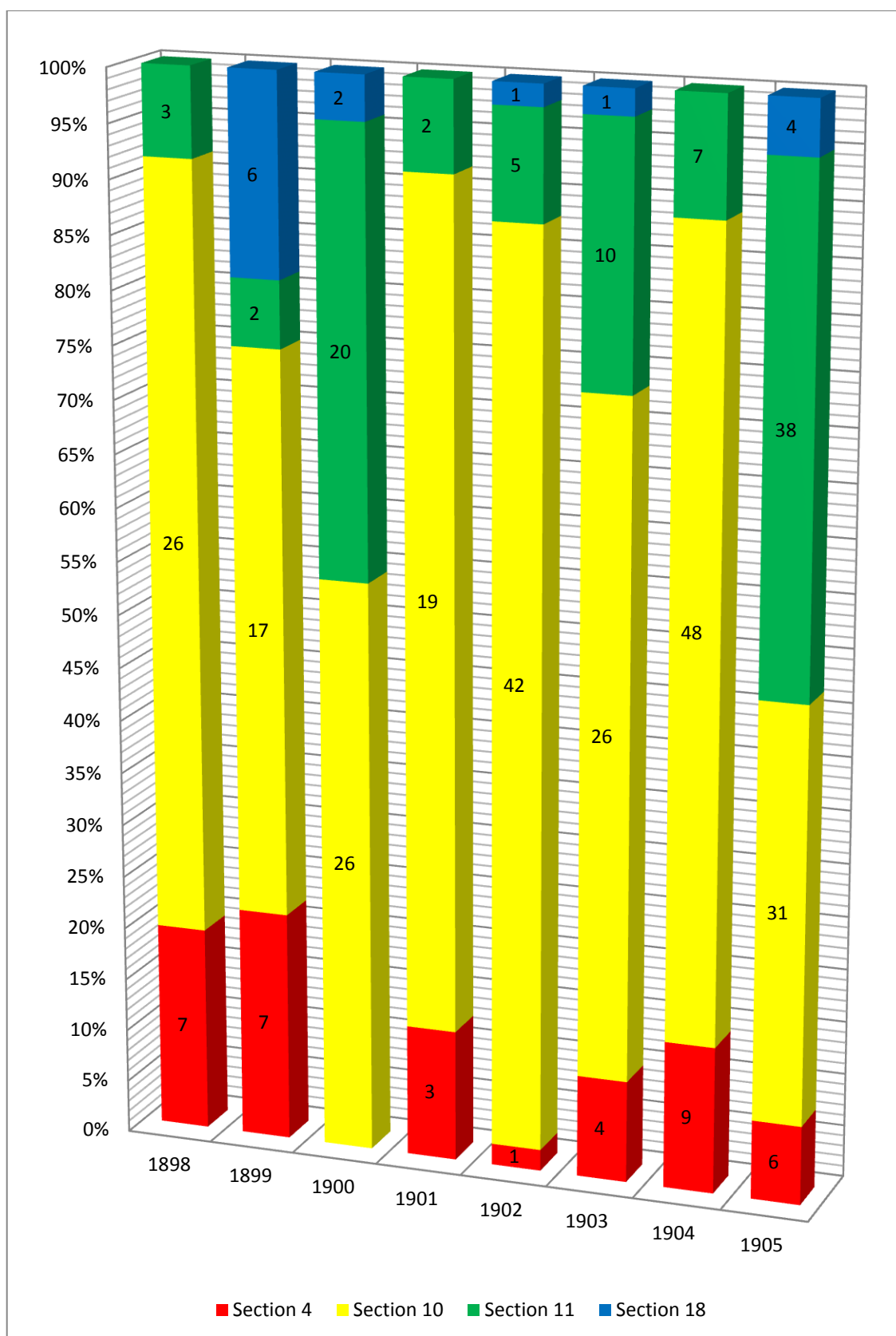


Figure 10: White Men, Sections of 1897 Lunacy Act under which admitted.

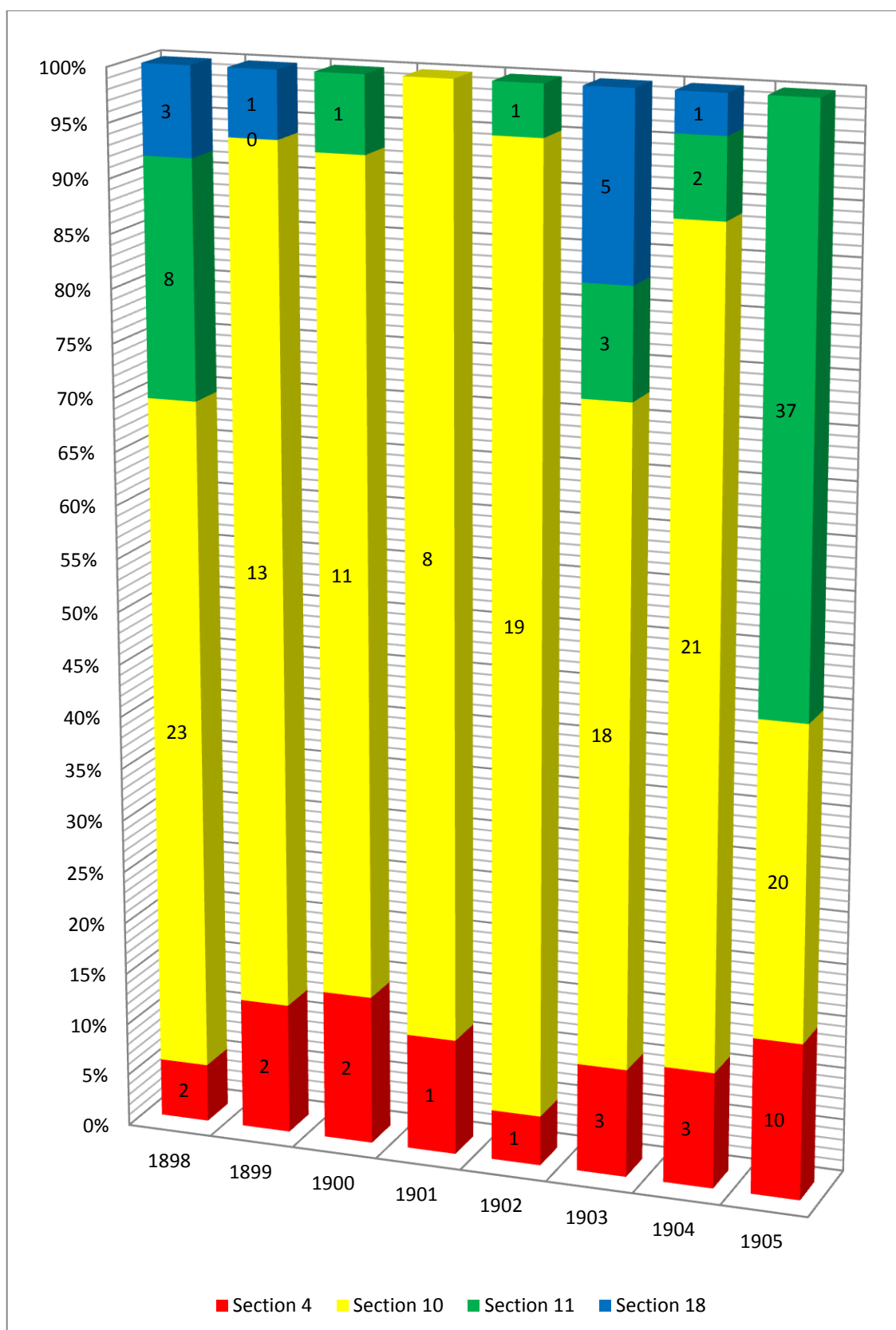


Figure 11: White women, Sections of 1897 Lunacy Act under which admitted

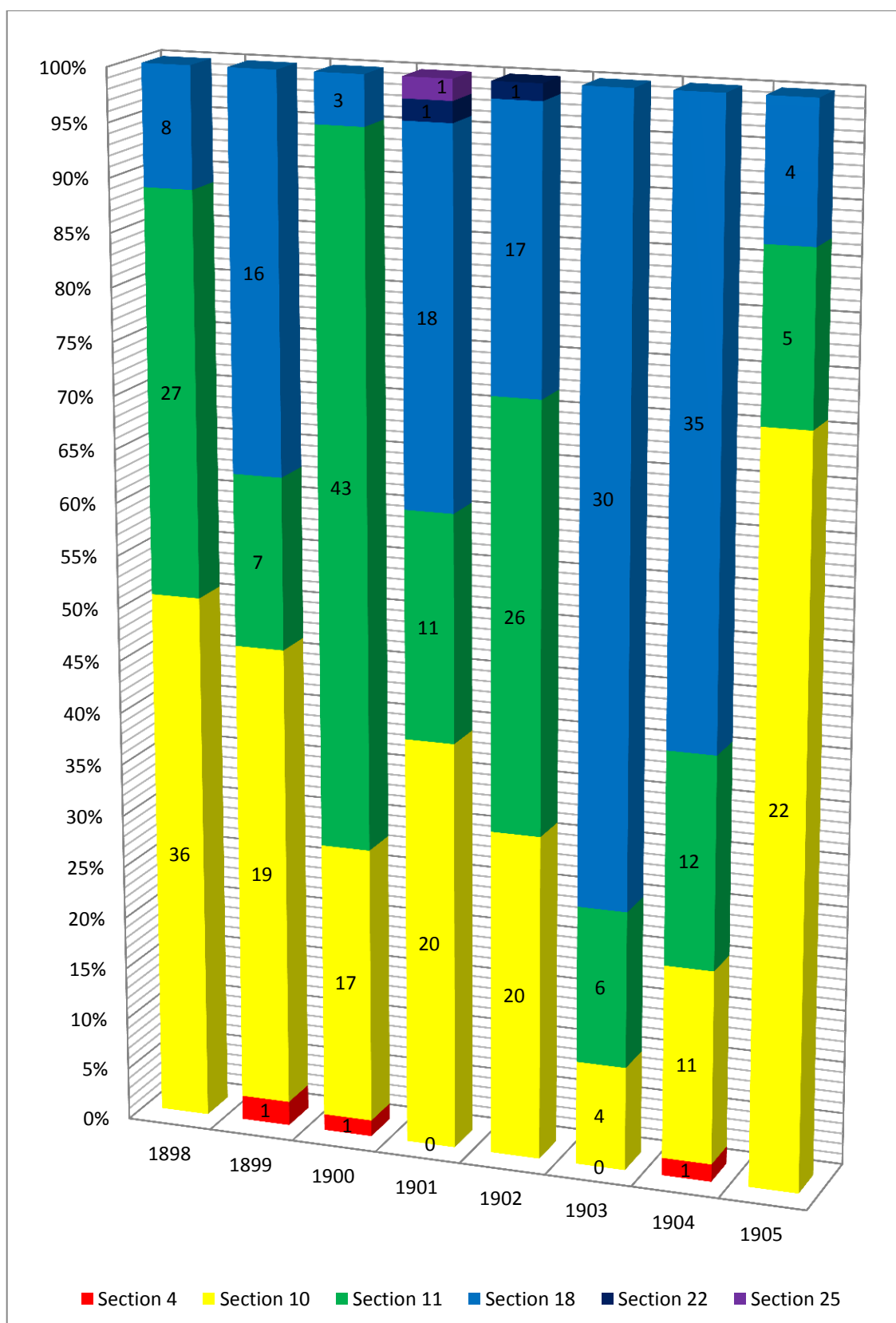


Figure 12: Black men, Sections of 1897 Lunacy Act under which admitted

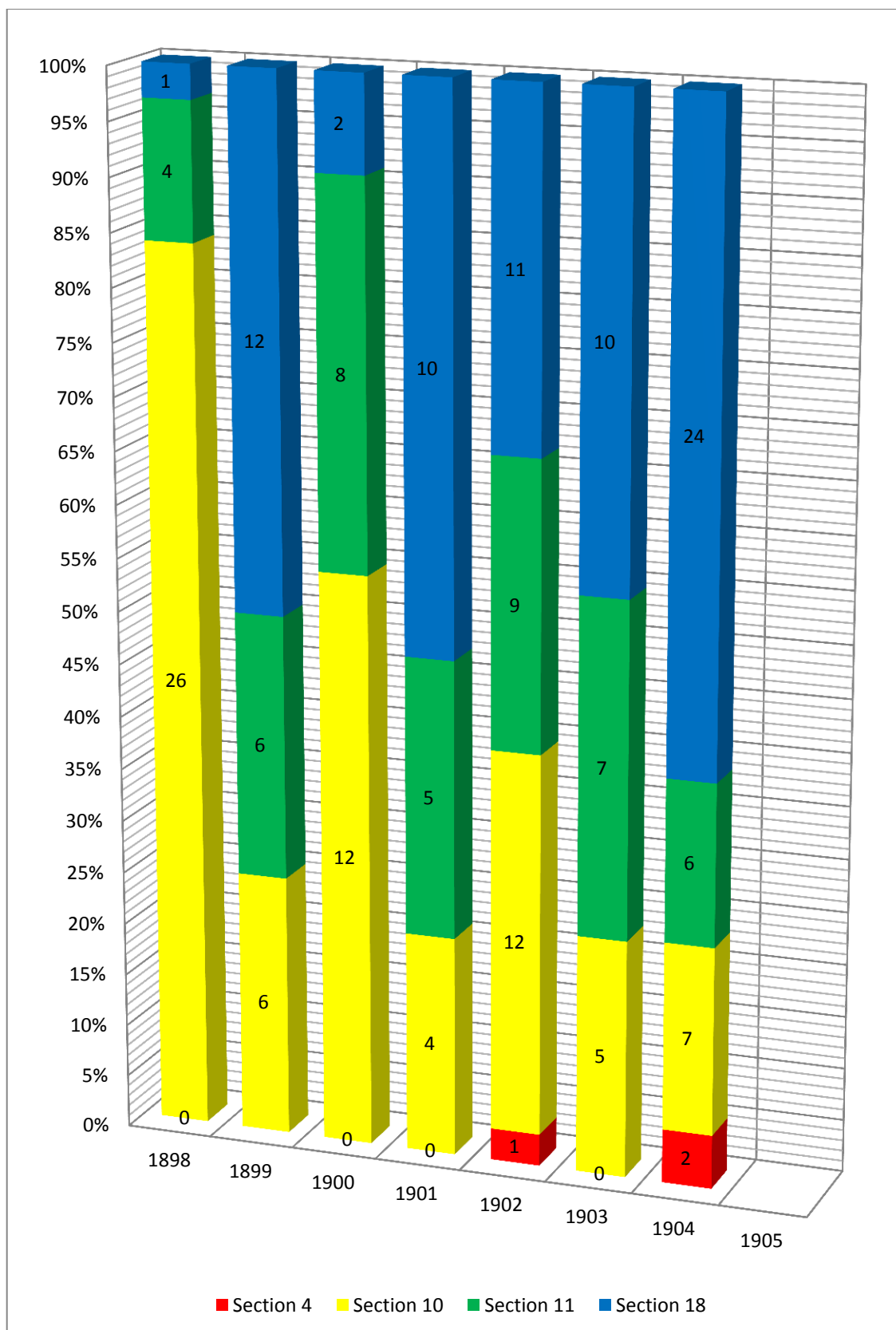


Figure 13: Black women, Sections of 1897 Act under which admitted

Section 4 of the 1897 Act governed lunatics admitted by Urgency Order, i.e. quickly and bypassing the usual legal machinery in order to effect quick admission. This was “voluntary admission”:

In cases where it is expedient either for the welfare of a person alleged to be a lunatic or for the public safety, that an alleged lunatic should forthwith be placed under care and treatment, he may be received and detained in any asylum or prison, upon an urgency order made (if possible) by the husband or wife or by a relative of the alleged lunatic, accompanied by a medical certificate, provided that:

1. If an urgency order is not signed by the husband or wife or by a relative of the alleged lunatic, the order shall contained a statement of the various reasons why the same is not so signed and of the connection with the alleged lunatic of the person signing the order, and the circumstances under which he signs his name.
2. No person shall sign an urgency order unless he is at least twenty-one years of age and has, within two days before the date of the order, personally seen the alleged lunatic.
3. No alleged lunatic shall be received under an urgency order unless it appears from the medical certificate accompanying the order than the certifying medical practitioner has personally examined the alleged lunatic not more than three clear days before his reception.
4. The admission of an alleged lunatic on urgency order shall forthwith be notified by the person receiving the patient to the resident magistrate of the district, who shall thereupon on production to him of the urgency order and the medical certificate proceed in the same manner as if the original application had been made by him for the issue of a summary reception order.
5. An urgency order shall not remain in force for a longer period than seven days from its date.

The wording of this section had several interesting features, and carried several presuppositions. One, is that it assumes that lunatics were both under threat and in themselves threatening. Secondly, the phrase “made (if possible) by the husband or wife or by a relative of the alleged lunatic” presupposes a social network, and further assumes that family connections were present and operation, and *further* supposes that these connections were spousal or consanguineous rather than merely those of friendship, and that said spouses would be compelled by spousal or filial duty to sign the documents authorising the retention of their family member or spouse. The Section further stipulates that if a relative or spouse is not available, then whoever does sign needs to say why nobody else is available, who they are, and how they know the alleged lunatic. In cases of insanity, and in colonial environments with large numbers of immigrants, this makes sense. However, the expectation seems to be that spouses or relatives are available *and* willing to consign a spouse or relative to the institution.

The 1897 Act was, of course, based on laws from Britain,¹⁰¹ where people were more likely to have tight-knit family or social networks. However, by 1897, Cape society was fairly well-established and had been for several generations, so it is not unreasonable to suppose that a spouse or family member was available. Further, the Section has built into it two provisions to ensure that nobody could be easily fraudulently committed: one, that a person of legal majority had seen the alleged lunatic within two days, and the second that the doctors whose examinations would prove or disprove insanity had to have seen the lunatic within three days of signing the declaration.

Section 10 of the 1897 Act provided for the committal of a lunatic to the asylum under the standard civil path of the Summary Reception Order, and made provision for the proper execution of medical examinations and appearances before the magistrate. It states,

If upon the certificate of the medical practitioners or practitioner who examined the alleged lunatic and after such determines that the alleged lunatic is a lunatic, and either is not under proper care, treatment or control, or is cruelly treated or neglected by any relative or other person having the care or charge of him, and that he is a proper person to be taken charge of and detained under care and treatment, or if the person having the care, treatment or control of the alleged lunatic consents to the issue of the order hereinafter mentioned, the magistrate may by order (in the Act termed a summary reception order) direct the lunatic to be received and detained in some asylum or other place to be named in such order. Provided that a summary reception order shall not be granted unless each medical practitioner on whose certificate it is supposed to grant such an order has personally examined the alleged lunatic not more than fourteen clear days before the date of the summary reception order, and that it shall not be competent for a magistrate to accept, for the purposes of such order, the certificate of any Asylum Medical Office or private medical practitioners to whose charge he proposes to commit the alleged lunatic by such order, or who has any interest in the payments to be made on account of such alleged lunatic; provided further that all proceedings under and the preceding section with respect to alleged lunatics shall be conducted in private. And provided further that if at any time after the issue of such order, the magistrate having jurisdiction to make such order is satisfied that some relative or friend of the lunatic who is willing to take such lunatic under his own charge, will take proper care of such lunatic and provide for his maintenance, it shall be lawful for such magistrate, on the recommendation of the District Surgeon, notwithstanding anything to the contrary in this Act contained, to discharge such lunatic to the care and custody of such relative or friend.¹⁰²

¹⁰¹ Swartz, "Psychiatric Knowledge in the Cape", pg. 72.

¹⁰² Lunacy Act of 1897, pg. 3687 – 3688.

Section 10 was the lengthiest and most detailed section under which individuals were commonly admitted. It is also the broadest and therefore most useful section (from the point of view of one admitting an alleged lunatic for examination and committal) under which lunatics were commonly admitted after 1896. The Section is a little equivocal: it seems to have been phrased to allow lunatics who might be suffering ill-treatment, or left to wander, or merely whose families wanted them out of the house, to be examined and committed. It makes provision for the reality that, on occasion, lunatics needed to be rescued.

Note that the phrasing “care, treatment and control” suggested that the three were all discrete possibilities: care by a family, treatment by a doctor, and control by the police. These Acts define who is insane as well as who has the responsibility for dealing with the insane. The phrase “proper care” is important as well; as Swartz, Parle and Swanson all note, the prevailing tendency was to position psychiatrists as the people best-qualified to deal with lunatics. Further, the idea that asylums were places that provided both care and custody is implicit in the phrasings of “taken charge *and* detained” and “care *and* treatment” (my italics). The reality of the situation might arguably have been more accurately described as “detention *and* care.” The administrative requirements for committing a lunatic under Section 10 of the 1897 Act were more time-consuming than those under Section 4, but also less hurried. Medical practitioners had to have seen the alleged lunatic within the past fortnight, which was relatively unhurried, compared to Section 4, but at the same time, they had to be doctors who had no personal stake in the lunatic’s committal. Section 10 also made provision for the release of patients admitted under it, providing they had someone willing to request their discharge and take them in.

Section 11 of the 1897 Act provided for the transfer of lunatics detained in hospitals, gaols or other asylums into the asylum; this was a significant move in that it meant that lunatics could be moved out of gaols or hospitals much more easily than previously.¹⁰³ Section 18 is similar in intention. Sections 10 and 11 between them accounted for between half and 95% of all patients admitted to the Grahamstown Asylum between 1898 and 1905, with Section 10 being the section under which most lunatics became patients at Grahamstown Asylum. White men, white women, and black women were all admitted to the Grahamstown Asylum, usually, under Section 10. Black men, however, were more often admitted under Section 11 and

¹⁰³ Lunacy Act 1897, pg. 3688.

furthermore often arrived in groups of Section 11 committals, having been transferred into the Asylum from whatever gaol cells or hospitals they had been detained in until space opened up. Both black men and women were much more likely to be admitted to Grahamstown Asylum under Section 18 than were their white counterparts, very few of whom were committed under that section as Governor's Pleasure lunatics. Instead, it seems that most white patients, when they were adjudged to require detention on psychiatric grounds, seemed to move along a direct path straight from the family or friend networks into the asylum. Black lunatics, by contrast, seemed to usually find themselves detained in a goal or hospital, or goal hospital, in the first instance.¹⁰⁴

Paying patients, despite being rather more privileged once inside the Asylum, did not come in via markedly different routes than their unpaying counterparts, except for a small number that were voluntary committals under Section 4. For example, in 1898, nine patients came in under Section 4; all but one of them was a paying patient, and all of them were white. Indeed, in no year between 1898 and 1905 did black patients outnumber white patients as Section 4 admissions. However, not all Section 4 admissions were paying patients. Being a voluntary admission committed under an Urgency Order did not always mean that a patient could pay, just that they had the necessary means to take advantage of the opportunity offered by Section 4 to bypass the delays and machinations of the more usual civil committal procedures.

The Cape Colony's legal framework for assessing mental illness was biased towards patients who were enmeshed within strong social networks, preoccupied with the protection of public order, and did not make an effort to provide equal care for all lunatics even as it pretended to treat them equally. However, it is fruitless to pretend that not all of the men and women admitted to the Grahamstown Asylum – indeed, any asylum – were alienated. They all were lunatics, at least for some part of their lives, and their lunacy – although not the only factor affecting their life-courses – had a profound effect on the duration and degree of their separation from the mainstream, sane strands of society. Their mental illness, whatever form it took and however long it lasted, placed them in a discrete category. Although, as this thesis shows elsewhere, the Grahamstown Asylum became a good environment for paying white patients at the expense of all others, it has been pointed out here that the Colony's efforts to provide asylum facilities and induce lunatics' families to make use of them was, fundamentally,

¹⁰⁴ PR 360-10, General Admissions Registers.

the right move. Hospitalisation was sometimes the best option; violent lunatics could not be easily cared for at home, for example, and in cases where a lunatic's family was not able or willing to provide care, an asylum was certainly a better option than homelessness or imprisonment.

Although the asylum as an institution in general and the Grahamstown Asylum in particular were embedded in Colonial society, and therefore reflected that society's biases and discriminations, it was still a place apart, populated by people who for whatever reason could not easily live according to society's normative rules and values. Who these people were and how they came to the Asylum is vital to understanding the character of the Asylum environment; the differences that arose due to gender and racial classification are indicative of both the Asylum environment and the social environment with which it was intertwined. The design of the 1879, 1891 and 1897 Lunacy Acts reflected the needs and attitudes of Colonial society and asylum doctors. It regulated the entrance of lunatics into the equally regulated asylum system in such a way that all lunatics legally defined as such had been admitted through the same channels. And this would have been all well and good if not for the reality that those channels had encoded in them the modes and methods of the discrimination that demarcated the asylum experience so profoundly along gender and racial lines, and entrenched the idea that lunatics were lunatics and not like the rest of us, or even like one another.

Inequality, prejudice and discrimination began to affect lunatics long before they became asylum inmates. The entire framework in which an inmate's life was understood hinged, in many ways, on their racial classification, and what stereotypes and connotations that were ascribed thereto. Everyone was not equal under the law; although the same laws applied to all lunacy committals, they were not applied evenly. As the previous chapter indicated, racial classification affected an inmate's chance of surviving the Asylum and largely dictated the state in which they would leave; this chapter has shown that racial classification influenced whether a lunatic even entered the Asylum in the first place, then how they were categorised once inside, and how that categorisation, in turn, affected, in part, the regard in which they were held by the Asylum staff, alongside their behaviour and conduct.

Implementing the Acts: Safety and Detainment under the 1891 and 1897 Lunacy Acts

The case of John Thomas E. would seem to illustrate that some lunatics were detained for their own safety, as well as the underlying logic behind the Acts' provisions to arrest lunatics behaving strangely or violently in public. John Thomas was admitted to the Grahamstown Asylum in 1896, under the auspices of the 1891 rather than the 1897 Act. His file contained extensive documentation about his committal to the Asylum, and even a cursory examination of these papers suggests that not only was John Thomas given to exhibiting public behaviour which bystanders could legitimately have regarded as alarming, but also that his life at home may have been abnormal and possibly abusive as well.

According to his father, John Thomas was employed as a schoolteacher before epilepsy caused him to lose the position, after which he returned to his parental home in Victoria West, where his father was employed on the railways. He had been admitted to the Asylum as a young man, but his father had withdrawn him after a few months and taken him home. Indeed, John Thomas's father seems to have been part of John Thomas's problem. One of the examining medical practitioners noted in carefully neutral tones that John Thomas claimed that his father has frequently "committed sodomy" with him. On another occasion, the Resident Magistrate of Victoria West, upon visiting the Edwards family home, had found John Thomas's father in bed with him. Nevertheless the Magistrate noted that John Thomas's father lived in fear of his son. His father, in the affidavit he gave before this same Magistrate, described how he had to tie his son to his bed in order to restrain him. In public, both of the medical practitioners noted, John Thomas could be ungovernable, irrational, violent and unrestrainable, with one of the practitioners recording that an informant had told him that John Thomas ran about naked and "desiring to make love to any children [he met]". Therefore in John Thomas's case, it seems reasonable to suppose that perhaps the Asylum provided a safer environment than his home had done. Being apprehended, detained, and then committed removed him from both a possibly toxic home environment and a public sphere in which he exhibited threatening behaviour.

John Thomas E. was admitted under the 1891 Act, which made provision for lunatics who were judged to be under threat or improperly cared for to be taken into the asylum. However,

his dangerous behaviour is what in fact led to his committal; what may or may not have been happening to him at home seems not to have been the motivating factor, and indeed the doctors make no mention of it except as further proof that John Thomas E. was insane and needed to be locked up for safety's sake. Of course, this is not to say that they did not acknowledge on some level that here was a man who needed protection, but in their eyes he would have been a grown man, formerly living an independent life, for whom things had gone wrong as a result of epilepsy and mental illness, and who was now presenting a threat to those around him. In the case of John Thomas E.'s admission to the Grahamstown Asylum, the Acts nominally worked in his favour – he was admitted by family, rather than arriving at the asylum via arrest and imprisonment. His route into psychiatric institutionalisation was kinder than it was for many people, but John Thomas E. was subject to the prejudices that Colonial society, as codified in the Acts, held against the violent, threatening insane. It was unconscionable that he be left to wander at large and potentially hurt someone; his household could not or would not any longer provide care for him, as they feared him; he was clearly not a man who would have been any better off on his own. Therefore, according primarily to the legal requirements for the maintenance of law and order in the Colony, and only secondarily to the compassionate aims of the Colony's medical profession, John Thomas E. was consigned to the Asylum, and ended up staying there for the rest of his life.

Of course, relatively few violent patients exhibited violence only before entering the Asylum. William H.B, for example, continued being difficult to manage and dangerous to be around for years following his committal to the Asylum, and was one of that institution's trickier patients. Having first being brought to the authorities' attention after threatening to commit suicide and kill his father, and attempting to injure a servant with a cleaver, he was judged by two medical practitioners to be epileptic, suicidal and dangerous, and entered the Grahamstown Asylum in 1896. As a dangerous patient admitted under the 1891 Act, he could not easily be transferred out at the wish of Greenlees, no matter how much trouble he gave. By September 1896, the examining physician described him as having given "a good deal of trouble since admission" – he was stubborn and demanding as well as violent. In March 1897, his occasional fits of rage "upset the whole place", and a note made some 18 months later warned that he was likely to try to fight with "the first person handy".

The particular Asylum environment did, of course, affect how tractable patients were inclined to be, and the way they interacted with the attendants and doctors played a role in how their negative behaviour affected their asylum experience. In early 1903, Greenlees noted that William H.B. was “a very troublesome fellow, taking spites against different attendants and trying to injure them,” although some months later he added that he himself “[found] William H.B. to be a very pleasant individual, always very civil and cheery” but added that “reports of many fights between him and the other patients are continually being made.” It is undeniable that William H.B. was a troubled and troublesome individual both before and after he was legally judged to be a lunatic and received into the Asylum, but in 1912 Greenlees’ successor Cowper noted that during that year, William H.B. had shown “much less irritability. This is partly due, I think, to the change of Attendants – at least it became noticeable after several of the old Attendants left the service. He is still subject to excitement at times, but there are not the scenes with him there used to be.” The case of William H.B. illustrates a central tension of both the Lunacy Acts and the day-to-day practices of life within the Asylum, and asylums more generally. The alleged point of establishing a regulated system of asylums in the Cape Colony was to provide for lunatics a better system of care and treatment than had previously existed. In practice, this project was noble only as far as the doctors’ prejudices allowed it to be – the Inspector of Asylums, William Dodds, while not quite as obviously prejudiced as T Duncan Greenlees of Grahamstown was, was nevertheless in support of segregation on the grounds of racial classification within the asylums under his purview. Furthermore, its resemblance to British lunacy legislations and British methods of operation meant that it usually failed to make sense of Colonial conditions of class, social norms, ethnic differences and racial classifications, and therefore fell short of providing suitable treatment to lunatics, especially black lunatics. But the underlying impetus that influenced the nature of the Acts and the asylum system, as Swartz points out, was care; improved care, specifically. William H.B., being a white man, fell into a group that was privileged outside the asylum as well as inside the Grahamstown Asylum, and therefore received better treatment both before his committal and after it. However, as the above description shows, he was nevertheless not especially beloved inside the Asylum, and had been considered troublesome enough outside it that his family gave up on keeping him at home and sent him away, to be cared for by other people. Cowper notes that William had become less of a handful when new attendants took over his care shows that even inside the Asylum, even among patients who were technically to be treated the same way, there were gradations of treatment. It is not recorded whether William H.B. disliked his attendants, or whether they disliked him, but it is fairly clear that the

attitudes of both parties had a distinct and negative effect on William H.B.'s experience inside the Asylum.

There was a tension in the Acts between providing care for lunatics and protecting them from harm by others, and protecting others from harm by lunatics. Frederick B. is an exceedingly pointed example of this. His admission papers do not note any particular violent behaviour or suicidal urges, so we cannot be entirely sure of what he had done or what had happened to trigger his family's decision to have him declared a lunatic and sent to the asylum, but it is reasonable to suppose that it had been something they could not handle, or perhaps simply no longer wished to handle. Inside the Asylum, like William H.B., Frederick B. was a member of a relatively privileged class and received perhaps not the love and respect of Asylum staff, but certainly a good share of their attention. Attention and patience were not meted out equally, either; black patients did not get quite as much attention or as many resources as white patients did. Frederick B.'s treatment and the records of his behaviour indicate that he took up a fair amount of attendants' time and the Medical Superintendent's attention. The first part of the Asylum staff's job was to provide care for him, and treatment as far as it was practicable; the second part was, perhaps, to prevent his behaviour from impacting negatively on his surroundings and those around him. The risk patients and lunatics outside the asylum posed to themselves seems to have been less of a pressing concern, since it did not involve the injury of other individuals and was not always noticeable to bystanders. However, threats of suicide obviously caused upset and distress for family members, who then saw the asylum as presenting a safer environment for suicidal people than their homes would have been. Moreover, violence and threats of or attempts at suicide often occurred together, as in the case of William H.B. By contrast, Franz E.F., admitted in 1900, was listed by his examining physicians and presiding Magistrate as suicidal but not dangerous at the time of his committal to the Grahamstown Asylum. He does not appear to have continued being suicidal inside the asylum, and never exhibited any violent or even unexpected behaviour inside the Asylum.

Quite often, the behaviour that was taken by family or physicians to indicate that a lunatic was violent was only slightly violent or threatening. After examining him in 1900, a medical practitioners said that Cornelius W "for whole days and nights...walks about knocking with sticks and slamming doors until exhausted", and even once inside the Asylum his behaviour seemed to be more odd than dangerous. In 1900, shortly after he arrived there, Cornelius W.

was described as having a “habit of rushing up in an excited and threatening manner, but is, in reality, quite harmless”. Indeed, the notes in his file do not contain any record made by a physician or attendant of any occasion where he hurt someone or appeared to have needed or received special treatment, restraints or seclusion. The same is true of Wessel D.K., who was admitted in 1900 and at the time was neither suicidal nor violent. However, Wessel differed from Cornelius in several profound respects, and was nevertheless a difficult patient with behavioural traits that upset or at least made extra work for Asylum staff. The case notes in his file record nothing more untoward than an expression of constant amusement, and one might assume that encountering unusual or inappropriate facial expressions was business as usual for Asylum staff. In February 1902, however, Greenlees wrote that although Wessel was relatively subdued, he was “very untidy in his habits, and will wander about with his trousers at half-mast if allowed. He masturbates.” In 1904, Greenlees recorded that Wessel – who had by then been in the Asylum for four years – had developed a habit of suddenly striking out, though with no specific intention of causing harm (although how Greenlees was sure of that, we cannot know). His violent tendencies seemed to intensify the longer he stayed in the Asylum, and there was no improvement in the other behaviours Greenlees judged as negative, either. Remaining slovenly in dress, Wessel masturbated openly and often (to the almost-concealed dismay of Greenlees and presumably the less well-disguised irritation of the attendants, who had to stop him), as well as becoming prone to “unexpected attacks of violence”, which got worse until in 1907, during a visit from his mother, he “cursed her in Dutch and tried to strike her”. (As in the case of John Thomas E. and William H.B., we may be able to deduce that there was some trouble at home, as well.)

The Grahamstown Asylum was nominally an institution which welcomed all lunatics who were in need of care, but in reality applied consistent discrimination in terms of who it accepted, and how it treated them once they were inside. The framework of Colonial society and the growing field of colonial psychiatry ensured that discrimination was woven into the process of admission and continued to be a factor throughout the patient’s sojourn inside the Asylum. Men had a qualitatively different experience of the asylum than did white women and black patients. The quality of these experiences was bound up with the ways in which their insanity – and thus its manifestation and potential for recovery – were understood, and this, in their turn, was influenced most strongly by the culture in which they, and the Asylum, were situated and had developed.

Chapter 5: Demographic Trends and Discriminatory Patterns in the Grahamstown Asylum

The authorities of the Grahamstown Asylum sold their idea of their institution to the public based on an untruth. How much of an untruth it was, and how deeply embedded it was in the various routines and practices of asylum life is discussed in Chapters Four and Six. Suffice it to say at this stage that the Asylum's authorities nominally espoused equal treatment for all those that came into their care; in reality, that was not the case, and the Asylum was not a safe haven for all lunatics.

This chapter examines two major clues to the discriminatory practices that the Asylum's authorities implemented in their efforts to avoid making the Asylum a truly inclusive, egalitarian place of care. The latter half of the chapter examines the demographics of death and discharge in the Asylum. By determining and analysing patterns of who left the Asylum alive, what sort of therapeutic or medical state they left in, and who did not leave at all, it is possible to understand the long-term results of the favouritism and prejudice ingrained into the Asylum's daily regimes. Before this will make sense, however, it is necessary to know who came to the Asylum in the first place, and this chapter will therefore examine the demographic trends among those who were admitted before progressing to an analysis of the aforementioned death-or-discharge trends.

The Asylum Population: An Overview

The Grahamstown Asylum was, at least in theory, mandated to admit anyone who met the legal and medical criteria for insanity severe enough to warrant committal to an asylum. The institution was situated in the Cape Colony, which had a diverse population made up of recent immigrants from the United Kingdom, Europe, the Americas and various British colonies, the families of Dutch and British settlers, and shifting populations of migrants from the indigenous societies just outside the borders of British territory (see Chapter Five). This linguistic and cultural diversity was dominated by a British-derived culture that held the socially dominant, privileged position in the region. However, mental disorder cares nothing for categories, and

the lunatic population of the Cape was varied in nature. However, what the Colonial administration and psychiatric fraternity could in some measure determine was who, exactly, was subjected to the authority of the various legal and medical organs that administered the Cape's lunatics.

As has been discussed, exactly what constituted grounds for committal varied somewhat according to where an individual fitted into the Cape's hierarchy of social privilege. Taking that into consideration, however, even when one factors in the ingrained racism and sexism of Victorian Colonial society, there is no escaping the fact that everyone inside the Asylum was deemed to be insane, and in being insane was removed from the mainstream of society, at least temporarily. This meant that they were different, in a noticeable way, from the majority of those around them. However, I intend to examine the Asylum's demographic profile according to age, race and marital status in order to ascertain who, exactly, entered the Grahamstown Asylum between 1875 and 1905.

Age and Marriage

Unlike the lunatic population of the Colony as a whole, the patient population of the Grahamstown Asylum between 1875 and 1905 was not very diverse. The reasons underlying this lack of heterogeneity will be examined in more detail elsewhere in this thesis, but in short arose from an attempt on the part of Asylum authorities to admit a rather specific kind of patient to the Grahamstown Asylum. In addition to this, there are certain potential aspects of living with serious mental illness - behavioural upset, inability to live independently, instability of mood and emotion, and in some cases violence, suicidal tendencies, or severe personality change - that shape the demographic profiles of any population of such individuals. For example, the age of onset for various disorders would influence the age at which individuals entered the Asylum.¹ This will be discussed below.

¹ Cook, JA, BJ Cohler, SA Pickett and JA Beeler, "Life Course and Severe Mental Illness: Implications for Caregiving within the Family of Later Life", *Family Relations*, 46, 4, 1997, pg. 428.

Age profiles in the Grahamstown Asylum

At the time of the Cape census in 1904 almost 60% of all men and women resident in the region were aged older than 15 years. In the white population, the largest proportion was between 20 and 49 years of age, with proportionately more men than women surviving into their 50s, 60s and 70s. This was equally true of the black population. From the time of its establishment in the mid-1870s, the population of the Grahamstown Asylum closely followed the profile of the region as a whole. The same pattern continued into the 1880s and 1890s, and into the early 20th century. On the whole, the patients in the Grahamstown Asylum during the first 30 years of its existence were young or middle-aged rather than elderly or even teenaged, and this mirrors the profile of the region as a whole.

It is not surprising that the Asylum population's age profile mirrored that of the Cape. The relative youth of patients inside the Asylum suggests that individuals with mental disorder severe enough to warrant certification were identified, whether by their families, friends or the Colonial authorities, quite early in life. Young adult men and women are physically stronger than the aged or the very young, and thus in cases where physical violence becomes a threat, it is likely to be more worrying to those around them because it is likely to be more hazardous. Although most people with serious mental disorders are not violent, caring for them can be considered stressful owing to the possibility of unruly, hostile, socially unsuitable and sometimes inexplicable behaviour.² Furthermore, young people were differently located within the social milieu; if they were unmarried, they might either still be living with parents, or living alone. If living alone, they may well be isolated from social networks, especially in colonial contexts where migration and emigration were common.³ If still living at home with parents, they may have been subordinate in the household in a way that married individuals generally are not, or treated as minors.⁴ Even once the Asylum was well established and widely known, and even once Greenlees' system of preferential treatment was entrenched by the mid-1890s, the age of lunatics being certified and then admitted as patients did not

² Maxine Thompson, "Violence and the Costs of Caring for a Family Member with Severe Mental Illness", *Journal of Health and Social Behaviour*. September 2007, pg. 319.

³ See David Wright, James Moran and Sean Gouglas, "The Confinement of the Insane in Victorian Canada: the Hamilton and Toronto Asylum, c. 1861 – 1891", in Porter, Roy, and David Wright, *The Confinement of the Insane: International Perspectives, 1800 – 1965* (Cambridge, 2003).

⁴ To my mind there is a grey area between being treated as a minor and being treated as something less than what I will term a 'full adult'. It is possible for unmarried individuals still living at home with parents or older relatives to be treated by their older relatives as though they are still children emotionally and in terms of household authority, but still nevertheless have adult responsibilities in terms of household work or income.

change much. Therefore, the age profile of the Asylum, at least, was not affected by factors internal to the Asylum, but rather external ones, both physiological and societal.

There were notable trends in the age profile of the asylum population between 1875 and 1905: men were likely to be admitted to the Asylum in their twenties or forties, while women were admitted in their twenties or thirties. Many of the trends among groups seem to be divide more readily across gender than race – that is, the differences between men and women tend to be more pronounced than those between black and white groups. However, one observable trend among those individuals who entered the Grahamstown Asylum was that there were fewer middle-aged black individuals than there were white people of the same age. There were also far fewer elderly black men and women in the Asylum population than elderly white individuals, although there were few inmates of any race that fell into this category. On the whole, age trends in the Asylum admissions between 1875 and 1904, were as follows: the people entering the Asylum were, for the most part, unmarried adults between the age of 20 and 49. Women were, on average younger than men when they were admitted; men were as likely to be married as they were to be unmarried. Black individuals were, on the whole, unlikely to come in with all their attendant information – the number of black individuals for whom marital status or age was unknown is much higher than it is among white individuals, and therefore it is not possible to construct an accurate profile of their age and marital status.

Bucknill and Tuke's 1879 edition of the *Manual of Psychological Medicine* remarks that, in their examinations of returns from various British and European asylums including those of Turin in Italy and the York Retreat, they had determined that although no age group was exempt from insanity, it was mostly likely to strike between the ages of 20 and 30: "If the experience of these institutions can be taken as fairly representing asylums generally, we should infer the increased liability of man to Insanity between the ages of 20 and 30, or that during this period he is brought into contact with an increased number of the causes of Insanity; probably both."⁵ As Sally Swartz has ascertained for Valkenberg Asylum, about 66% of all men and women admitted there arrived between the ages of 25 and 44, with men

⁵ John Charles Bucknill and Daniel Hack Tuke, *The Manual of Psychological Medicine: The Manual of Psychological Medicine: Containing the Lunacy Laws, Nosology, Aetiology, Statistics, Description, Diagnosis, Pathology and Treatment of Insanity with an Appendix of Cases*. (London, 1879), pg. 76.

averaging slightly younger than women at the time of committal, in their later 20s rather than early 30s.⁶ Parle's analysis of patients at the Natal Government Asylum for roughly the same period shows that the vast majority of all patients there were between the ages of 25 and 45.⁷ These returns are consistent with those for the Grahamstown Asylum, suggesting that Bucknill and Tuke's assertion held true in metropolitan Europe and America as well as in the Cape Colony.

Marriage profiles in the Grahamstown Asylum

According to the Cape census of 1911, the only age groups in which the majorities had never been married were those aged 19 and younger; at the other end of the spectrum, more people older than 60 years were widowed than had surviving spouses. In the main however, residents of the Cape of Good Hope were, if aged between 20 and 69, much more likely to be married than to be unmarried: between 60% and 80% of all people in that age range were married, with slightly more men than women remaining single. The Grahamstown Asylum did not replicate this pattern at all. Between 1875 and the early 1900s, unmarried people made up approximately half of all white men, black men and white women in the Asylum; only black women were equally likely to be married or single, as well as the largest proportion of divorced or separated individuals. Also, in all groups, but especially among black men, there were those whose marital status was unknown; they were a minority, however, vastly outnumbered by those who were recorded as married or single.

Trends here are clear and consistent: individuals entering the Asylum were more likely to be single than married, and this pattern was more pronounced among men than women. In the same vein, men were more likely to reach the Asylum with incomplete histories than were women, as evidenced by the higher number of men admitted with their marital statuses listed as "unknown". It is hard to tell from the available evidence whether this was because they were unwilling or unable to disclose such information. Anecdotal evidence gleaned from individual patient files, however, suggests that male patients were more likely to enter the asylum unaccompanied by any evidence, documentary or anecdotal, of marriage than were female patients. By comparison, women were more likely to enter the Asylum as widows,

⁶ Sally Swartz, "Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920", Unpublished PhD thesis, University of Cape Town, 1996, pg. 41.

⁷ Julie Parle, *States of Mind: Searching for Mental Health in Natal and Zululand, 1868 – 1918* (Scottsville, 2007), pg. 109.

following the death of a spouse, than were men. At Valkenberg Asylum, 70% of men and approximately 50% of all women were single when they were admitted,⁸ and the same was true of the marital status of men at women admitted to the Natal Government Asylum. Globally at the time, of course, marriage decreased risk of committal among men but increased it among women.⁹ This was the result of differential roles in the social structure as well as, quite likely, an ongoing debate about whether marriage was beneficial or not for insane men and women. Bucknill and Tuke held that,

“The strongest dispersuasion ought to be employed to prevent the marriage of [insane] females who have not passed the child-bearing period of life. With regard to [insane] males, marriage would no doubt be highly beneficial in many instances, and if the risk of progeny is not run, may well be encouraged, provided the consenting party is fully informed of the individual’s prior history and of the degree of liability of a relapse which exists.”¹⁰

In the case of men and women both, the risk of having children who might themselves become lunatics is stressed, but it is the attitude that marriage might benefit men that is interesting here, especially considering that more single men than single women entered asylums in the colonies *and* the metropole. In colonial settings, the demographic makeup of the population probably accounted for the proliferation of insane single men in asylums – in the absence of tight social structures or households, insane men might genuinely have nobody else to care for them. That the presence of a wife might obviate this suggests that marriage was considered a great stabilising influence. If we hold this beside Parle’s remark that marriage increased the risk of committal for women, however, we can see the effect of nineteenth-century attitudes regarding the delicate female mind in the assertion that marriage would *destabilise* women. The possibility that husbands might be less inclined to tolerate an insane wife than vice versa is implicit.

The distributions of marital status were similar between white and black individuals admitted to the Asylum, with the major differences evident being the higher likelihood that black individuals would enter the Asylum with their marital statuses unknown, relative to white patients. There was also a slightly increased likelihood – relative to white patients – that black patients would be married when they entered the Asylum, though the majority were still single. It is of course not out of the question that the reason some of these individuals had

⁸ Swartz, “Psychiatric Knowledge at the Cape”, pg. 42.

⁹ Parle, *States of Mind*, pg. 110.

¹⁰ Bucknill and Tuke, *Manual of Psychological Medicine*, pg. 65.

remained unmarried was unrelated to their mental disorder, such as being unable to do so for economic reasons, or something as simple as being unable to find someone they were able or prepared to marry.

As Rosenfield and Wenzel state, individuals who suffer from chronic and long-term mental illnesses tend not to develop quite the same broad networks of social interactions as those without do; the social networks of the mentally ill are smaller, simpler and contain more kin than do those of people in society at large.¹¹ Also, there is some evidence that individuals with serious mental illnesses are less likely to marry than those without, owing largely to difficulties in forming stable emotional bonds outside the family,¹² and, to a degree, in becoming economically able to sustain a household role. Under these circumstances, marriage becomes a tricky proposition: finding a suitable spouse can be a stressful process even for those regarded as well-adjusted individuals, and it is important to note that high rates of mental illness among unmarried people does not suggest that the unmarried state in itself is responsible for mental illness, but rather that the mentally ill population may include a number of people who are not wholly suited to marriage.¹³ That said, the role of social sanctions in creating stress that might trigger mental illness in a susceptible individual should be considered. Adulthood, in contemporary and 19th century society, entailed work, marriage and parenthood in various combinations, and men and women who for whatever reason failed to meet these milestones experienced both external criticism and internalised stress.¹⁴ Among Colonial men, for example, marriage was a sign of passing unquestionably into adulthood and affirmed masculine identity and the social roles of husband and father.¹⁵ Men who did not marry were seen as somehow in violation of this social norm, which may have precipitated considerable internal stress, worsening whatever existing problems there were. Furthermore, among contemporary patients with depression, interrupted or unsettled interpersonal relationships are a problem, manifesting as poor social adjustment, distress

¹¹ Rosenfield, Sarah and Suzanne Wenzel, "Social Networks and Chronic Mental Illness: a Test of Four Perspectives", *Social Problems*, 44, 2, 1997, pg. 200.

¹² Rosenfield and Wenzel, "Social Networks", pg. 200.

¹³ Walter T Marlin, "Status Integration, Social Stress, and Mental Illness: Accounting for Marital Status Variations in Mental Hospitalization Rates", *Journal of Health and Social Behaviour*, 17, 3, 1976, pg. 282.

¹⁴ Cook, Cohler, Pickett and Beeler, pg. 430.

¹⁵ Robert Morrell, "Of Boys and Men: Masculinity and Gender in Southern African Studies", *Journal of Southern African Studies*, 24, 4, 1998. pg. 218 and 215.

within spousal and familial networks, a lack of intimate relationships, and rejection by potential romantic partners.¹⁶

The preponderance of relatively young, unmarried individuals in the Asylum makes sense if one considers that most serious mental illnesses – certainly those severe enough to warrant admission to an Asylum – first begin to grow severe in early adulthood.¹⁷ Also, as already mentioned, severe mental illness impacts on how likely it is that a person will form long-term relationships outside the biological family. The high proportion of unmarried people admitted to the Asylum may be the result of resilient family and social ties holding married individuals firmly in their social networks. Married people are less likely to be hospitalised than are unmarried people¹⁸ and being married is associated with lower rates of hospitalisation.¹⁹ As is the case today, in the 19th century individuals with recognisable serious mental illnesses were less likely to be married.²⁰ This would of course mean a larger proportion of single people entering an asylum. Married women, on the other hand, are more likely to be admitted to an asylum than are married men. This may have to do with the relative unwillingness or inability of men to provide care to an incapacitated wife.²¹ It is also true that the work women performed in the home tended to be underappreciated relative to the more economically remunerative work men performed outside the home. At the same time, women were under considerable pressure to perform this work to the satisfaction of not only their male partners but society as a whole. This may have caused higher rates of stress among women, and therefore higher rates of mental illness.²²

Furthermore, the average age of onset for the most severe mental illnesses – schizophrenia, bipolar mood disorder, and depression – all fall within the late teenage years, early adulthood, and middle age. In the case of schizophrenia, the period of greater risk for onset is between 15 and 35 years of age, with the chances of developing the disorder decreasing as one gets

¹⁶ Segrin, Chris and Lyn Y Abramson, “Negative reactions to depressive behaviors: A communication theories analysis”, *Journal of Abnormal Psychology*, 103, 4, 1994, pg. 655.

¹⁷ Cook, Cohler, Pickett and Beeler, pg. 428.

¹⁸ Marlin, “Status Integration”, pg. 292.

¹⁹ Cochrane, Raymond, *The Social Creation of Mental Illness* (New York, 1983), pg. 40.

²⁰ Wright, Moran and Gouglas, “Hamilton and Toronto Asylum”, pg. 123.

²¹ Walter R Gove, “The Relationship between Sex Roles, Marital Status and Mental Illness,” *Social Forces*, 51, 1, 1972, pg. 34; Cochrane, *Social Creation*, pg. 40.

²² Gove, “Sex Roles”, pg. 34.

older.²³ Those who develop bipolar mood disorder tend to do so in their late twenties or early thirties, although onset does occasionally happen earlier.²⁴ Depression is more variable, with onset in the forties being common.²⁵ These are general age ranges, but they are congruent with the Asylum's age profile.

Marriage is an indication, even today, that the individuals involved at least nominally have the social and economic skills to form an independent relationship and establish their own household, or at least contribute meaningfully to an existing household. In the case of most of the lunatics certified and admitted to the Asylum, this does not appear to have happened. Fragmented social structures and severe mental illness can both lead to a situation where marriage is either unsuccessful or not an option in the first place. In the Asylum's particular context, that of the 19th century Cape, lack of social networks could sometimes, particularly in the case of black lunatics, lead to arrest and rapid certification, and then confinement. Societies and communities with high rates of emigration, immigration and internal migrancy are, obviously, at higher risk of weak social structures, with a consequent increase in the number of people without strong social networks.

Place of Origin: Immigration and Migrancy

At the time of the Cape census of 1904, over 90% of persons then living in the Cape Colony had been born there: more than 95% of black men and women in the territory had been born there, as had just over 80% of the white population. This was not the case earlier in the Colony's history. Among the Asylum's white population, of those that had been born elsewhere, the great majority were from the United Kingdom, particularly England; immigrants from Scotland, Ireland and Wales each contributed only a handful of people to the Cape population, as did Germany, Russia and a number of other European, North American and Australasian countries. Among the black population, those born outside the Cape Colony were usually immigrants from Basutoland or German South West Africa, and they made up only tiny proportions of the Cape population as a whole. Overall, the population of the Cape

²³ Emery, Robert E. and Thomas F. Oltmanns, *Essentials of Abnormal Psychology*, (Upper Saddle River, 1999), pg. 354.

²⁴ Emery and Oltmanns, *Abnormal Psychology*, pg. 127.

²⁵ Emery and Oltmanns, *Abnormal Psychology*, pg. 118

Colony by the beginning of the 20th century was autochthonous, with – among the white population – a high proportion of British ancestry.²⁶

This was true of the Asylum population as well. Although the nomenclature with which an individual's origins was categorised changed, often eliding the distinction between descent, national origin and cultural alliance,²⁷ it is possible to identify a strongly Anglophone majority in the Asylum's white population. English, Dutch and Irish individuals, and a small number of Scots, made up the bulk of the white patient population of Grahamstown Asylum into the 1880s. In the 1880s, identity markers became more vague with the introduction of the category "Colonial". The category of "Colonial" was presumably so imprecise that it soon was subdivided into "English colonial", "Dutch colonial", "Cape colonial", "Natal Colonial" and so forth as Asylum staff adapted it to their uses. Among black individuals admitted to the Grahamstown Asylum throughout the period 1875 to 1905, the groups "Kaffir" (usually used to indicate isiXhosa speakers) and "Hottentot" (usually used to indicate individuals of Khoi or San descent)²⁸ made up the two largest groups. This, perhaps, reflected – like the prevalence of British or British Colonial individuals among the white population – the makeup of the population in the regions of the Cape from which the Grahamstown Asylum drew its patients. It also clearly shows the determination to categorise and differentiate Colonial subjects, both black and white, that was central to the colonial project, *qua* Vaughan, Parle and Swartz.

The predominance of British or English individuals in the white Asylum population and of "Kaffir" and "Hottentot" individuals in the black Asylum population is most likely a reflection of the demographic profile of the eastern half of the Cape Colony. Because of long-term, extensive British settlement, Anglophone people of British extraction outnumbered the Dutch

²⁶ This, of course, changed somewhat when the former Boer Republics were incorporated into the Cape Colony following the South African War of 1899-1902.

²⁷ For example, by the 1890s, it is not possible to tell whether someone classed as "English" was so classed because they spoke English, were born in England, and/or were broadly culturally British. The case is rather clearer with Scots, Irish, Germans, Russians, and so on. Moreover, classification of black patients in the Asylum was even more slipshod and vague. Although Sally Swartz notes that after 1910 the designation "Coloured" began to be divided into "Kaffir", examination of the Grahamstown Asylum admissions register shows that the subdivision began at the time of the Asylum's establishment, remained multifarious for the first fifteen years, and in fact became *less* divided as the 19th century drew to a close. (Swartz, Sally, "The Black Insane in the Cape, 1891 – 1920", *Journal of Southern African Studies*, 21, 3, 1995, pg. 403).

²⁸ "Malay", "Mixed" and later "Bastards" were a separate categories. Please see the Notes on Terminology.

in the Grahamstown area, which had, unlike the gold- and diamond-fields to the north, a relatively low immigrant population by the turn of the 20th century. Likewise, the area had formerly been the territory of Xhosa-speaking groups and had also had a small Khoi population; Khoi had also come east from the western regions of the Colony as agricultural workers and small-scale farmers. There were, simply, more of these groups in the region and although the Grahamstown Asylum would eventually draw its patients from as far away as Natal, Cape Town and the Bechuanaland Protectorate, the majority came from much closer by.

The Asylum population had a white majority overall during the first 25 years of its existence. The population of the Cape region was not majority white. Towards the end of the 19th century, British annexation of Xhosa territories and relaxing immigration rules for residents of territories outside the Cape meant that the black population of the Cape rose steadily. Provided that cases of insanity are dispersed equally throughout all population groups, that the Asylum had even a small majority of white patients is an indication of the discriminatory practices that the Asylum authorities enacted in their admissions policies. Although many black inhabitants of the Cape and surrounding British colonial territories may have taken steps to avoid resorting to Western psychiatry, others were caught up in the legal and criminal machinery of the colonial state, while still others availed themselves of the asylum as a method of dealing with insane friends and relatives. For most white patients, the asylum was the obvious, deliberately-chosen option in circumstances where care in the home or among friends was not practical.

Committal, Recovery and Death in the Grahamstown Asylum, 1875 – 1905

As the preceding section and other parts of this thesis have shown, the Grahamstown Asylum was to a degree selective of who was admitted there. Dodds, Hullah and Greenlees all intended it to be a place where white patients - preferably white patients *able to pay* – would benefit from the well-appointed surroundings, and recover quickly before returning to their previous lives or a semblance thereof. However, they could not – and in many cases did not strongly attempt to – guarantee this.

Some patients, inevitably, died while in the Asylum, while others, for whatever reason, did not experience full recovery. As has been discussed, the Asylum authorities' long-term goals did not include making adequate provision for unrecovered cases of chronic insanity. Most of the men and women who entered the Asylum were eventually released after having recovered to a degree. Others were unrecovered and were transferred to other, poorly-equipped asylums where chronic care was provided. An individual's prospect of recovery usually became apparent before six months had passed, and although a smaller number stayed on for up to two years, very few inmates become long-term residents of the Grahamstown Asylum.

Examining the durations of patients' confinement and patterns of discharge from and death within the Asylum illuminates the ways in which the differential treatment of patients inside the Asylum affected their chances of recovery. In a system as characterised by the uneven distribution of resources as that of the Grahamstown Asylum, it is no surprise that black patients showed higher rates of death and lower rates of recovery than did white patients. The inequality of the Asylum, and the Colonial asylum system as a whole, had permanent and irreversible effects on the poor and/or black lunatics that entered its premises. Often, meagre resources and deficient treatment only retarded their recoveries, leading to long-term confinement in places such as Fort Beaufort Asylum or Port Alfred Asylum. It could, and altogether too often did, also effectively make death from deprivation very likely.

On the whole, it appears that women, black and white, who were committed to the Grahamstown Asylum were not hospitalised for as long as their male counterparts. Of the white women who entered the Asylum in 1875-1879,²⁹ while Hullah held the reins, over a quarter were discharged within a month,³⁰ but in the same period white men seemed to be more likely to stay longer: only 20.8% left within one to two years. Black men like white men, tended to be hospitalised for longer than women. If a lunatic could not be safely cared for at home – assuming they had a home – the Colony, as discussed earlier, offered only the alternative of confinement in a gaol or general hospital. Once a lunatic left the Asylum, unless s/he went into the custody of a friend or family member who could provide adequate care, his/her options were few, and harsh. Also, the science of psychiatric institutionalisation had

²⁹ PR360-1, "Grahamstown Asylum General Register of Patients", 1875-1896, Cory Library, Grahamstown.

³⁰ PR360-1, "General Register", 1875-1896.

not progressed much beyond the provision of pleasant surroundings and some sort of custody aimed at keeping lunatics separate from the general population for the safety of both. Drug regimens and 'talking therapy', let alone cognitive behavioural therapy, were not yet available; lunatics leaving the Asylum in effect left all the trappings of treatment, even moral therapy, behind. Recovery, for those who had in fact experienced relief from symptoms, was not guaranteed to be permanent. For those who had not experienced recovery but rather a temporary cessation or alleviation of symptoms, the future might well include another sojourn in the Asylum. (As has been noted elsewhere, the presence of previous attacks was very often listed as cause of insanity at the time of committal.)

In the Asylum's early years, those residing in the Asylum could not leave of their own volition unless a family member or friend was prepared to undertake the legal obligation to care for them. If suitable custody outside was available, they could leave the Asylum even if the Medical Superintendent did not judge them fit to do so. Under the 1879 Lunacy Act, however, the Medical Superintendent was able to block a patients' release, but was not afforded any more options as to what to do with them. When an Asylum inmate was discharged as 'recovered', they were judged to be in a suitable state to leave the Asylum and be returned to mainstream society. This did not necessarily mean that they were completely recovered or at all "cured", only that they had met the requirements to be deemed recovered by the examining physician. The Medical Superintendent, for example, often deemed female patients to be recovered from their disorder, and consequently fit for discharge, sooner than he did male patients in the same position, suffering from the same disorder. This did not mean that the female patient had recovered more quickly, but rather that the Medical Superintendent was prepared to move her out of the Asylum sooner than he was prepared or able to do with the male patients, perhaps even in order to open space for incoming female patients. The availability of reasonable care at home may have had some influence on the decision.

The Lunacy Acts of 1879 and 1897 made provision for the release of lunatics into familial custody in cases where a stay in the asylum had not effected cure. Therefore, the medical authorities of the Grahamstown Asylum discharged patients whom they deemed incapable of further improvement into familial custody or into institutions, such as the Port Alfred Asylum, designed to provide long-term care for cases of chronic insanity. The Grahamstown Asylum was not an institution that wished to provide long-term accommodation for incurable cases

unless it became absolutely unavoidable (for example, if the incurable case paid top rates for his or her accommodation). The main practice of Asylum doctors was to effect a rapid cure or at least some improvement in a patient's disorder and discharge her or him back into the world as swiftly as they could. If recovery was not possible, they were still referred to hospitals geared to the custody of chronic, irrecoverable cases of insanity.

In the early 1880s, women were likely to stay in the Grahamstown Asylum for only nine months or less, while white men tended to remain hospitalised for between nine months and five years. This makes sense, given that there was more accommodation available in the Grahamstown Asylum for white men, and that, white women admitted to the Grahamstown Asylum were more firmly entrenched in familial networks which could accommodate them when they left the Asylum. Male patients were also more likely to exhibit violent or otherwise unsafe behaviour, which made discharging them problematic; a patient likely to harm himself or someone else could not safely be sent home, or away, and had to be kept in the institution until either another facility was found for him, or he became easier to handle, which could take an indefinite amount of time. Hullah battled to persuade the Colonial government to make provision for the expansion of Asylum facilities, and thus was forced to do what he could with the space available to him. In the early 1880s, also, there was still very limited asylum space in the Colony as a whole, and although demand did not increase overnight, there was increasing knowledge of the availability of the Asylum as an option that families could take up if they could not care for their lunatic relatives. And this was in the case of white patients, who came from a group that was socially and economically dominant in the Colony. Black patients faced a somewhat different reality.

Black men who were admitted to the Grahamstown Asylum in the 1880s stayed there for longer, on the whole, than their white counterparts. For black women in the Asylum, longer periods of institutionalisation were, startlingly, more common. Until Fort Beaufort Asylum was established for black patients, there was, quite often, nowhere else for black lunatics to go. The poor accommodation and poorer care provided by Asylum authorities to black patients, combined with increasing numbers of lunatics of all races requiring Asylum accommodation, meant that the conditions conducive to recovery – rest, space, kindness, recreation, and adequate food – were simply not provided to black patients by Asylum authorities. In fact, if we say that the Asylum provided care to its white patients, we can equally say that what it

provided for black patients would be best described as custody. And custody is not something that an individual would generally wish for themselves; it is imposed on an individual, not adopted by them. Civil or criminal authorities generally take people into custody for the benefit of people *other* than the detained themselves. As discussed in Chapter Four, much of the concern around lunatics in general was centred on issues of maintaining law and order (see Chapter Four). Higher numbers of black lunatics than white lunatics entered asylum custody after coming to the attention of law officers. Evidently, then, the length of time for which a person admitted to the Grahamstown Asylum between 1875 and 1884 was related to their race or sex. In the two periods compared thus far, white men were on average hospitalised for longer than white women, who were discharged relatively quickly; black men and women did not show the same pattern, and evidently ended up confined in the Asylum, neither recovering nor improving, for longer.

As has been discussed, the Grahamstown Asylum had more accommodation available for men than it did for women; likewise there was more, and better, space available to house white patients than there ever was, at any asylum in the Colony, for black patients. The unequal provision of accommodation for male patients, at least, makes sense given that there were simply more men being committed to the Grahamstown Asylum. It certainly was the case that white male patients enjoyed, if that is the word, superior living conditions in the Asylum. The somewhat longer duration of hospitalisation among male patients in the late 1870s and early 1880s may have resulted, at least in part, from the relatively large amount of space available to house them in the Asylum.

Relatively high numbers of the individuals who entered the Grahamstown Asylum between January 1885 and December 1889 – the last few years of Hullah’s employment as the Medical Superintendent – were discharged less than a month after admission; this period also showed a slightly higher proportion of individuals remaining hospitalised for longer than a year. It would appear that among the white men admitted in this period, the majority were hospitalised for less than two years, specifically less than nine months.³¹ White women showed a slightly different distribution, suggesting that recovery or at least sufficient improvement to allow release occurred fairly swiftly.

³¹ PR10 360-1, “General Register”, 1875-1896.

Among black men, the distribution is, however, quite different: none of those admitted in the period under discussion were hospitalised for fewer than three months, and relatively large proportions remained hospitalised for long periods, exceeding two years.³² This strongly shows the effect of the lack of provision in the 1879 Lunacy Act for allowing Medical Superintendents to authorise the discharge from asylums of patients who were certified as criminal lunatics; of course, as already mentioned, more black patients, particularly men, were admitted as criminal lunatics than any other group. This would remain a problem up until Greenlees and Dodds finally brought about legislative change with the 1897 Lunacy Act. The poor treatment that black men, particularly, received in the Asylum could be argued to have lowered their chances of recovery, as could poor diagnoses and, of course, actual intractable mental illness resulting in a poor prognosis.

Black women admitted in this period do not show similar patterns. This is an improvement on the previous periods, but raises questions about the fate of these women, who if not recovered and if not able to return home, faced deeply uncertain futures. Clearly, black patients seemed to remain hospitalised for somewhat longer than their white counterparts, although very long-term patients remained relatively rare in all groups, with the possible exception of black men, although even in that case there were not very many. The Grahamstown Asylum was, even before Greenlees assumed control, not a place that easily could provide long-term care of good quality; these few long-term black patients suffered severe deprivation in every way, especially in comparison to the goods and services provided to their white counterparts. The bulk of all patients admitted left within two years, however, rather than remaining in the Asylum; most of these left within less than a year. Very few patients indeed remained in the Asylum for more than 12 years, and nobody admitted in this period remained in the Asylum for more than 20 years.

This difference in the duration of hospitalisation among black, especially black female patients, may be the result of several factors, among them: flawed intake and diagnostic procedures, and the provision of comparatively poor care for black patients. As discussed elsewhere, with black patients, Asylum staff often found the process of gathering information – biographical,

³² PR 10 360-3, "General Register of Patients, 1896 – 1918".

etiological and nosological – and interpreting it in order to come to a diagnosis to be problematic, as it could be hampered by language barriers and cross-cultural misunderstandings. Furthermore, as a result of medical preconceptions surrounding the forms that mental disorder assumed among black patients, many of them were deemed to be the victims of intractable or at least incurable insanity that was, oddly, also considered simpler in form than the curable forms of insanity that affected white lunatics (as discussed in Chapter Three). This in turn often meant that Asylum administrators provided black patients with inferior care more akin to mere custody than any attempt at amelioration of suffering precisely because they were considered less likely to recover and therefore received less attention. This provision of inadequate care definitely did not aid whatever recovery could take place, and in fact may sometimes have retarded it; it certainly led to a rather higher black mortality rate, as will be discussed at the end of this chapter.

It needs to be noted here that black patients were not passive receivers of this administrative indifference. The admission procedures in the Asylum involved physical measurements, undressing and re-dressing, and being photographed. As Du Plessis notes,³³ many black patients resisted what was probably a noticeable difference in attitude during the admission process, as well as the process itself, and were therefore on occasion, quite possibly, forced to present certain attitudes in order to meet the attendants' requirements. There is also the possibility that, because photographs can be staged, that some patients ended up *artificially* displaying the characteristics of madness: averted gaze, distress, unkempt appearance, etcetera.

Greenlees succeeded Hullah (who had died in office) as Medical Superintendent at roughly the same time that Dodds became the Colony's first Inspector of Asylums, the 1891 Lunacy Act was passed by the Cape legislature, and major changes in the Colony's asylum system began. Dodds' task was to align Colonial asylum practices with those used in the United Kingdom, but he attempted to do so without addressing the major inequalities in treatment that were already entrenched. The 1891 Lunacy Act further entrenched the practice of certifying black lunatics as of unsound mind only once they had come to the attention of Colonial law

³³ Du Plessis, Rory, "Photographs from the Grahamstown Lunatic Asylum, South Africa, 1890–1907," *Social Dynamics*, 40, 1, 2014.

authorities, and although this reflected greater Colonial concerns around the maintenance of civil order, it also created a large class of ‘criminal lunatics’ who could not be freely moved through the Colonial asylum system (see the next chapter). The deepening incongruence of the resources and treatment patients received in the Grahamstown Asylum, combined with Greenlees’ goal to create a private sanatorium out of a crowded public asylum, and the red tape created by regulations around criminal lunatics, all combined to have profoundly negative effects on the hospitalisation of black patients.

In the early 1890s, when Greenlees was still settling into his position, the great majority of all individuals admitted to the Asylum were discharged within two years of admission, with most being discharged within nine months. The number of patients that remained institutionalised for longer than two years was small. They were, of course, preferred patients, and Greenlees was under no pressure – or feel compelled – to discharge them quickly in order to make more space for incoming patients. Among white women, hospitalisation in the early 1890s lasted longer than it did among white men, the majority, once again, being discharged within a year. As with white male patients in the Asylum, recovery seemed to be an easier outcome for white female patients than for their black counterparts. This had been the case since the earliest days of the Asylum and remained the case well into its second decade of existence, evidencing a long-seated system of preferential treatment for some patients at the expense of others.

Black men who entered the Asylum in this period remained in custody for extremely short periods; most black men coming into the asylum system in that part of the Colony were assessed and stabilised in the Grahamstown Asylum, and then transferred. A quicker discharge from the Grahamstown Asylum did not necessarily indicate recovery: instead, it merely meant that patients were sent elsewhere. The majority of the black women admitted within this period left within two years: 80.3% of the total intake. The practice of ‘admit, assess, and re-assign’ was as much part of the black female Asylum experience as it was for their male counterparts. Greenlees, forced by circumstance to allow the Asylum to be a sort of central processing hub for all lunatics in the Eastern Districts, reserved it as a *residence* only for white patients.

Many of the white men admitted between 1895 and 1899 were discharged within the first nine months of their hospitalisation. The same is true of the black men admitted in the late 1890s, of whom fully 40.2% left the Asylum between three and six months after admission. Among white women admitted in the period 1885 to 1880, 17.8% left between one and three months, 21.5% left between three and six months, and 28.3% left between six and nine months.³⁴ Black women, like the other three groups already discussed, showed a majority of the individuals that were admitted left within three years of entering the Asylum.³⁵

Overall, then, the majority of individuals admitted to the Grahamstown Asylum were not in the institution for longer than two years; of these, the great majority were discharged within nine months. At the same time, relatively few of the people entering the Asylum were released within less than a month, which strongly suggests that there was little chance of a patient being considered cured in less than that time. Acute cases had to be stabilised and kept in the Asylum until it was apparent that the recovery would hold. Also, the relatively low number of individuals who remained hospitalised for more than two years suggests that a cure generally did not take very long to effect before discharge was possible, or alternatively that in cases where Asylum patients did end up deemed incurably insane, they were sent elsewhere. The goal of high patient turnover led to some complications for Greenlees. As has been discussed, Greenlees was concerned about the pressure black patients placed on Asylum resources, and was almost equally unenthusiastic about conceding space and funding to provide accommodation for poor and/or incurable patients. It appears, from the percentages of patients discharged swiftly, that he was, at least, successful in his mission to prevent the Asylum from becoming clogged by long-term patients by making them, where possible, someone else's problem. The clearest evidence of this is the decrease in the amount of time black patients spent at Grahamstown Asylum: cured or deemed incurable, they were not accommodated at the Asylum for any longer than was strictly necessary.

The proportions among the intake of patients into the Grahamstown Asylum between 1900 and 1904 do not particularly closely resemble those of previous periods,³⁶ however, it remains

³⁴ PR360-1, "General Register", 1875-1896; PR 10 360-3, "General Register of Patients, 1896 – 1918".

³⁵ PR360-1, "General Register", 1875-1896; PR 10 360-3, "General Register of Patients, 1896 – 1918".

³⁶ T. Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of*

evident that most admissions were brief, rarely exceeding two years. This intake shows a marked drop in the number of individuals in all groups staying in the Asylum for longer than two years.³⁷ Among the black men admitted, 60.7% of the total intake fully 85.4% of the black men admitted between 1900 and 1904 came and went within two years. 86.3% of black women admitted in the years between 1900 and 1904 remained in the Asylum for less than a year.³⁸ The reason for this minor preponderance of black women staying for slightly longer periods in the early 1900s may have been that they were relatively rarely encountered by asylum authorities; throughout the period 1875 to 1905, they were routinely the smallest group of patients in the Asylum. For this reason, when they failed to recover, there were few other options open to them beyond further hospitalisation under poor conditions. The relatively low number of black women (relative to black men) living in the Cape Colony and likely to come into contact with civil and medical authorities furthermore meant that there were fewer facilities available for their care and treatment, leading to overcrowding, inferior living conditions, and consequently poorer prognoses for recovery.

The fact that an institution such as the Asylum had a high percentage of patients discharged after relatively short periods of committal did not unreservedly indicate a high rate of success for its methods of cure, care or custody. It may instead indicate that although some groups of patients received adequate care and consequently recovered swiftly, others were quickly

Asylums for 1900, part VI: Grahamstown Asylum, CCP1/2/1/115, G41-'01, Western Cape Archives and Records Service, Cape Town pg. 88; T. Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1901*, part VI: Grahamstown Asylum, CCP1/2/1/115, G41-'01, Western Cape Archives and Records Service, Cape Town, pg. 113; T Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and of the Inspector of Asylums for 1902*, CCP1/2/1/123, G60-'03, Western Cape Archives and Records Service, Cape Town, pg. 114; T Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and of the Inspector of Asylums for 1903*, G55-'04, CCP1/2/1/126, Western Cape Archives and Records Service, Cape Town, pg. 120; T Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and of the Inspector of Asylums for 1904*, CCP1/2/1/135, G57-'05, Western Cape Archives and Records Service, Cape Town, pg. 79; T Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and of the Inspector of Asylums for 1905*, CCP1/2/1/137, G32-'06, Western Cape Archives and Records Service, Cape Town, pg. 81.

³⁷ *Ibid.*

³⁸ *Ibid.*

deemed to be beyond the help the Asylum could offer and were swiftly transferred away, whether this meant into the custody of friends or family, or another institution.

Between 1875 and 1905, the Grahamstown Asylum's record keeping system employed three categories of discharge: individuals were discharged with their disorders unrelieved, with disorder relieved, or discharged recovered from their disorder. In addition, the Asylum staff also kept a tally of patients who died while in the Asylum, and recorded their causes of death. The percentages of patients who left the Asylum relieved, unrelieved, recovered or dead are derived from returns published in the Annual Reports, and were calculated on the Asylum's average daily population. This average daily population indicated, roughly, the number of people resident in the Asylum rather than the actual number, which varied from day to day. What is clear, however, is that the number of people in the Asylum only increased between 1875 and 1905, consistent with both the increased demands for Asylum accommodation and the amount of asylum accommodation available. The general upward trend placed stress on the Asylum's resources, particularly among the black patient body, which had less well-appointed accommodation and worse facilities than their white counterparts. As a result, the frequency and type of discharge among white patients differed from those among black patients. Death inside the Asylum was relatively rare, compared to recovery; in fact, fewer than 20% of the Asylum's total average number resident died while institutionalised. This death rate nevertheless does approach one in five.

The total average death-rate for the Grahamstown Asylum showed a continuous decrease between 1875 and 1905.³⁹ Clearly, then, the Grahamstown Asylum did have a fairly good recovery rate and a low death-rate, at least when the rate was calculated against the entire population. Upon closer examination, the picture was rather skewed. The total recovery rate, calculated according to the Asylum's average daily population, was highest in 1882, with 47.07% of the patients being discharged recovered. The lowest point was 1875, the Asylum's first operational year; only 4.5% of the individuals admitted had been discharged deemed to have recovered from their disorders.⁴⁰ Overall, just under a third of the Asylum's population was released with their disorders deemed cured. As expected, the lowest recovery rate was

³⁹ Greenlees, "Grahamstown Asylum 1905", pg. 81. The table referenced here included returns for the entire period 1875 to 1905.

⁴⁰ Greenlees, "Grahamstown Asylum 1905", pg. 78.

found when the Asylum was new and relatively inexperienced. This rate rose in the following years by the early 20th century, just over a third of patients were discharged as recovered.⁴¹

The correlation between death and recovery rates in the Grahamstown Asylum is not clear. Tables published in the Annual Reports only give percentages for the patients discharged recovered and those who died in the Asylum, and do not give figures for patients discharged with their symptoms relieved but without their conditions cured, or for those who left the Asylum (often to be transferred to another asylum) with their conditions unchanged. This is due to the fact that all of these, even if patients were transferred to another asylum, were recorded as “discharged”, meaning they were discharged from the Grahamstown Asylum, but not necessarily the Colonial asylum network as a whole. It is difficult to get a clear idea of the relative preponderance of deceased versus recovered patients without the other two discharge groups being factored in.⁴²

Moreover, whether a patient recovers is not decided solely by the doctors caring for them; long-term prognosis, short-term prognosis and the risk of relapse are determined at least partly by the form of the disorder from which the patient suffers. However, the quality of treatment a patient receives – and this includes not only whatever disorder specific care they receive, but also the environment they are in while in recovery – dictates to a large part how likely recovery is, and how complete it is. Malnourishment and overcrowding, as experienced daily by the black patients in the Grahamstown Asylum, would retard the chance of recovery by placing further mental and physical stress on individuals already experiencing trauma, as well as increasing the likelihood that they would die of causes unrelated to the disorders they were suffering from. The goal of all doctors should ideally be to bring about recovery in all their patients; as will be shown, in the Grahamstown Asylum, doctors’ efforts towards effecting recovery were reserved largely for white, favoured patients. Conversely, at Valkenberg Asylum, 40% of men and women were discharged deemed to be recovered; at Fort Beaufort, less than 15% of men and 20% of women were ever deemed to have recovered.⁴³

⁴¹ Greenlees, “Grahamstown Asylum 1905”, pg. 78.

⁴² As a result, the following percentages were calculated from figures given in the Annual Report for 1905.

⁴³ Swartz, “Psychiatric Knowledge at the Cape”, pg. 146.

A trend amongst the Asylum's population between the years of 1875 and 1905 is that more white than black patients were discharged having been deemed recovered by the Asylum authorities. The average percentage during this time of white patients discharged having recovered was 36.9%; among black patients, the average recovery rate was only 28% - a difference of almost 10%.⁴⁴ The recovery rate among white patients increased steadily as the Asylum became more established. The recovery rate among black patients, however, declined, dropping more noticeably towards the end of the 19th century.⁴⁵

These greatly different recovery rates suggest that prognosis was, on the whole, worse among black than white patients across the entire period 1875 – 1905. Several factors were probably at play here: firstly, that discharge happened fairly quickly even though no recovery was present indicates that the Asylum authorities did not wish to keep black patients for any longer than they had to. Secondly, it indicates that the care provided for black patients was inadequate: as there is no biological evidence for the contention that black patients suffered from more intractable forms of mental disorder than white patients did, the difference must lie in the perception that they did, which would have influenced the type and quality of the care they received. The logic was, arguably, that patients who were not going to recover did not warrant caring treatment, and may as well be transferred elsewhere to make space for patients who would recover. Unsympathetic and begrudged care would hardly have made for an environment favourable to recovery.

Patients who had not improved sufficiently to be deemed recovered could still be sent out of the Asylum, whether to their homes or another asylum, and were deemed to be relieved. In this category, black patients exhibit higher percentages of relieved cases than did their white counterparts, at least as exhibited by the yearly percentages. However, black patients evinced a somewhat higher average percentage of individuals discharged with symptoms relieved than did white patients.⁴⁶ It needs to be noted here that, compared to Valkenberg Asylum, Grahamstown Asylum discharged far more patients who were "not improved." In the period

⁴⁴ Greenlees, "Grahamstown Asylum 1905", pg. 78.

⁴⁵ Greenlees, "Grahamstown Asylum 1905", pg. 81.

⁴⁶ Derived from the admissions registers, PR 10 3060, Cory Library, Rhodes University, Grahamstown, and Greenlees, "Grahamstown Asylum 1905", pp.79 and 81.

running up to 1909, Valkenberg discharged 20% of men and 15% of women “not improved”, while Grahamstown discharged 20% of white men and nearly 25% of white women in this state, as well as over 35% and nearly 40% of black men and black women respectively. In the same period, Tower Hospital in Fort Beaufort discharged 20% of men and nearly 30% of women as “not improved.”⁴⁷ This suggests, firstly, that Grahamstown’s regimes may not have been as effective as those at Valkenberg even for white patients, and that they were markedly *worse* for black patients.

Black patients were more likely to be discharged from the Asylum with their symptoms relieved, rather than recovered, than white patients were. This might indicate that, faced with the prospect of poor chances of recovery, and the pressure to open up space for incoming acute cases, Asylum authorities were more than willing to discharge unrecovered black patients into either the custody of friends and family (who would then be required to care for them), or transfer them to long-term chronic-care asylums. Whatever the end result, it seems clear that whatever methods the Grahamstown Asylum under Greenlees employed in its care and custody of black patients, they were not as likely to effect a cure as those used for white patients. The same patterns are present among individuals that left the Asylum with symptoms completely unalleviated, those who fell into the category “discharged unrecovered”.

Between 1875 and 1905, an average of 22.1% of black patients left the Grahamstown Asylum with their conditions believed by Asylum staff to be unchanged. By comparison, only 14.6% of white patients in the same period exited the Asylum in the same state in which they left.⁴⁸ It should be remembered that the category of “discharged unchanged” was used to label patients who were transferred to other asylums from the Grahamstown Asylum, as these patients had technically been discharged from one asylum before being re-admitted to another. The changes introduced by the 1897 Lunacy Act allowed Greenlees to move criminal and dangerous lunatics out of the Grahamstown Asylum at his own discretion and undoubtedly caused this change: for the first time, Greenlees was free to redirect as many black lunatics out of Grahamstown Asylum as he could, whatever their mental state might have been.

⁴⁷ Swartz, “Psychiatric Knowledge at the Cape”, pg. 134.

⁴⁸ Greenlees, “Grahamstown Asylum 1905”, pg. 79.

The comparatively high rates of recovery among white patients, and the high rates of less successful recovery or complete lack of recovery among black patients are reflections of the effects of inequality in care, custody and treatment within the Asylum. Although the differences in the amounts of time individuals of various groups stayed in the Asylum were not great, they do indicate a likelihood that the duration and outcome of an individual's institutionalisation was influenced at least partly by the treatment they received, and that this treatment was in turn influenced by their race, marital status and gender. Another factor was their prognosis, or the severity of their disorder. Most of the men and women who were committed to the Grahamstown Asylum were discharged within a matter of months, in keeping with the Asylum's practice of treating acute cases and generally preferring to avoid the accumulation of long-term chronic cases.

The Asylum seemed to give up, so to speak, on black patients fairly easily: although they did not stay for much longer than did white patients, they were not as likely to recover in the time they spent in the Asylum, and were more likely to still be in an unstable state, manifesting symptoms of disorder, when they left. Given that this indicates a lack of recovery, the question arises as to why they were leaving the Asylum at all. The answer is partly that space for black patients was generally begrudged and often minimal, and therefore under constant pressure. This, combined with Greenlees' belief that black patients suffered from more intractable forms of insanity and were less amenable to treatment, certainly increased the number of black patients who departed the Grahamstown Asylum physically fit for release, but still suffering from the disorders that had landed them there in the first place.

As already mentioned, death in the Grahamstown Asylum, if averaged out over the period 1875 to 1905, was relatively uncommon. Nevertheless, it was certainly not unlikely, and in fact was rather *less* unlikely for some groups than for others. How likely a patient was to die while inside the Asylum was influenced by who they were, and to a lesser degree, the time at which they were there. Death rates were higher in the Asylum's earlier years but improved as time wore on – unsurprisingly, considering the basic facilities available in the earlier years, and the likelihood that patients had endured stress and poor care in gaols and private houses before the Asylum became available. However, over the course of the first quarter-century of the

Asylum's existence, the death rate decreased steadily. Death rates among white patients decreased steadily between 1875 and 1905 from a peak of 52.2% in 1877 to 5.96% in 1905, while the percentage of black patients who died in the Asylum likewise decreased.⁴⁹ While care for white patients, particularly those of better means, improved as better facilities were supplied, the reverse is true of care for black patients. Asylum authorities simply did not address the issues of overcrowding, lack of recreation, inferior diet and inferior facilities for black patients with the alacrity of enthusiasm they showed when attending to their counterparts on the white side of the Asylum. Administrative indifference and poor living conditions that were not solved made for a rather more unhealthy black population, and consequently for a lower likelihood that any particular black patients would leave the Asylum upright and alive.

The Grahamstown Asylum straddled an uneasy line between being a cash-strapped public institution and wishing to appear otherwise. It was crowded, busy, and experienced a rapid turnover of patients and staff. This rather leaky ship was steered by the Medical Superintendent who had near-autonomy in the Asylum's daily running and could decide, without reference to others, the fate of the patients in his care. Hullah and Greenlees both promoted the interests of white patients over those of black patients to the point where actual care and recovery became difficult for the latter, leading to reduced rates of recovery and increased likelihood of death. But the Asylum was not an isolated or completely inhumane establishment. While altruism may not have been a strong imperative in the treatment offered patients, the twin factors of favouritism (towards white patients, particularly male white patients, particularly wealthier white male patients) and racially-based prejudice (against black patients, wealthy and male or otherwise) are apparent from the records. This 'selectiveness' began long before the man or woman entered the Asylum, and continued to work for or against them even once they were inside. It could prove fatal, or be a major factor in their recovery; which, depended on how the Asylum happened to classify them. Experience was, in part, decided by which category a patient was put into, rather than who they were as an individual human being.

⁴⁹ Greenlees, "Grahamstown Asylum 1905", pg. 79.

Chapter 6: Conditions Inside the Grahamstown Asylum

Previous chapters have shown that any individual patient's experience of the Grahamstown Asylum depended to a large degree on where they fell within the Asylum's hierarchy of patients. Indeed, the Asylum's authorities considered providing a therapeutic rather than custodial environment a priority only in the case of a select group of wealthy, acutely ill inmates. The aim of this chapter is to examine the minutiae of the Asylum's daily routine and to interpret what these meant for the larger Asylum project, as well as the achievement of Greenlees' goal of providing better treatment for some inmates than for others. It is entirely possible that Greenlees and his Asylum staff saw no contradiction between providing moral therapy and treating some patients better than they treated others – each according to their needs as understood by the Asylum's authorities. Differences, however, were present and multifarious.

In any institution, total or otherwise, getting a number of people through the daily routine in as orderly a fashion as possible is key to the institution's smooth running, and to this end, protocols and procedures are developed to make sure that staff complete the mandatory tasks in the correct way, and inmates receive the correct treatment. The chapter begins with an examination of the provision and assignment of work details among inmates in the Asylum, then examines the kinds of recreation the authorities made available for the inmates, and concludes with an examination of the menu offered to inmates at the Asylum. Protocols and procedures, and the ways in which they were implemented will be examined.

Idle Hands: Work and Therapy in the Grahamstown Asylum

Niall McCrae observes that as asylums grew bigger and bigger, running costs multiplied; as government funds were in short supply, asylums sought to deal with financial shortfalls by becoming as self-sufficient as possible.¹ The physical labour provided by able-bodied patients was crucial to the asylum economy, and the practice at almost all public asylums in the British

¹ Niall McCrae, "The Beer Ration in Victorian Asylums", *History of Psychiatry*, 15, 2, 2004, pg. 157.

system was to put patients to work as soon as their behaviour had become more predictable.² This had the double benefit of providing cheap and even free labour for the asylum, and – ostensibly – providing a therapeutic service for patients.³ Given that high-class, paying patients in public asylums were generally exempt from being assigned work details, it is generally the pattern that only poorer patients worked.⁴ In the Cape Colonial context, and at Grahamstown Asylum in particular, this translated to a system in which able white patients worked if they chose to, and able black patients worked as a matter of course.

Asylums needed to keep running costs down. At the same time, work was believed to be therapeutic. As a result of these twin imperatives, asylums often developed extensive infrastructures – gardens and farms, laundries, workshops, and kitchens, as well as sewing workshops and brewhouses.⁵ Most of the clothing that asylums supplied to their publicly-funded inmates was made and kept laundered on the asylum premises, thus keeping costs to a minimum.⁶ At this point, it needs to be emphasised that work, like accommodation and recreation and food, in asylums was generally divided up by class and gender, along lines that were much like those in operation in the world outside the asylum.⁷ In Cape Colony asylums, authorities also split work along the lines of racial classification. In the Grahamstown Asylum, according to Swanson, unpaying patients specifically were put to work: white men were employed as artisans and contractors,⁸ while black men were generally made to carry out the heavier menial tasks and outdoor work, such as farm and stable work. It is my finding that white men also performed some interior cleaning jobs such as floor polishing, worked in the stores, did clerical work, and were put to coir-picking. Swanson also notes that women in the Asylum were assigned domestic tasks such as laundry, sewing, cleaning and cooking. The Asylum's rigid gender segregation would account for why men carried out such 'feminine' tasks on the male wards. Those who were obliged to work were sometimes rewarded with

² McCrae, "Beer Ration", pg.157.

³ Scull, Andrew, "A Convenient Place to Get Rid of Inconvenient People: the Victorian Lunatic Asylum", in Anthony D. King (ed.), *Buildings and Society: Essays on the Social Development of the Built Environment* (London, 1980), pg., 407.

⁴ Scull, "Convenient Place", pg. 407

⁵ Edginton, Barry, "Moral Architecture: the Influence of the York Retreat on Asylum Design", *Health and Place*, 3, 2, 1997, pg. 94.

⁶ Harmlett, Jane and Lesley Hoskins, "Comfort in Small Things? Clothing, Control and Agency in County Lunatic Asylums in Nineteenth- and Early-Twentieth Century England," *Journal of Victorian Culture*, 18, 1, 2013, pg. 103.

⁷ Swartz, Sally, "'Work of Mercy and Necessity: British Rule and Psychiatric Practice in the Cape Colony, 1891 – 1910", *International Journal of Mental Health*, 28, 2, 1999, pg. 86.

⁸ Swanson, Felicity, "'Of Unsound Mind': A History of Three Eastern Cape Mental Institutions, 1975 – 1910", Unpublished MA Thesis, University of Cape Town, 1994, pg., 134.

extra tobacco and food rations.⁹ These are, however, only guidelines: in the Grahamstown Asylum, as an examination of some patient case files will show, exactly who worked and what work they did occurred under a regime more flexible than the one Swanson has outlined.

Work formed part of the therapeutic regime in Cape asylums from their inception, along with pleasant surroundings and an adequate diet.¹⁰ The same was true in asylums of the British Raj,¹¹ the Australian territories,¹² and of British asylums. In the nineteenth century, the ability to undertake remunerative work was considered the *sine qua non* of adulthood,¹³ and the ability to work was seen as both a sign of mental improvement and an important part of an individual's self-esteem.¹⁴ Asylum work was seen as something that could occupy the patient's mind, distracting them from delusions and obsessions, as well as providing a potential avenue of occupation for patients once they were discharged and, before then, contributing to the asylum's upkeep.¹⁵

John Conolly's seminal asylum design text, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, published in 1847, noted that "among the means of relieving patients from the monotony of an asylum, and of preserving the bodily health and at the same time of improving the condition of the mind, and promoting recovery."¹⁶ Simply put, Conolly believed that women who worked in kitchens, laundries and wards and men who worked in gardens and farms recovered.¹⁷ Under Conolly's schema, patients were not to be made to work against their will, do one kind of work when they preferred another, and be made out as indolent when they were too sick to work.¹⁸ Coercion would remove the

⁹ Swanson, "Of Unsound Mind", pg. 134.

¹⁰ Swartz, Sally, "The Black Insane in the Cape, 1891 – 1920", *Journal of Southern African Studies*, 21, 3, 1995,, pg. 401.

¹¹ Ernst, Waltraud, "Idioms of Madness and Colonial Boundaries: the Case of the European and 'Native' Mentally Ill in Early Nineteenth-Century British India", *Comparative Studies in Society and History*, 39, 1, 1997, pg. 168.

¹² Malcolm, Elizabeth, "Australian Asylum Architecture Through German Eyes: Kew, Melbourne, 1867", *Health and History*, 11, 1, 2009, pg. 53.

¹³ Carol L. Huffine and John A. Clausen, "Madness and Work: Short- and Long-Term Effects of Mental Illness on Occupational Careers," *Social Forces*, Volume 57, Issue 4, 1 June 1979, pg. 1049.

¹⁴ Huffine and Clausen, "Madness and Work", pg. 1050.

¹⁵ Steven Cherry and Roger Munting, "'Exercise is the Thing'? Sport and the Asylum c.1850-1950," *The International Journal of the History of Sport*, 22,1, 2005, pg. 45.

¹⁶ John Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* (London, 1847), pg. 77.

¹⁷ Conolly, *Construction and Government*, pg. 79.

¹⁸ Conolly, *Construction and Government*, pg. 80.

therapeutic benefit of work. Although we do not know how closely the Asylum adhered to Conolly's advice, Conolly was not an outlier and it is highly probable that his views were typical. They were certainly influential.

Each patient's case file in the Grahamstown Asylum contained extensive notes on their progress and mental state during their time in the Asylum. Given that many nineteenth-century psychiatrists believed that work was therapeutic and in some cases also brought income to the Asylum, it is not surprising that the case files make frequent mention of the work patients' undertook – and, oddly, seldom make mention of recreational activities, which might also reasonably be considered therapeutic. By examining a few patient case files, all belonging to adult white men admitted to the Asylum between 1882 and 1905 (thereby keeping the variables to a minimum), some patterns in the allocation and requirements for work can be discerned.

For example, Petrus G.¹⁹ was a non-paying patient admitted in 1882. His former occupation as a schoolteacher apparently had no usefulness inside the Asylum; nor, indeed, was Petrus really able to teach, given the perceived extent of his mental instability. Nevertheless, this did not render him unfit for all work, and he was put to work as a servant for one of the Asylum's male attendants. By 1894, the examining physician noted that he was "always happy and interested in his work". This involved fairly basic menial tasks such as making beds and dusting in the men's wards. Petrus G entered the Asylum aged 23; by the age of 67 he was still working, and throughout the intervening period he was evidently happily and constantly employed, even though his case notes repeatedly describe him as "silly" and "demented". Evidently, regardless of his mental state, as long as he was physically capable and willing to work, he was assigned tasks.

By contrast, Arthur H.,²⁰ admitted in 1892, only went to work two years after he was admitted to the Asylum; until then he had been judged too recalcitrant and unpredictable to be put to work. An early note in his file states that he was "blistered" to prevent masturbation. This caused some degree of physical discomfort and may have therefore impeded his ability to

¹⁹ ME 01, Patient File of Petrus G.

²⁰ ME 08, Patient File of Arthur H.

work,²¹ not to mention probably also having an adverse effect on his willingness to co-operate with Asylum authorities. Only by 1897 did his case notes begin mention of Arthur H. doing any work. Unlike Petrus G., he was noted to be of little use as a worker, though he did go daily to the coir-picking room. (Given that coir-picking is a job so unpleasant and tedious that in the 19th century it was often usually carried out by prisoners, it is perhaps unsurprising that Arthur H. did not throw himself into it with enthusiasm.)

Sometimes patients evidently did little but work; Pietro B.,²² an Italian immigrant who battled to communicate with other patients and Asylum staff due to language barriers, was admitted in 1900 and by 1908 was described as “the best worker in the place.” The nature of the work he undertook is not noted in the file. This description appeared to hold true until 1933 or so, by which time Pietro’s productivity had dropped off, unsurprisingly, given that by that time he was aged 72 and had been living in the Asylum’s confines for upwards of 30 years.

It should be noted at this point that all of these men were inside a closed institution, and although they were members of a relatively privileged group – white males - within the Asylum, they were still under the Asylum’s control. If it had been a hard and fast rule that all able-bodied men and women had to work, then there might have been no chance that these men could have avoided being assigned to one or another work detail. There would have been no element of choice in the matter. However, not all unpaying men did work, despite Swanson’s contention that they did, and this might suggest that at the Grahamstown Asylum, white inmates were only made to work in instances where the Asylum’s authorities believed that it would be therapeutic to them.

John McG,²³ Thomas T.²⁴ and Juan C.²⁵ all had, at best, patchy employment records inside the Asylum. John McG, for example, set the tone for his stay in the Asylum by violently attacking an attendant, and did not mellow appreciably until 1905. Five years after admission, John was

²¹ In most nineteenth-century hospitals, patients who compulsively masturbated were often punished in some way, or at least restrained. Blistering the hands or the penis was one way of physically preventing masturbation.

²² ME 35, Patient File of Pietro B.

²³ ME 29, Patient File of John McG.

²⁴ ME 30, Patient File of Thomas T.

²⁵ ME 38, Patient File of Juan C.

finally noted to be engaged in a little bit of ward work – though, evidently, he carried it out somewhat reluctantly. The role of John’s disorder is evident throughout his case notes, especially in regards to the effect it had on his ability to work. In August 1907, the attending physician stated that John was confused and “lost”, as well as a little delusional but still worked a little. Two years later, his condition had deteriorated to the point what he could do “practically nothing” (except that he was apparently able to initiate an escape from a walking party and get as far as the Drostdy Arch, about 2km away in distance. He was also engaged in writing “fantastic” letters to the Asylum’s Medical Superintendent.) By 1915, however, his condition had deteriorated to the point where he had ceased to do anything productive, and spent his days standing in the sun unoccupied.

Like John McG., Thomas T.²⁶ had an Asylum employment history that combined being inclined to work with being disinclined to try very hard at it – and there is, as with John McG., little evidence in the case notes that he was at any time coerced to work. Thomas T. was admitted to the Asylum in 1900, aged around 40, having spent several years in Valkenberg. He had no family in the Colony, and was, like John McG., a non-paying patient. His Grahamstown Asylum records note that although he worked in the coir-picking room between 1901 and 1907, he was virtually idle. After a period of inactivity in 1908, he began to “go out” with a working party, suggesting that he was then engaged in outdoor work, although even there, according to the file notes, he was not particularly productive. Sometime after 1913, he ceased to work entirely, preferring to spend his days walking around or sitting idly. Whether or not he was allowed to be idle at this point, when he would have been in his 50s, is unclear from the notes, but there is a specific reference in late 1922 to the effect that he categorically “refused to be employed”.

Juan C.²⁷ was a non-paying patient, an Argentinian man who had ended up in the Grahamstown Asylum aged 25 in 1900 after a frankly impressive run of bad luck including being left behind by his ship, and who had, furthermore, a problematic relation to Asylum authorities and work. Juan’s case notes, perhaps unsurprisingly, make repeated mention of his habit of destroying Asylum property and also, even less surprisingly, his unintelligibility. Given that his first language was probably Argentinian Spanish rather than the Castilian with which

²⁶ ME 30, Patient File of Thomas T.

²⁷ ME 38, Patient File of Juan C.

Asylum authorities might conceivably have been familiar, and the fact that he was profoundly disturbed (his diagnosis in 1900 is listed as Dementia Praecox: Hebephrenia), it is hardly likely that Asylum authorities understood what he was saying even when he was at his most lucid. All the same, he was put to work polishing floors, but only in 1905 – prior to that, he had been in restraints after several escape attempts. Although he had been apparently quite happy to work once he had begun to do so, he was not greatly productive – a note from 1908 states that he often went to sleep over his work, and repeated notes by the attending physician in 1909, 1915 and 1920 observe that he was in fact incapable of carrying out complex tasks.

The patient files of non-paying (i.e. state-funded) white men who entered the Asylum would seem to indicate that although they were encouraged to undertake work – ward chores, coir-picking, heavy cleaning and outdoor work – they were not forced to work when they did not wish to do so, and furthermore they were not made to work when their disorders were acute. It was the practice in British asylums to put patients to work once they were over the worst of their instability; Cape asylum practice was modelled closely on British systems.²⁸

Paying patients in the Grahamstown Asylum, however, did work on the inside, even though they did not technically have to, since the fees they (or their sponsors) paid covered their contribution to the Asylum's running costs. Norman Stanley O.,²⁹ who paid £36 a year in fees, entered the Asylum in 1894 and almost immediately he was noted to be usefully employed on the garden work detail, and an enthusiastic participant in games. It is telling that there is very little mention of any recreation at all other than walking parties in the files of non-paying patients. In 1897, Norman was stated in the notes to be doing "occasional" work but mostly "amus[ing] himself and others in the Billiard Room"; the majority of references to Asylum work in Norman's file state that he worked in the gardens, although by 1913 he was occasionally doing some clerical work for the Head Attendant. However, Norman O. is something of an exception; Cornelius W.³⁰, who paid £91 a year, undertook the same work as the non-paying men already discussed – ward work, garden work, and cleaning, when he worked at all. There does not appear to have been a correlation between payment status and work, at least among white patients.

²⁸ Swartz Sally, "'Work of Mercy and Necessity: British Rule and Psychiatric Practice in the Cape Colony, 1891 – 1910", *International Journal of Mental Health*, 28, 2, 1999, pg. 73.

²⁹ ME 09, Patient File of Norman Stanley O.

³⁰ ME 12, Patient File of Cornelius F.

Frederick G.,³¹ however, categorically did not work for most of his time in the Asylum, for reasons that had little to do with the £152 a year he paid in fees. Throughout the notes in his file, attending physicians repeatedly state that Frederick's use of foul language and "revolting habits" made him very difficult to deal with; also evidently giving attendants and doctors pause were his insistence on consorting with black patients,³² an escape attempt in June 1900 where he was at large overnight and was eventually apprehended on the Peddie road, several kilometres away over rough terrain, and an occasion in January 1900 when he was discovered in bed with another male patient. Given that he was evidently a severely troubled man by the criteria of Asylum authorities, it is not surprising that whether or not he undertook to work was rather less of a concern than his instability and unpredictability. Nevertheless, by 1908, he was noted to be doing some work, although what it consisted of is not stated.

Clearly then, based on the above-mentioned case files of some white men admitted in the later 19th and early 20th century, Asylum authorities did not assign work equally, and did not require all patients to work. Work, as already mentioned, was thought to play a therapeutic role quite separate from, but twinned with, the economic advantages it brought to the Asylum. Norman O., Cornelius W., and Frederick G. were not *required* to contribute to their upkeep in the Asylum, being fee-paying patients. Petrus G., Pietro B., John McG, and Juan C. definitely might have been required to sing for their supper, but evidently were not. Nevertheless, there did not seem to be very much difference between the patterns of work among white paying male patients and unpaying ones. This could well indicate that there was more emphasis on the therapeutic role of work within the philosophy of moral treatment as it was applied to white patients.

As Swanson notes, for white paying patients, the Grahamstown Asylum experience was more like that of a convalescent home³³ - therefore it is not particularly surprising that they worked whether or not they were in fact required to: it aided in their convalescence, at least theoretically. The presence of white paying patients in the Asylum, and the need to continue

³¹ ME 38, Patient File of Frederick G.

³² That he was able to do this would in fact suggest that segregation on the grounds of racial classification inside the Asylum was not particularly rigid, at least outdoors, or that some patients knew ways to circumvent it.

³³ Swanson, "'Of Unsound Mind', pg. 133.

admitting more, meant that the basic standard of care at Grahamstown was better across the board for all patients – regardless of racial or class classification - than it was at, for example, Fort Beaufort Asylum.³⁴ This may explain why the unpaying white patients discussed above were not made to work if they refused to do so.

Du Plessis notes that photographs of inmates of the Asylum, at least those taken for public consumption, constructed the idea that black men and women inside the Asylum were put to work in order to mould them into biddable workers. He further contends that, especially for black patients, work was a crucial part of the process of effecting cure and recovery.³⁵ As will be discussed at more length in the next section of this chapter, black patients, particularly black men, were not included in the recreational activities planned for white and especially wealthier white patients, leaving work to be their sole form of occupation. Photographs of black men in the Asylum show no signs of comfort in their surroundings or of anything other than a stark regime of work and rest in between periods of work. This lack of recreation, with inevitable attendant boredom and weariness, combined with the relatively Spartan surroundings of the black patients' wards, no doubt had some notable impact on the relatively low rates of recovery and high mortality rates among black patients.³⁶

Work inside the Asylum seems to have been clearly delineated across lines of race and gender. As early as 1875, men in the Asylum were employed in chopping wood, while women were given needlework.³⁷ When the laundry was built in 1877, although it was also intended to provide the Asylum with a small income, its primary purpose was to provide employment for some of the Asylum's more violent female patients, in order to distract them from causing mischief and damage elsewhere in the Asylum.³⁸ The Asylum gardens employed those male

³⁴ Swanson, "Of Unsound Mind", pg. 143.

³⁵ Du Plessis, Rory, "'Photographs from the Grahamstown Lunatic Asylum, South Africa, 1890–1907,'" *Social Dynamics*, 40, 1, 2014, pg. 13.

³⁶ A comprehensive discussion of these photographs, which were not used for this thesis, may be found in Rory Du Plessis's salutary article, referenced above, as well as his more recent "'Beyond a clinical narrative: casebook photographs from the Grahamstown Lunatic Asylum, c. 1890s,'" which can be found in *Critical Arts*, 29, 1, 2015.

³⁷ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report of the Surgeon Superintendent of the Grahamstown Asylum for 1875*, CCP1/2/1/29, G21-'76, Western Cape Archives and Records Service, Cape Town, pg. 2.

³⁸ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report of the Surgeon Superintendent of the Grahamstown Asylum for 1877, together with the Report of the Visiting Committee to that Institution for the same period*, CCP1/2/1/35, G24-'78, Western Cape Archives and

patients who could be trusted not to abscond if allowed outdoors without intense surveillance by attendants.³⁹

Clearly, then, the Asylum implemented a gendered division of labour even in its early days. Paying patients were not required to work unless they wished to. Anecdotal evidence contained in reports of the various accidents and deaths in the Asylum suggest that while white patients, particularly men, did work, the majority of the work done by patients at the Asylum was carried out by black patients, both men and women. More skilled work was done by white male patients - for example, assisting the artisan attendants in making minor changes and improvements to the Asylum buildings⁴⁰ - while manual labour seemingly remained the province of black male patients. As Greenlees noted when discussing the transfer of black patients to the new asylum at Fort Beaufort, most physical labour in the Cape Colony was carried out by "natives", so transferring them to another asylum, although he was definitely in favour of it, would deprive the Grahamstown Asylum of many of its labourers.

In 1875, three men engaged in work in the Asylum were made to chop wood; one of these men was white and two were black; another white man was made to assist in the Asylum's stores.⁴¹ An equal number of men were unemployed – one black male patient "avoided" work by escaping from the asylum, while another three (two white and one black) were excused because they were "affected by excitement", and one white patient because he was a "better-class patient."⁴²

Records Service, Cape Town, pg. 2. One does wonder at the wisdom of putting allegedly violent patients in a room with boiling water, lye and caustic soda, but as no laundry-room mishaps are reported, it is likely that their "violence" was overestimated.

³⁹ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report on the Grahamstown Lunatic Asylum for 1878*, CCP1/2/1/39, G31-'79, Western Cape Archives and Records Service, Cape Town, pg. 20; Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report on the Grahamstown Lunatic Asylum for 1879*, CCP1/2/1/43, G53-'80, Western Cape Archives and Records Service, Cape Town", pg. 2.

⁴⁰ T. Duncan Greenlees, "Part 6: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1890, part VI: Grahamstown Asylum and Chronic Sick Hospital*, CCP1/2/1/79, G37-'91, Western Cape Archives and Records Service, Cape Town, pg. 43.

⁴¹ Hullah, "Grahamstown Asylum 1875", pg. 11.

⁴² *Ibid.*

Meanwhile, white female patients were employed, in four cases, in sewing, and three others assisted on the wards; three others did not work, being either too old, or affected by excitement.⁴³ The output of the four women engaged in sewing bears mention: 405 articles were produced, mostly of fairly straightforward items such as mattress covers, hand- and neck-kerchiefs and pillowcases, but also including women's dresses, nightgowns, and petticoats.⁴⁴ Only one of the women inside the Asylum had been a seamstress before entering the hospital,⁴⁵ although most others would have had at least some proficiency in sewing, due to needlework being both a household skill and a form of recreation among women of the time. Among the male patients, none had previously been employed as a woodsman or a clerk. Obviously, then, there had been no move to place patients in modes of work in which they had previous experience, but instead patients were given work according to what needed to be done or what was thought to be beneficial to them. It is possible that the relative simplicity of the work that Asylum authorities wanted done meant that there was no need to get skilled patients to do it. In these reports, no mention is made of the income derived from patients' work, and evidently the wood and the sewn items were used in-house rather than sold.

After 1875, the Annual Reports did not include much detailed information on the nature of work undertaken by the Asylum's patients except to detail the amount of needlework done by the female patients.⁴⁶

In 1891, 79% of men were "employed usefully", compared to 63% of women;⁴⁷ these percentages remained high in 1892. The tables printed thereafter only list work according to gender: 67% of men and 57% of women were usefully employed. 1893 saw 59% of men and 59% of women, 1894 65% and 74%, and in 1896, 65% of men and 78% of women. In 1900, the Grahamstown Asylum Annual Report recorded that 65% of male patients and 53% of female patients were usefully employed, making up 61% of the total Asylum population. These proportions remained steady through the early 1900s, dropping slightly by 1905, at which

⁴³ Hullah, "Grahamstown Asylum 1875", pg. 12.

⁴⁴ Hullah, "Grahamstown Asylum 1875", pg. 13.

⁴⁵ Hullah, "Grahamstown Asylum 1875", pg. 6.

⁴⁶ Hullah, "Grahamstown Asylum 1879", pg. 17-18.

⁴⁷ T. Duncan Greenlees, "Part 6: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1891, part VI: Grahamstown Asylum and Chronic Sick Hospital*, CCP1/2/1/82, G36-'92, Western Cape Archives and Records Service, Cape Town, pg. 42.

point 58.4% of men and 48.9% of women were employed, only 53.4% of the Asylum's total population. The reason behind the tabulation of these figures was to indicate which proportion of the Asylum's population was engaged in work, and more specifically, work that had a "useful" application, doing something that the Asylum needed done. The redemptive quality of work may also have meant that the Asylum's authorities wished to make it clear that the men and women in their charge were engaged in activities which would lead to the improvement of their mental states.

Because the Annual Reports only divide their statistics on work by gender and do not detail the exact types of work undertaken by each group, it is not possible to get a particularly comprehensive picture of work inside the Asylum. Given that asylums generally did not double as money-making institutions but did need to be as economical as possible, the types and amount of work undertaken were most likely only those which could be explained as therapeutic, with any income derived being appreciated but generally incidental. One exception to this may have been the work done on the Asylum farm: the evident importance to the Asylum of the money this saved suggests that although its therapeutic side effects were appreciated, they were subordinated by the need to complete large tasks, such as weeding or harvesting.

Also quite obvious is that not all patients were made to engage in work; typically around a third of the Asylum's patient body were not employed, whether because they were somehow unfit for work or because of physical infirmity or severity of mental symptoms – or because, as paying patients, they were not obliged to do so. Quite why the upper classes were exempt from work inside the Asylum is not clear, but it may be because most upper-class Victorians had inherited wealth and did not work for a living as a rule. Conolly states that patients of "better class" were not to be made to work,⁴⁸ but this alone does not explain much.

That work was required to form part of the therapeutic regimen at asylums that followed, even broadly, the tenets of moral treatment is inarguable. That inmate work provided income to asylums and kept costs down is also inarguable. In the Grahamstown Asylum, these two strands interwove to create an environment where all inmates were encouraged to undertake

⁴⁸ Conolly, *Construction and Government*, pg. 82.

work of some kind, but only some – those of lower status, i.e. black patients – were obliged to do so. This further indicates that not only was the Grahamstown Asylum physically segregated, but also segregated in terms of what was expected of, and for, the patients. There were, basically, two worlds within the Asylum: one for white patients, which resembled an asylum providing care and kind treatment, and the one for black patients, which was rather more of a place of confinement and exploitation. The latter supported the former in many important ways – black patients undertook much of the heavy Asylum work and, as discussed in Chapter One, lived in inferior accommodations while the available Asylum funds were earmarked to improve conditions in the wards that housed white patients.

One final note on the nature of work in the Asylum, and asylums in general, is necessary: there is, no real incentive to try to excel at asylum work. Goffman notes that in the world outside asylums, the relationship between the employer and the employee is limited: the employer's authority usually ends when the employee leaves the place of employment and does not extend to what the employee does with the payment they are given for their labour.⁴⁹ In asylums, the employee does not leave at the end of the day, and they are hardly free to go spend their money on whatever they wish to, if they are paid at all. Moreover, the inmate's meals, accommodation and sundry needs are taken care of, and are not contingent upon them making a payment from whatever they might earn from Asylum work.⁵⁰ Therefore, the asylum can only offer a trifling, unattractive incentive to work in the form of small, often largely token benefits like an increased tobacco ration or a small increase in privileges.⁵¹ Work inside the asylum only materially benefits the asylum, and in the case of the Grahamstown Asylum, the practice of putting men on "working parties" on extra rations (discussed later in this chapter) only served to camouflage this reality; the food was not payment or even really a benefit, but a tacit acknowledgement that harder work required better nutrition. That the Asylum authorities were unconcerned with forcing white patients to work when they did not wish to suggests that the work, in itself, was unimportant when compared to the therapeutic benefits it conferred; if the patient in question would not benefit, they were not made to work. That this concession was not given to black patients suggests that the Asylum authorities felt differently about them, and were less concerned with their wellbeing and recovery than they

⁴⁹ Goffman, Erving, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York, 1961), pg. 20.

⁵⁰ Goffman, *Asylums*, pg. 20.

⁵¹ *Ibid.*

were about that of white patients. It also suggests that blacks, whether institutionalised or not, belonged to the labouring class in the Colony's social and racial hierarchy.

“This Entire Change from the Monotony”: Entertainment and Recreational Activities in the Grahamstown Asylum

Recreation formed an integral part of asylum life; the therapeutic purpose of asylums espousing moral treatment meant that having an asylum in the first place was pointless if life there was characterised by boredom and isolation.⁵² Indeed, recreation was believed to be an integral part of the Asylum's commitment to improve the lives of their patients; Conolly noted that attendants had to pay special attention to getting patients out for exercise.⁵³

However, as discussed at length elsewhere, overcrowding and lack of space plagued the ability of Asylum staff to provide much entertainment – providing recreational activities indoors meant that some spaces, usually the larger ones such as dining halls or day rooms, had to double up in purpose.⁵⁴ Holding a dance or a games evening required clearing out the room in which it was to be held, then putting it back to rights afterwards; often this also required employing extra staff outside of their usual working hours, with no overtime.⁵⁵

However, despite the considerable inconvenience they occasioned, recreational activities such as dances usually went ahead in any case, and – indoor or outdoor – were one of the most important ways in which asylum life linked back to the way life was lived outside. It was also one of the more important points of contact between the asylum population and the society outside the asylum's walls.⁵⁶ Because of the ever-present pressure on asylum finances, any entertainments that could not be provided for free by attendants had to be provided by volunteers from the outside world. Fund-raising by volunteers on the outside of the Asylum in aid of the Asylum contributed to its Recreation Fund. An advertisement for a concert of

⁵² Dolly McKinnon, “Divine Service, Music, Sport and Recreation as Medicinal in Australian Asylums, 1860s-1945,” *Health and History*, 11, 1 2009, pg. 128.

⁵³ Conolly, *Construction and Government*, pg.

⁵⁴ McKinnon, “Divine Service”, pg. 128.

⁵⁵ McKinnon, “Divine Service”, pg. 136.

⁵⁶ McKinnon, “Divine Service”, pg. 131.

classical music in the *Graham's Town Journal* for 17 October 1884⁵⁷ indicates that seats cost 2s 6d for reserved seating, 1s 6d for unreserved seating, and a "family ticket", admitting five people, could be had for 10s. The proceeds, which may have been in excess of £20, were to go to the Asylum's Recreation Fund.

However, although some of the Asylum's more stable paying patients may have attended this concert, it was a recreational activity intended for the Asylum's benefit but not its residents. Even inside the Asylum, recreations were very seldom intended to include the institution's entire population⁵⁸ - just as in the world outside, some activities were deemed more suitable for one group of people (in the case of sport, men) than for others.⁵⁹ Also, the resources required to supply recreation had to be drawn from a pool of finances that was usually spread thinly to begin with, so recreation was also often reserved for only those deemed most deserving, or for those who could pay. This was certainly the case in the Grahamstown Asylum, in which the provision of entertainment in the period under discussion was certainly divided by race and gender, as well as by class.

In 1876, the first full year of the Grahamstown Asylum's existence, a piano and harmonium were purchased with the funds that the "ladies of Grahamstown" had raised by holding a collection and a dance in town; this dance and another one had in fact been attended by some patients from the Asylum.⁶⁰ It was more likely that the patients allowed to attend entertainments held outside the Asylum grounds were only those whom the Asylum authorities trusted to behave appropriately – the Medical Superintendent's report does indeed note that the chosen patients "conducted themselves well".⁶¹ In evidence here is the Asylum's need to create and maintain a positive public image – the patients allowed to attend had been selected from the ranks of those inside the Asylum, and presumably had been chosen on the grounds that they would, firstly, behave themselves in an appropriate manner, and, secondly, would appreciate being at a dance. From these criteria we might surmise that only patients of a "better class" were allowed out to these dances. The Asylum took care that

⁵⁷ *Graham's Town Journal*, 10 October 1884.

⁵⁸ McKinnon, "Divine Service", pg. 138.

⁵⁹ McKinnon, "Divine Service", pg. 133.

⁶⁰ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report of the Surgeon Superintendent of the Grahamstown Asylum for 1876*, CCP1/2/1/33, G22-'77, Western Cape Archives and Records Service, Cape Town, pg. 2.

⁶¹ Hullah, "Grahamstown Asylums 1876", pg. 2.

its ambassadors would be lunatics whose appearance and behaviour would be palatable to the charitable ladies of the town.

Possibly to get around the problem of selecting patients to attend public events, and more likely to do with keeping costs down, in the Asylum's early years entertainments were held at the Asylum rather than in town. In 1877, the Grahamstown Recreation Society performed Byron's *£100 000*, one of several entertainments in the year,⁶² while the same company performed two plays inside the Asylum in 1878.⁶³ Also in 1878, the nucleus of an asylum library was established with papers and books sent to the Asylum by "friends in England as well as in the Colony", while at the New Year a Christmas tree and some kind of slideshow were given,⁶⁴ a pattern repeated in 1879, along with the performance of a musical by the pupils of a Grahamstown music teacher.⁶⁵ As was the case with the performers of the Grahamstown Recreation Society, Hullah includes a note in the Report, thanking the actors for their "kindness in thus coming for patients' amusement."⁶⁶ Evidently at this time there was little entertainment provided by the Asylum itself beyond a little music, and no distinction between who could or could not attend the entertainments was mentioned. Given Hullah's concern, discussed in a previous chapter, with keeping violent and impolite patients away from the public eye, and his disdain for these patients, it is reasonable to assume that these events could only be attended by certain, well-behaved, respectable patients.

In 1880 again, some patients attended entertainments in town in addition to the ones held at the Asylum. Hullah noted here for the first time that the Asylum had no dedicated space in which to hold entertainments, as it was slated to be provided for by temporarily clearing two wards, which would, because of the demand for asylum accommodation already discussed, be occupied directly upon completion.⁶⁷ This pattern continued, with entertainments being restricted to music and the odd picnic or entertainment in town; in 1887, Hullah noted that the Queen's Jubilee had been celebrated in the Asylum with a holiday and "an extra good

⁶² Hullah, "Grahamstown Asylum for 1877", pg. 2.

⁶³ Hullah, "Grahamstown Asylum 1878", pg. 2.

⁶⁴ Hullah, "Grahamstown Asylum 1878", pg. 3.

⁶⁵ Hullah, "Grahamstown Asylum 1879", pg. 2.

⁶⁶ *Ibid.*

⁶⁷ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report on the Grahamstown Lunatic Asylum for 1880*, CCP1/2/1/39, G31-'81, Western Cape Archives and Records Service, Cape Town, pg. 5.

dinner as at Christmas".⁶⁸ Flower Sunday, an annual event in which teachers and scholars from Grahamstown's Sunday Schools distributed bouquets to Asylum patients, was described by Hullah as being "a kindly and pleasing custom, as it shows the patients that they are not utterly forgotten. Indeed," he added, "the public generally is extremely liberal to the patients."⁶⁹ Entertainment other than basic musical divertissements at this stage seem to have been largely in the hands of volunteers from Grahamstown's cultural groups: the Recreation Society, the Cape Mounted Rifles' band, and the 1st City Volunteers' Band, all of which performed for free. The picnics and in-town excursions may or may not have been arranged by outside parties; payment and costs are never mentioned. Also not mentioned in the Annual Reports written by Robert Hullah is exactly who attended these entertainments; no specific groups are mentioned as being included or excluded.

With the arrival of T Duncan Greenlees in late 1890, however, the record becomes more detailed. He notes in his first year of charge that,

[D]ances, dramatic entertainments, concerts, magic lantern entertainments, 'sociable evenings' and cricket comprise our chief methods of amusing and entertaining our patients, and I am about to introduce croquet and lawn-tennis for women.⁷⁰

With an eye to expansion and improvement that would become typical, Greenlees goes on to point out that "A hall, large enough to hold associated entertainments, is urgently required, for it is well-recognised that amusements form an important factor in the treatment of the insane."⁷¹ He also mentioned that the "rudimentary library" was to be expanded, which he believed to be important, because by reading patients were kept in touch with events outside the Asylum.⁷² The maintenance of links between the Asylum world and the one outside was a constant feature of the Asylum's entertainment programme, which present a constant rota of members of the public entering and members of the Asylum exiting its confines, albeit under a

⁶⁸ Robert Hullah, "Part VI: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1887*, CCP1/2/1/71, G15-'88, Western Cape Archives and Records Service, Cape Town, pg. 18.

⁶⁹ Robert Hullah, "Part 6: Grahamstown Asylum and Chronic Sick Hospital", in *Annexures to the Votes and Proceedings of the House of Assembly. Reports of the Colonial Medical Committee, the Vaccine Officer and on Government and Public Hospitals and Asylums for 1888*, CCP1/2/1/73, G5-'89, Western Cape Archives and Records Service, Cape Town, pg. 19.

⁷⁰ Greenlees, "Grahamstown Asylum 1890", pg. 43.

⁷¹ Greenlees, "Grahamstown Asylum 1890", pg. 44.

⁷² *Ibid.*

fairly strict set of rules. However, once again, exclusivity is evident: Greenlees does not say so directly, but the list of amusements in the quote above suggest that only patients of a better class and good behaviour were present at these events. Croquet, lawn tennis and cricket are all games which require a prior knowledge of the rules and the use of equipment; they are also games in which only a limited number of players can participate at one time. Those who can participate are limited by both whether they have any prior knowledge of how the game is played, and the time available in which to play. Both of these could become grounds for exclusion, and it is fairly unlikely that participation in sports was “equal opportunity”.

Traffic between the outside community and the world of the Asylum does however seem to have been fairly frequent: in 1891, dances were held weekly and fortnightly, “magic lantern entertainments”, and concerts and picnics were arranged. The Asylum cricket team had played several matches against visiting teams on the Asylum’s own pitch, which, Greenlees wrote, made “our grounds look quite bright and cheerful with visitors, patients and cricketers.”⁷³ The same report noted that “an number of patients have on frequent occasions been allowed to attend entertainments in Grahamstown, which they appreciate very much, the sight of fresh surroundings and new faces giving variety to their otherwise monotonous lives.”⁷⁴

There are two particularly interesting things about Greenlees’ statement regarding the entertainments he described. Firstly, by naming “visitors, patients and cricketers” separately, it is not clear whether or not patients were on the cricket team, which may have included male attendants and almost certainly did not include many black players. Secondly, the phrase “a number of patients” suggests fairly clearly that not all patients had been afforded the opportunity to enjoy entertainments. It makes sense that patients who were liable to be violent or disruptive would not have been allowed into town; although this of course does not exclude all black patients from entertainment in town, it is nevertheless likely that there were both racial and social distinctions among the Asylum’s amusements. The classical concert of 1884 mentioned above would have been unofficially off limits to the black residents of Grahamstown, in conformity with the norms of social segregation; it is entirely consistent that it would have been likewise a no-go area for black lunatics.

⁷³ Greenlees, “Grahamstown Asylum 1891”, pg. 40.

⁷⁴ *Ibid.*

In 1893, Greenlees listed several additions to the entertainments held at the Asylum: as well as the “sociables”, concerts, dances, sports and so on, a “nigger troupe” [sic] called the Fort England Nightingales had been formed. Several of the private (paying) patients had also been frequently allowed to go for drives, presumably in a carriage, around Grahamstown. Excursions to Port Alfred had also been made three times that year, about which Greenlees became quite enthusiastic:

This entire change from the monotony of the Asylum life, the sight of the ever-changing ocean, and the sea breeze are all conducive to and invigorating to both the mental and physical health. I would advocate the renting of a house at Port Alfred for a few months every year so as to enable me to extend this useful and health-giving plan.⁷⁵

Although there is no direct mention of exactly which group would have been eligible for this seaside vacation, it could be determined from context that probably it was mostly private patients who would have benefited. Renting a house, even at off-season prices, would have been an additional expense, and, given the primacy of providing funds for food and daily living-costs, it was a luxury outlay which had to be carefully weighed up as necessary by a permanently cash-strapped institution. A house could also presumably not have accommodated more than eight or ten patients, which, given the Asylum’s population, would have meant that some sort of prioritisation applied; there were also staffing considerations, as a chaperone or attendant would have had to be present as well. It seems that only those patients who were thought to be of sufficiently good prognosis to benefit from a change of scenery would go, as well as those paying enough to be considered for special treatment. By 1896, it seemed to have become practice to send only convalescent and paying patients to the house at Port Alfred.⁷⁶ The various groups of patients were, of course, provided with different forms of accommodation, meals and entertainment at the Asylum.

⁷⁵ T. Duncan Greenlees, “Part 6: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1892*, CCP1/2/1/84, G17-’93, Western Cape Archives and Records Service, Cape Town”, pg. 18.

⁷⁶ T. Duncan Greenlees, “Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1896, part VI: Grahamstown Asylum*, CCP1/2/1/101, G20-’87, Western Cape Archives and Records Service, Cape Town”, pg. 6.

By 1893, the lack of a dedicated space to hold recreational activities at the Asylum was making itself felt, as Greenlees once again mentioned, noting that entertainments were “an important factor in our treatment”, and that efforts to hold them in whatever space was available were greatly inconvenient. His own house was “thrown open week after week for the patients’ dances, and in wet weather this is not conducive to my own personal comfort, while, when the nights are dark, occasionally an escape occurs that creates much anxiety.”⁷⁷

Greenlees was diffident about the establishment of an Asylum library, especially if it was going to be, as he appeared to assume, a poorly-stocked one. “The average asylum library,” he noted disdainfully, “usually consists of old three-volume novels, and an excessive number of depressingly religious works.”⁷⁸ Instead of such a limited library, the Grahamstown Asylum possessed a number of novels which the staff would lend to such patients as were thought able to appreciate them, and illustrated newspapers were constantly being sent to the wards. Consequently, Greenlees did not feel the lack of a library was particularly serious.⁷⁹ It would also seem that Greenlees and, perhaps also the attendants, thought that books should only be issued to inmates who they believed would benefit from it; evidently not all patients, even those who were literate, were deemed to be able to ‘appreciate’ a book. This is further evidence that considerable favouritism was at play in the Asylum’s provision of recreational materials, namely that they were only supplied to inmates that staff considered to be deserving of them. Access to reading material may also, therefore, have been used to provide an inducement to good behaviour or co-operation from some patients.

In his report for 1894,⁸⁰ Greenlees states that the recreation hall had been built, with concomitant increases in the amount of diversions that the Asylum staff could supply for the

⁷⁷ T. Duncan Greenlees, “Part 6: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1893, part VI: Grahamstown Asylum*, CCP1/2/1/89, G24-’94, Western Cape Archives and Records Service, Cape Town, pg. 50. The Medical Superintendent lived some distance from the Asylum proper, almost three miles away.

⁷⁸ Greenlees, “Grahamstown Asylum 1893”, pg. 50. One assumes that he believed that the Asylum’s readers would not have *wanted* to trawl through such publications. As he had previous experience in British asylums, we might assume that he had first-hand experience of what such libraries could be like and the consequent lack of interest displayed in them by inmates.

⁷⁹ *Ibid.*

⁸⁰ T. Duncan Greenlees, “Part 14: Grahamstown Asylum and Chronic Sick Hospital”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and*

inmates. He proudly noted that “Hardly a day passes but something or other is ‘on’, and our resources are often put to the test to introduce new and varied means of amusement.”⁸¹ It does seem, therefore, that all white patients received the same access to entertainments held at the Asylum itself, except for the aforementioned carriage drives, which were restricted to private patients. However, the exact nature of these entertainments differed according to the racial group to which they were offered. Whether or not all patients took advantage of the amusements is not clear.⁸²

The range of entertainments on offer increased in 1898: there were 24 separate special entertainments held, in addition to the usual weekly dances; this was the year of the Grahamstown Exhibition. The Exhibition Orchestra performed at the Asylum, while some patients attended the public entertainments held in Grahamstown proper. During 1898, many of the means of entertaining patients were arranged in-house: an Asylum band made up of attendants had been formed and was improving, while the Asylum staff were active in producing musical and dramatic entertainments for the patients.

Greenlees was supportive of these new developments: given that staff worked long hours and had limited spare time. He was grateful that the nurses and attendants who participated were so much willing to sacrifice time to rehearsals: “I would,” he wrote, “express my thanks to the various members of my staff for thus unselfishly assisting in providing enjoyable entertainments for my patients.”⁸³ Football and cricket clubs in the Asylum evidently also participated fully in the local leagues, joined by a nurses’ tennis club in 1902.⁸⁴ Some of the players on the football teams were attendants,⁸⁵ and no patients participated in matches

Asylums and Report of the Inspector of Asylums for 1894, part VI: Grahamstown Asylum, CCP1/2/1/92, G16-’95, Western Cape Archives and Records Service, Cape Town, pg. 61.

⁸¹ Greenlees, “Grahamstown Asylum 1894”, pg. 62.

⁸² Greenlees, “Grahamstown Asylum 1896”, pg. 6.

⁸³ T. Duncan Greenlees, “Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital”, *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1898, part VI: Grahamstown Asylum*, CCP1/2/1/108, G21-’99, Western Cape Archives and Records Service, Cape Town, pg. 5.

⁸⁴ T Duncan Greenlees, “Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital”, *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and of the Inspector of Asylums for 1902*, CCP1/2/1/123, G60-’03, Western Cape Archives and Records Service, Cape Town, pg. 106.

⁸⁵ T. Duncan Greenlees, “Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital”, *Annexures to the Votes and Proceedings of the House of Assembly. Reports on*

against visiting teams. In 1899, Greenlees finally agreed to the establishment of an Asylum library by purchasing 500 books with the plan of increasing the Asylum's holdings by £5 worth of books each year, thereby building up a collection of both classic and modern texts which would be accessible to staff and patients alike.⁸⁶ Again, I would point out here that building a library does not benefit those patients who are not literate, and in this case, given the societal context of the 19th century Cape Colony, it is more than likely that few of the Asylum's black patients would have benefited much from the expenditure on the library.

In 1905, Greenlees noted that entertainments, because they broke the monotony of the highly regimented Asylum lifestyle for staff and patients alike, were thereby important therapeutic agents.⁸⁷ There was, however, a degree of differentiation between the quality of entertainments experienced by different groups inside the Asylum, which the 1905 Annual Report, unusually, makes clear. Private patients received twice-daily drives around the Asylum's location.⁸⁸ This practice had evidently drawn some kind of criticism, probably on the grounds of extravagance – a horse and carriage had to be maintained by the Asylum, along with, possibly, a driver, and the patients had to be accompanied by an attendant, making the rides a considerable outlay of time and effort. Greenlees admits that,

It may be considered by some an extravagant, and even an unnecessary, luxury, giving drives to Asylum patients, [but] the Government should recollect the profits made out of these patients...In all well-managed Asylums, where private patients are kept in large numbers, carriage drives form part of the routine treatment, for they are certainly of great benefits, and held to give relief from the monotony of Asylum life.⁸⁹

The record of entertainments held inside the Asylum is notable for two things: the consistency with which they were reported despite their predictability – the frequency and form of entertainments did not vary much from year to year, occasional deviations aside – and the

the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1899, part VI: Grahamstown Asylum, CCP1/2/1/112, G25-'00, Western Cape Archives and Records Service, Cape Town, pg. 4.

⁸⁶ Greenlees, "Grahamstown Asylum 1899", pg. 4

⁸⁷ T Duncan Greenlees, "Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital", *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and of the Inspector of Asylums for 1905, CCP1/2/1/137, G32-'06, Western Cape Archives and Records Service, Cape Town, pg. 73.*

⁸⁸ Greenlees, "Grahamstown Asylum 1905", pg. 73

⁸⁹ *Ibid.*

way in which the only divisions amongst patients that receive mention in these sections of the Reports are those referring to paying versus unpaying patients.

Unlike the sections of the Annual Reports that dealt with the food and living conditions within the Asylum, the entertainment reports usually make specific references only to paying patients, most likely because only paying patients were thought to warrant special consideration with regards to the activities provided for their amusement. Most patients, it would seem from the wording of the Annual Reports, could attend whichever entertainments were held, except those such as carriage rides and trips to the seaside, which were reserved for patients of better means. In reality, evidently, this was true only of *white* patients. In the 1896 Annual Report, Greenlees, while describing the year's entertainments, wrote that,

“The amusements – both in and outdoor – continue as varied as possible. Besides the regular weekly dance, on fifteen occasions during the year special entertainment was provided for the amusement of the patients. These included concerts, lantern and dramatic entertainments, the circus, and picnics, *and, for the native patients, a dance is held in the hall every [?] months* [my italics].”⁹⁰

This is the only mention of the fact that separate amusements were held for black and white patients. Segregation was the norm in most other aspects of Asylum life, so it is unlikely that entertainment would have been subject to a different set of rules?.

Furthermore, entertainment was provided differently for paying and non-paying patients, and evidently, to some degree, different for male and female patients, particularly in the case of sports. The cricket and football teams were exclusively male, whether staff or patient, all of which were white, at least according to surviving team photographs.⁹¹ The tennis teams were exclusively female and white. (These profiles may not have been peculiar to the Asylum). Although the exact composition of the groups of patients engaged in croquet, quoits, and similar activities are not recorded, one may further assume that there was unlikely to have been a majority of black players. (It is also likely that fewer black patients engaged in sport, as more were made to work, and thus less time would have been set aside for them to engage in recreational activities.) Given that paying patients received more varied entertainment than

⁹⁰ Greenlees, “Grahamstown Asylum 1896”, pg. 4.

⁹¹ These are in the possession of Fort England Hospital, Grahamstown, and are not open to the public.

their non-paying counterparts – or at least, that more effort was put into their recreational programme by asylum authorities – it seems more likely than not that there was indeed individual patients' access to entertainment depended on their place in the Asylum's hierarchy.

On the whole, the provision of entertainment in the Asylum did in fact follow the general rules of life on the outside – that is, well outside the bounds of the total institution: paying patients received the most access to and the most varied forms of entertainment, which might also have been the most complex, involving the expenditure of considerable resources and effort. Unpaying patients did not receive as much of a variety or as complex forms of entertainment, and evidently black patients did not receive the same form, frequency or quality of entertainment as did the white Asylum population. This proves that entertainment in the asylum fell into patterns typical of colonial institutions, with white, relatively wealthy patients receiving better treatment and therefore being afforded higher status than relatively poorer white, or black, patients.

“Suited to Their Requirements and Habits”: Food in the Grahamstown Asylum

Food, and the provision and preparation of food, is one of the least glamorous but most ubiquitous aspects of any part of society, and yet it quite often, in asylum-related literature, seems to be of secondary importance to factors such as living space. Any long-term gathering of people – whether a permanent institution, temporary refugee camp, professional conference or military post - will, sooner or later, need to be fed, repeatedly. The elements of any meal are affected by time and location: the availability of ingredients depends on what any particular location can access, which in turn is affected by trade and supply networks, themselves dependent on both local and foreign conditions; the same is true of food supplied grown locally. As a result, what any group of people eats while living in a particular location depends on which foodstuffs they can most easily access, and ease of access depends as much on place as it does on price. From the range of foodstuffs that are for sale, only some will be affordable; of those, only some will be preferred, and this latter holds true of locally-produced foods. It is from the list of foods that are both available and favoured that menus must be compiled. In an institution, the shape of the diet dispensed to staff and residents is further influenced by the number of people that have to be catered for, the type of cooking facilities that are available, and what the group or groups of people being catered for are thought to

want to eat or, perhaps most importantly for the purposes of this study, what they are thought to want to eat. This is an equally valid problem for small households, of course, but the challenges multiply exponentially as the number of people to be catered for increases. Between financial constraints, limited preparation equipment and skills, the need to plan ahead and, to a lesser degree, food availability and, less easily defined, what people do and do not habitually eat, it is not entirely surprising that many institutional diets become repetitive and rather dull.

The Grahamstown Asylum's dietary scale was no exception, as T Duncan Greenlees noted in 1898: "It is not conducive to the appetite to know that on Monday one kind of dinner is provided, and on Tuesday another kind."⁹² The unavoidability of having some kind of repetition did not, however, daunt Greenlees, who upon his appointment as Medical Superintendent in 1890 immediately set about amending the patients' diet; he believed that the type of food asylum inmates ate, apart from being simply fuel for the body, was an important element of treatment. Although the constituents of the patients' diet in use before 1890 are not recorded, Greenlees determined that they included too much "animal matter" (he appears to have meant meat, rather than butter, cheese or milk), and therefore reduced the amount of meat and filled in the gaps with more vegetables and "farinaceous ingredients" (apparently bread, rice and puddings). This made the diet more varied, and evidently to his mind less detrimental to patients' health and wellbeing.⁹³ It was also cheaper, and would become still more economical once the Asylum began to produce a sufficient amount of vegetables, meat and milk upon its own estate.⁹⁴

The kinds of foodstuffs making a regular appearance on Asylum plates can be deduced from a brief examination of tenders that the Civil Commissioner for Albany placed periodically in the *Graham's Town Journal*, usually in a prominent position on the front page. On 22 October 1875, the Civil Commissioner placed the first call for tenders for "Groceries, Provisions, Sundries and Scavenger Work" for the "Lunatic Asylum, Grahamstown".⁹⁵ All subsequent tenders would follow the same format: the supplies the Asylum needed were listed in each categorically, alphabetically, and both the quantity and precise nature of the product were

⁹² Greenlees, "Grahamstown Asylum 1898," pg. 4.

⁹³ Greenlees, "Grahamstown Asylum 1890", pg. 43.

⁹⁴ *Ibid.*

⁹⁵ *Graham's Town Journal*, 22 October 1875.

stated. Among the groceries the Asylum required soon after opening were arrowroot (which was also used for treating indigestion), beans, barley and butter, coffee, curry powder, flour and meal, mustard, oatmeal, split peas, pepper, rice, raisins, salt, sago (tapioca), and tea. Provisions included beef and beef suet (with an allowance for bone mass), white and brown bread, fresh eggs, milk, mutton, pork, potatoes and fresh vegetables. That the exact vegetables needed are not specified suggests both that the menu was flexible and dependent on seasonal availability.

It is possible to extrapolate, from this list of ingredients, that tea and coffee played as important a role in the smooth running of Asylums as it does in most institutions, and that at least a token attempt to provide flavoured food was made: salt, pepper, mustard and the rather unexpected curry powder (unexpected because curry does not feature much in institutional cooking of this time; see the coming discussion of the Asylum's diet scales). Beans, barley and split peas suggest soups or thickened stews; flour and meal being purchased separately from bread, and raisins, are strong indicators that boiled puddings made an appearance now and then; suet suggests that some of these, at least, were made with a fairly rich suet crust. However, there is no mention of syrup or jam, suggesting that sugar was rare and the diet was weighted towards bland foods.

On the other hand, a very particular approach to meat is indicated by the tender's insistence that butchers provide meat in certain cuts: "beef and mutton sent as fore- and hindquarters, not necks, hocks or shins"; it was also said that the pork provision was not to include heads and feet. The preparation of meat in the Asylum, then, seems to be inclined towards roasted or stewed meats, with rather more of the former. Roasting and stewing are easier to do on a large scale than frying, and need less attention from the cook, less equipment, and fewer ingredients – a fire, some water and some sort of metal receptacle are all that is required.

Most surprising of all, however, in the dietary shopping list, is that it includes a startling amount of liquor: brandy, both French and Boer, Cape sherry and dry Pontac wine are all listed. Some of this may have been used for medicinal purposes, or as a reward for work, but it is also likely that much of it was consumed by staff, who ate their meals on the premises,

rather than with patients. Oatmeal,⁹⁶ milk⁹⁷ and both fresh and salted butter, as well as fresh pork, were added to the list by subsequent tenders later in November 1875. While the addition of oatmeal suggests an expansion of the breakfast menu and perhaps an attempt to extend stews or soups by bulking them out with starch, the repeated requests for milk and pork suggest that the Asylum staff found that the original suppliers had provided unsuitable amounts or quality.

The weekly requirements of the Asylum kitchens remained fairly static until 1885, when a supply of fresh fish was requested.⁹⁸ In 1886, also, the list of alcoholic beverages required by the Asylum was expanded to include “Hollands Gin”, English ale and English porter.⁹⁹ “Souchoung” [sic] tea, pearl barley and Maizena also appeared on the tender list for the first time. The tea that had been provided to the patients and staff until then was, presumably, Indian tea. Interestingly, while vegetables are on this grocery list, they are marked as being required for the Chronic Sick Hospital only; by this time, the Asylum farm garden was evidently producing enough for the Asylum’s requirements.

Other additions to the Asylum’s list of provisions indicate an expanding palate: hop beer, soda water, lemonade, ginger beer and ginger ale in 1890,¹⁰⁰ as well as dry yellow sugar. In 1891, baking powder, candied lemon peel, cinnamon, essence of lemon, mealie meal, brown rice, mixed spice, goat meat, sheep’s heads and necks, Colonial draught ale, and beef extract were added to the list of requisitions.¹⁰¹ While candied peel and spices in addition to flour and shortening may have been the ingredients for cake, they were more likely intended for the ubiquitous boiled puddings; although cake did appear from time to time, it was not a frequent item on the menu. The soft drinks and beer are also worth noting; if one looks at dietary scales produced a handful of years later, there is no space on the menu for anything like ginger ale, let alone beer or indeed any of the alcoholic beverages mentioned on these lists. Also, there were some menu items that the Chronic Sick Hospital’s patients received but which were denied to Asylum patients: cocoa, hops beer, and cheese in particular.¹⁰² Indeed,

⁹⁶ *Graham’s Town Journal*, 10 November 1875.

⁹⁷ *Graham’s Town Journal*, 5 November 1875.

⁹⁸ *Graham’s Town Journal*, 6 October 1885.

⁹⁹ *Graham’s Town Journal*, 22 April 1886.

¹⁰⁰ *Graham’s Town Journal*, 10 April 1890.

¹⁰¹ *Graham’s Town Journal*, 12 May 1891.

¹⁰² *Graham’s Town Journal*, 9 April 1889.

the Asylum's diet was rather heavily weighted towards starchy foods – rice, potatoes, flour-based puddings, porridges and bread - and mid-quality meat, with relatively little dairy, and fairly small amounts of fresh vegetables. Although this was not a menu lacking in nutritious value, it seems to be rather underwhelming in terms of variety and flavour.

The dietary scale in use before 1899 comprised almost entirely of foods purchased rather than grown or otherwise produced by the Asylum. "Provisions and necessities" routinely made up one of the Asylum's highest expenditures: £268 in 1875, £1296 in 1876, £2446 in 1878, and £2691 in 1880, continuing to increase each year until 1890, when £3412 was spent on "provisions". In the 1890s, however, the expenditure decreased: £2916 in 1891, £2670 in 1892, £2509 in 1893, before rising to £3276 in 1896 and then to £4452 in 1899. Some of this increase is undoubtedly the result of economic inflation and the rising Asylum population. For much of its early history, however, the Asylum's finances simply had to absorb the cost of food, although a garden had been established as early as 1875. Hullah wrote in that year's Annual Report that he hoped that "great economy will result in the vegetable contract, if indeed it is not found that the whole of the vegetables required can be grown on the Asylum grounds."¹⁰³ But the garden did not make a difference to expenditure much before 1878, due to a drought in the area.

In 1878, however, the garden, which was worked by patients, produced sufficient vegetables to supply the patients' diets for several months.¹⁰⁴ (Because they were not mentioned, this suggests that attendants and nurses were already on a separate menu and therefore received different – possibly better – food than did patients. After all, attendants seldom needed to be kept away from foods that might "inflamm[e] their sensibilities"). The garden was quite extensive: six morgen¹⁰⁵ were under cultivation, producing potatoes and tobacco, as well as a small amount of fruit.¹⁰⁶ A horse and cart had been purchased, which would enable more ground to be put under cultivation, if more land was available. Hullah was much in favour of purchasing land around the Asylum as it came up for sale: "At present," he wrote in 1879,

¹⁰³ Hullah, *Grahamstown Asylum 1876*, pg. 2.

¹⁰⁴ Robert Hullah, *Annexures to the Votes and Proceedings of the House of Assembly: Report of the Surgeon Superintendent of the Grahamstown Asylum for 1876*, CCP1/2/1/33, G22-'77, Western Cape Archives and Records Service, Cape Town, pg. 2.

¹⁰⁵ 12 acres, 4.8 hectares, or 0.04856km².

¹⁰⁶ Hullah, *Grahamstown Lunatic Asylum 1879*, pg. 2.

The Asylum estate is much too small for our requirements. We are surrounded and hampered by private individuals and market gardeners whose proximity to an Asylum must be a discomfort to them, as it is frequently an annoyance to us.¹⁰⁷

Evidently living next door to an asylum aroused in the neighbours a certain degree of apprehension which may have had as much to do with competition for land and water as it did with whatever 'nimbyism'¹⁰⁸ existed (although indications of the nature of relations between the town and the Asylum are not accorded much attention in the Annual Reports, there does seem to be some evidence that whatever relationship existed was civil and that the townspeople were charitable but not exactly enthusiastic about the Asylum). The consistently constrained financial state of the Asylum meant that becoming as self-sufficient as possible would free up funds to be used elsewhere – especially, given the constant need for more living room, for new construction. Given the Asylum's situation relative to Grahamstown, which had spread to surround Fort England's previously isolated location, there were constraints preventing the Asylum from expanding physically without coming into contact – or competition – with other parties who wanted the land. Therefore, expanding the Asylum's gardens was both preferable and a wise course of action, but also one fraught with difficulties.

By 1892, however, under Greenlees' oversight, the Asylum's farm had become well-established and quite productive, and was expanding.¹⁰⁹ Land had been purchased, providing grazing for cows, which Greenlees wanted to acquire in order to offset the Asylum's considerable milk bill; he also wanted to set up a henhouse to augment the egg supply.¹¹⁰ Ever practical, Greenlees noted that he did not see why cows and chickens would not prove quite profitable for the Asylum, given that they did not have to pay rent for the land and had free labour.¹¹¹ The cows were indeed purchased, and supplied £42 worth of milk that year. Pigs, worth £34, were also purchased for the Asylum's farm, and brought in more than £40 worth of pork and bacon, which was sold at a profit. Pork, evidently, was for the most part sold, with

¹⁰⁷ Hullah, *Grahamstown Lunatic Asylum 1880*, pg. 41.

¹⁰⁸ "Nimbyism", from "Nimby", a person who objects to the siting of unpleasant developments in their neighbourhood. (Judy Pearsall (ed.), *The Concise Oxford English Dictionary*, Tenth Edition, Revised (Oxford, 2002), pg. 963.)

¹⁰⁹ Greenlees, "Grahamstown Asylum 1882", pg. 18.

¹¹⁰ *Ibid.*

¹¹¹ *Ibid.*

relatively little being consumed inside the Asylum except in slaughtering season.¹¹² The income from this was used to offset some of the Asylum's expenses.

By 1893, the Asylum gardens and farm were producing potatoes, peas, mealies, other kinds of green vegetables, as well as oranges and other fruit, including strawberries (which provided revenue of £4 10s in 1892¹¹³ and £26 7s 6d in 1893).¹¹⁴ Tobacco was also produced in some quantity; like most of the vegetable produce, milk, and eggs, this was used by the Asylum, and the resulting saving was used to offset expenditure.

The farm continued to be profitable throughout 1892; by 1894, the milk production had increased to the point where Greenlees felt that he would soon be able to cancel the milk supply contract from a Grahamstown dairy,¹¹⁵ while £56 had been made from the sale of pork and bacon. Three acres of land were added to the farm in 1895; in 1896, the farm made a profit of just over £118, in addition to providing £67 worth of milk,¹¹⁶ despite the drought that began that year and continued into 1897, in which year the harvest was so poor that Greenlees reported that even the seed potatoes had failed.¹¹⁷ At the same time, ever on the lookout for opportunities to push his agenda of self-sufficiency, he wrote that an asylum needed one acre per head to be self-supporting (that would be 4047m²), currently had 30 acres, and needed 370. In 1897, he wrote,

Steady increase in the Asylum demands the early consideration of the purchase of more land for agricultural purposes and I regret that the Government have, on several occasions recently, neglected to secure valuable property in this neighbourhood.”¹¹⁸

¹¹² Greenlees, “Grahamstown Asylum 1893”, pg. 53.

¹¹³ Greenlees, “Grahamstown Asylum 1892”, pg. 19.

¹¹⁴ Greenlees, “Grahamstown Asylum 1893”, pg. 53.

¹¹⁵ Greenlees, “Grahamstown Asylum 1894”, pg. 65.

¹¹⁶ Greenlees, “Grahamstown Asylum 1896”, pg. 6.

¹¹⁷ T. Duncan Greenlees, “Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital”, *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1898, part VI: Grahamstown Asylum*, CCP1/2/1/108, G21-’99, Western Cape Archives and Records Service, Cape Town, pg. 7.

¹¹⁸ Greenlees, “Grahamstown Asylum 1898”, pg. 7.

This was not looking likely as the 19th century drew to a close in the throes of a severe drought and the beginnings of the South African War. In 1899, the farm had only just broken even,¹¹⁹ and in 1900 incurred a £67 loss. Cultivation continued, however, because as Greenlees pointed out, the provision of fruit and vegetables to the Asylum, was only its secondary purpose; primarily, he said, the farm was intended to provide labour – thus productive activity, thus therapy and cure – to patients.¹²⁰ Although this seems fairly unequivocal, it nevertheless seems to be at odds with what was reported as significant about the farm. Greenlees' preoccupation with securing private patients and finding cost effective ways to provide food to the Asylum appear to be two sides of the same coin – to run it on the model of a business rather than a government-subsidised institution

For all the attention paid to producing vegetables and expanding the gardens, the diets as outlined by the Medical Superintendent in 1902 do not seem to be overly loaded with vegetables. The dietary scaled submitted to the Inspector of Asylum office by Greenlees in that year had been in use since about 1890,¹²¹ and had not been amended since then except as a “result of experience in the practical working of them”.¹²² In his letter to the Inspector of Asylums, Greenlees explains that in the scales he had sent improvements had been factored in without increasing the cost. He further explained that the large number of different menus contained within the scales was the inevitable result of having black and white patients, paying and non-paying patients, and staff, all of which needed to be separately provided for.¹²³

¹¹⁹ T. Duncan Greenlees, “Part 2 Section 1: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital”, *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1899, part VI: Grahamstown Asylum*, CCP1/2/1/112, G25-'00, Western Cape Archives and Records Service, Cape Town, pg. 7.

¹²⁰ T. Duncan Greenlees, “Part 3: Grahamstown Asylum, Institute for Imbecile Children, and the Chronic Sick Hospital”, *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1900, part VI: Grahamstown Asylum*, CCP1/2/1/115, G41-'01, Western Cape Archives and Records Service, Cape Town, pg. 82.

¹²¹ author unknown, (presumed T. Duncan Greenlees), *Grahamstown Asylum Dietary Scale 1902*, CO 7955, G49B, Western Cape Archives and Records Repository, Cape Town.

¹²² *Ibid.*

¹²³ However, will be seen, all of these diets were fairly similar, and the dietary scales laid out for each group's different meal plans make for fairly repetitive reading. This suggests that the *idea* of separate menus was as important as the practice.

Upon implementing the changes he had made to the Grahamstown Asylum's patient menus in 1890, Greenlees had observed that the "Native" patients evidently had different requirements to the white patients; accordingly, he changed the content of the native patients' dinner three nights a week to one which he believed to be "more suited to their requirements and habits."¹²⁴ This had made for a diet that was both more economical and "satisfactory". Apart from this, the introduction of a fish dinner once a fortnight in 1899¹²⁵ was the only change to the diet noted in the Annual Reports before Greenlees submitted the dietary scales for inspection in 1902. To be fair, Greenlees was well aware that the diet was dull and repetitive, or at least would become so, and regretted it: he twice mentioned the need to vary diets, in 1891 stating that since there were no real rules for "dieting the insane."¹²⁶ He was able to vary the diet from time to time; in 1898, he stated that sometimes a different meal was prepared as a surprise for the patients, adding that "such variations in the menu are much appreciated by them."¹²⁷

Notwithstanding such occasional variations, the overall monotony of the Asylum diet was unrelieved. Although, as Greenlees noted to the Inspector of Asylums, there was a fair amount of differentiation between black, white, paying, and non-paying patients, each of these diets were in and of themselves quite boring (the amount of variety increased according to the fee each patients paid, with pauper patients receiving basic scale and paying patients receiving more varied meals). Three meals a day were supplied – breakfast, tea and dinner – as well as supper, which was only supplied to those paying patients who "sat up" at night.

Breakfast was the same across all groups: a pint of coffee and bread. The bread varied across gender and race: men received 250g of bread and women 170g, while black patients received brown bread, and only obtained a butter ration if they were paying towards their maintenance.¹²⁸ As this only became possible in 1902, it can be assumed that dry bread for breakfast was the norm for black patients until then. White paying patients received porridge and milk as well as bread and coffee; those paying more than 3s a day also received an egg or another extra, such as bacon. The tea time menu was much the same: white and black

¹²⁴ Greenlees, "Grahamstown Asylum 1891", pg. 39.

¹²⁵ Greenlees, "Grahamstown Asylum 1899", pg. 3.

¹²⁶ Greenlees, "Grahamstown Asylum 1891", pg. 39.

¹²⁷ Greenlees, "Grahamstown Asylum 1899", pg. 4.

¹²⁸ CO 7955, G49B.

patients got a pint of tea and 170g of bread, with whites also getting 14g of butter. Jam, syrup or 56g of cheese were occasionally dispensed in lieu of butter, and cake was issued instead of bread on Thursdays. Paying white patients also received an egg, tinned meat, or sardines. Two of the day's three meals, therefore, consisted of a hot beverage (neither milk nor sugar is mentioned) and bread, and sometimes, for some people, butter.

Attendants had somewhat better, or at least had more varied, meals than patients did. Although their basic breakfast was the same as that for patients – coffee, bread and butter – attendants received extras unavailable to all but the highest-paying patients. Breakfast extras for attendants included eggs, mutton chops, sardines, salmon, bacon, steak or jam, jelly or syrup, as well as porridge and milk if they wished. At a glance, then, attendants had better food than most white patients, let alone most black patients. Tea, at least, was the same as that issued to white patients. Memos attached to this dietary scale indicated that day staff were served early coffee (sweetened with sugar and condensed milk), while night staff were issued extra coffee, milk and sugar.

Although this particular version of the dietary scale apparently did not contain the menu for European patients' dinners as supplied *circa* 1902, it did lay out the plan for "native" dinners, presumably including the adjustments Greenlees had made in 1891. Meat and vegetables made up three dinners a week: roast beef, Irish stew, and meat pie. Mealie meal, dripping, and syrup were served twice a week, soup and bread once, and currant pudding once. Only on Sundays did pudding follow the basic meal. This scale does not distinguish between paying and non-paying black patients as the breakfast and tea scales did.

An idea of what white patients, paying and non-paying, ate for dinner can be gleaned from another dietary scale preserved alongside the one already mentioned; although it is not precisely dated, it probably dates from between 1891 and 1906.¹²⁹ In this scale, meat and vegetables were served to white patients every day of the week: roast beef, Irish stew, meat pie and curry, accompanied by soup on three days; fish could be had instead of Irish stew on Fridays. Pudding accompanied the meal on four days of the week. On this scale, unpaying

¹²⁹ On this scale, paying and non-paying native patients diets are much like those described in the scale already discussed; likewise the attendants' diets.

white patients received the same as their paying counterparts, but without the pudding or bread.

What is indicated on this scale rather than the other is the degree to which working black patients received more and better food than non-working ones. On Tuesdays and Thursdays, those black males who were on work detail received the same dinner as pauper/unpaying white males, but those who were not received mealie meal, sugar, and “fat” (presumably this meant dripping or butter, as the provision of unflavoured fat would have only made this meal duller). This is congruent with the amounts laid out in the first dietary scale, which also noted that women engaged in laundry work were issued with extra bread, tea and condensed milk (or rather, the head laundress was issued with these rations, which she then dispensed over the week). Tobacco was only issued to working patients, at a rate of 170g a week.

There was, therefore, a distinct but minor difference between the meals received by black and white patients and paying and non-paying patients. The one major dietary difference that can be unequivocally attributed to perceived racial differences was the substitution of mealie-meal on Tuesdays and Thursdays. Most of the other differences might be explained more readily as the results of attempts to economise; even the introduction of maize meal was noted to have been cheaper as well as in keeping with perceived racial preferences.

It should be remembered that most black patients were non-paying; Indeed, almost all were admitted as pauper patients before 1902. Proportionately more white patients were paying patients; indeed, Dodds in the Inspector of Asylums report for 1896 stated quite baldly that “Coloured patients...should be more economically provided for than white patients”¹³⁰ in order to keep costs down in the Colonial asylum system. A confluence of racism, racial stereotyping, and the ever-present pressure to cut every corner that could safely be cut led to the compilation of dietary scales that led to black patients, paying or not, having a bland and less nutritious set of meals.

¹³⁰ WJ Dodds, “Part 8: Report of the Inspector of Asylums for the year ending 31st December 1896”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1896, part VI: Grahamstown Asylum*, CCP1/2/1/101, G20-’87, Western Cape Archives and Records Service, Cape Town, pg. 79.

Despite being rather repetitive, the diet scale in place at the Grahamstown Asylum was fairly diverse, at least in terms of ingredients if not finished dishes. On a list of foods the Asylum would need to feed its residents for a period of 12 days, approximately 52 separate foods are listed; these became only about 12 finished dishes. This list did not itemise different cuts of meat or types of vegetables separately. The amounts of variety a patients' diet contained, of course, depended on what they paid; the quantity of the food they received was likewise on something of a sliding scale. Commenting on the dietary scale submitted to his office by Greenlees in 1902, Dodds suggested that the "native diet" be re-arranged to include more fat, substitute mealie meal for bread one breakfast a week, replace roasted meat with boiled or stewed meat (this would mean that tougher cuts, which were cheaper, could be used) and that the amount of vegetables be reduced on Sundays; he also suggested replacing meat pie and currant pudding dinners with "stamped mielies" and potatoes. Keeping costs down seemed to occupy his mind considerably; even in relation to the paying white patients' breakfast. He criticised the proposed allowance of 2 oz of sugar, saying that 1/2 oz should be enough (mysteriously adding, as an aside, that he was "especially astonished that a member of the Caledonian Society should propose it"),¹³¹ and also advising that the milk ration be reduced.

To be fair to Dodds and Greenlees, prices of basic provisions were rising in the 1890s and early 1900s, and almost every Inspector of Asylums report for in that period contains at least one sentence explaining that the high daily maintenance rate was the result of Colonial prices being higher, overall, than those in England. Indeed, prices were not standard between different regions of the country, which meant that even with efforts to standardise, asylums seldom paid the same price for the same item.

Compared to some other Cape asylums and those of the English county system, the Grahamstown Asylum did not pay unusually high prices. Tables given in the Inspector of Asylums reports in the 1890s list the prices of around 16 items evidently in common use at the Colony's five manor asylums, comparing them to the English price for the same item. The first

¹³¹ This may be a reference to the stereotypically pecuniary nature of Scots; Greenlees had Scots antecedents.

such table, published in 1893,¹³² comprehensively illustrates that, for most items, Colonial prices were higher – beef was cheaper (at £1 4s 11d in the Cape, but £1 17s in England), but all the other items listed came in as more expensive, most notably sugar, soap and coal; coal, in particular, cost £2 5s per 90kg in the Colony, but only 14s in England. Sugar cost £1 5s 9d per 45kg in the Colony, but only 15s 7d in England. By 1894, this had narrowed to 15s 7d in England and between 26s and 23s per 45kg in the Colonial Asylums.)¹³³

Considering that by 1902 the Grahamstown Asylum was using 371kg of white sugar and 86kg of brown sugar over a 12-day period, high sugar prices amounted to a considerable expenditure. Bread, milk, tea, coffee and butter were also used in considerable quantities: almost 1950kg of white bread and 907kg of brown bread were used every 12 days at the Grahamstown Asylum by 1902, as well as 43kg of tea, 99kg of coffee, and 136kg of butter (the amount of milk used over 12 days is not recorded, possibly because it varied). In 1901, at Grahamstown Asylum, 45kg of white bread cost 15s 6d, brown bread 13s 6d, milk was 4½d per 1.13 litres (one quart), tea and coffee were £4 10s and £3 5d per 45kg respectively, and butter was £6 15s per 45kg.¹³⁴

By comparison, Valkenberg Asylum paid 14s 3d for white and 10s for brown bread, £6 for butter, nothing for milk, £4 17s for tea and £3 10s for coffee. In England, bread cost 9s 2d, butter £4 7s 6d, coffee £4 10s 8d, and tea a whopping £7 3s 6d; the price of milk was not given, but it averaged 2½d for a quart.¹³⁵ Therefore the “white” asylums of Grahamstown and Valkenberg paid largely the same price for these items (sugar, however, was much more expensive in Grahamstown than in Cape Town, where Valkenberg was situated: £1 3s 6d at Grahamstown, but only 19s 9d at Valkenberg; the British price per 45kg was even cheaper:

¹³² WJ Dodds, “Part 18: Report of the Inspector of Asylums”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1893, part VI: Grahamstown Asylum*, CCP1/2/1/89, G24-’94, Western Cape Archives and Records Service, Cape Town, pg. 141.

¹³³ WJ Dodds, “Part 19: Report of the Inspector of Asylums”, in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Public Hospitals and Asylums and Report of the Inspector of Asylums for 1894, part VI: Grahamstown Asylum*, CCP1/2/1/92, G16-’95, Western Cape Archives and Records Service, Cape Town, pg. 158.

¹³⁴ WJ Dodds, “Part 2 Section 1: Report of the Inspector of Asylums” in *Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1901, part VI: Grahamstown Asylum*, CCP1/2/1/118, G70-’02, Western Cape Archives and Records Service, Cape Town, pg. 73.

¹³⁵ Dodds, “Inspector of Asylums 1901”, pg. 73.

12s 9d.) It seems that Dodds repeated protestations that he could not further reduce the daily maintenance rate of the Coloured asylums because of the high cost of articles in the Colony relative to those in the United Kingdom held true.

Also, inevitably, inflation caused prices to rise. The increasing costs of provisions and consequently increased expenditure in the Asylum have already been mentioned. Food made up the bulk of items categorised as “provisions”. Therefore the changing cost of food and the increasingly large amounts of it that were needed to keep the Asylum population fed, certainly weighed on the Medical Superintendent’s mind. This is evidenced by the detailed reports on the production of the Asylum’s farm and the equally painstaking calculations that accompanied the dietary scales compiled by Greenlees.

Between 1890 and 1900, the black patient population of the Grahamstown Asylum increased. Although many black patients were transferred to the asylum at Fort Beaufort and did not remain at the Grahamstown Asylum, the increase – coupled with the probability that most of these would not have been paying patients – would, to the eyes of Dodds and Greenlees alike, have presented an economic challenge. How were costs to be kept down if the number of non-paying patients kept increasing? The result was separate dietary scales for paying and non-paying patients, white patients, and black patients. These divisions also converged neatly with the Asylum management’s inchoate racism and racial stereotyping.

The most notable feature of this separation of diets according to economic and racial divisions was the heavy prevalence of mealie meal and maize samp in the “native” diets, along with the inclusion of brown rather than white bread. The scale of quantities provided with Greenlees’ 1902 dietary scales lists mealie meal and maize samp separately from maize. We might assume that mealie meal porridge, too, was reserved for black patients’ meals, as oatmeal is listed in similar quantities and was the usual basis for porridge in England and Scotland. By the early 1900s, the Asylum was purchasing 119kg of mealie meal to use over 12 days, an increase from 32kg in earlier years. The amount of oatmeal had remained about the same, dropping from 97kg to 92kg. Mealie samp consumption rose from 138kg to 308kg. However, on the same list of quantities, brown bread consumption dropped from 1180kg to 746kg; this would square with Dodds’ suggestion that mealie meal be substituted for bread in the native

breakfasts, and that black patients who did not work should receive mealie samp three times a week.

There are concurrent reductions in the consumption of beef and mutton: beef sides dropped from 1341lb to 1022lb, beef legs from 19 to eight (legs), and beef shins from 19 to 8 (shins); mutton consumption dropped from 1219lb to 1128lb. These may have resulted from the fact that relatively fewer people were receiving meat at meals. In the case of beef consumption, at least, reduced consumption might also be linked to rising prices: 45kg of beef in 1894 cost 22s 6d at the Grahamstown Asylum, but this had risen to £1 2s in 1895,¹³⁶ £1 10s in 1896, £2 10s 3d in 1898,¹³⁷ and £2 5s 10d in 1901.¹³⁸ Even with the slight drop in price, beef nevertheless remained one of the most expensive standard-issue items on the Asylum menu (butter, cheese and bacon were more expensive, but were not issued to everyone and were not used every day). Mutton, the only other meat on the dietary scale, spiked in price between 1896 and 1898, going from a relatively steady £1 12s 6d for 45kg in 1896 to £3 5s in 1898, before declining to £2 1s 8d in 1901.

Under these circumstances, it made economic sense to serve meat as selectively as possible, while retaining some semblance of a balanced and/or palatable diet. Butter, being similarly an expensive item, was likewise restricted to the wealthier elements of the Asylum population. The scale of quantities already mentioned also includes a small amount of sausages, presumably pork – 55lb. As sausages appear on the menu only at breakfast and then only as an extra for paying patients and attendants, we can assume that too were fairly expensive or difficult to obtain.

Although the relationship between the need to economise and the subsequent dietary short-changing of the Asylum's black patients is fairly clear, another aspect of the Asylum's dietary practice was the supplying of extras to patients who were considered to be of higher status. Partly this may have resulted from the obligation to provide better food for paying patients,

¹³⁶ Dodds, "Inspector of Asylums 1896", pg. 133.

¹³⁷ WJ Dodds, Part 2 Section 1: Report of the Inspector of Asylums" in Annexures to the Votes and Proceedings of the House of Assembly. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1898, part VI: Grahamstown Asylum, CCP1/2/1/118, G70-'02, Western Cape Archives and Records Service, Cape Town, pg. 139.

¹³⁸ Dodds, "Inspector of Asylums 1901", pg. 73.

and it may also have been part of the Asylum's quest to make itself more attractive option for paying patients.

Conclusion

The Grahamstown Asylum is still in operation today. It is possible to go to Grahamstown, find any high point in town, and pick out the hospital's red tile roofs among the trees on the south side. Formally segregated in 1908, the institution, now known as Fort England Hospital, was desegregated only in the 1990s, when South Africa's democratic transition began, and now operates as a public psychiatric facility with a rehabilitation centre, a maximum-security forensic unit, and counselling services available alongside inpatient treatment and outpatient programmes. Certain things remain the same: the patients are still under the authority of the staff, who operate in a strict hierarchy; patients sleep in dormitories, eat together, and engage in activities meant to provide therapy through occupation. They are not free to come and go as they please. They are still, in some ways, vulnerable to the staff and the preconceptions and prejudices those staff carry. The modern South African medical landscape is now made up of a relatively underfunded and under-resourced public health system and a rather better-resourced private healthcare industry; the institution now known as Fort England Hospital operates in the former sphere, in straightened circumstances. This too echoes the financial situation of the later nineteenth and early twentieth century, but instead of the poor and the rich sharing a campus, they are now relegated to quite different locations. Funding in the public sphere is meagre; infrastructural provisions do not always come as promptly as they need to; administrative corruption exists; overcrowding and providing adequate quality of care to patients are concerns for ward staff, medical staff and administrators alike.

In some ways, of course, Fort England Hospital may as well be an entirely new place. The laws and practices that admission to hospital in what became South Africa have changed considerably in the last century, with the introduction of decentralised community care and the promotion of less restrictive hospital environments creating a change from the closed custodial communities of the colonial and apartheid eras.¹ Drug therapy is available; talking and behavioural therapies form an integral part of the hospital's treatment practice. Care is, at least officially, in the ascendant over custody. Care in the community is the ideal, and in areas where this has been realised, this has led to reduced demand for centralised psychiatric

¹ Peterson, Inge and Crick Lund, "Mental health service delivery in South Africa from 2000 to 2010: One step forward, one step back", *South African Medical Journal*, 10, 101, 2011, pg. 751.

hospitalisation.² Public attitudes towards mental disorder and those who live with it are changing, and while stigma and discrimination around mental disorder are still present,³ they are progressively lessening. Sensationalist tabloid treatment of mental illness is as likely to be met with shouts of disapproval as shouts of horror.⁴ Even though whether or not the psychiatric profession now has a certain grasp of mental illness and how to treat it remains debatable,⁵ psychiatric knowledge has certainly progressed far beyond the reductive understandings based on race and gender that are outlined in this thesis.

The Eastern Frontier of the Cape Colony was a deeply contested space. The first contests occurred between indigenous peoples and colonial interlopers, then between missionary-led parties who wished to build a somewhat egalitarian society and settler-led parties that wished for domination and the entrapment of a large African labour force. As the settler party took ascendance and established a widespread British-based civil society to complement the British-based legal and military infrastructure, a tension arose. In the medical establishment, discourses of racial inferiority and subjugation took hold. In the asylums that grew from this establishment, tensions evolved between universalist discourses of moral treatment and racist discourses of evolutionary science, and both were meshed into the so-called “civilising mission” of colonialism and colonial medicine.

² Govender, Catherine, “The Deaths of 94 Mental Health-care Users in Gauteng, South Africa”, *Public Health*, 5, 126, 2017.

³ Peterson and Lund, “Mental health service delivery”, pg. 755.

⁴ Nevertheless, there appears to remain an appetite for salacious narratives around mental illness in entertainment media. In mainstream popular entertainment, a psychiatric setting is still often shorthand for chaos, misrule and depravity. To take one of the more lurid examples, the popular *American Horror Story* US-based television series, lumps psychiatric hospitals in with carnival freak-shows, haunted houses, cults, and covens of witches.

⁵ In recent years, public scepticism regarding the efficacy and predominance of drug therapy, once lauded as the surest way to provide relief for people with mood or cognitive disorders, has grown. Studies indicate that widely-prescribed treatments for depression, for example, may be inefficacious. In some quarters, there is a growing conviction that medication does not solve the problem despite being thought of as the silver bullet. For example, see Irving Kirsch, “Antidepressants and the Placebo Effect”, *Zeitschrift Fur Psychologie*, 3, 222, 2014; Kirsch is also the author of *The Emperor’s New Drugs: Exploding the Antidepressant Myth*, published in 2010, reviewed by Daniel Carlat in “Antidepressants: placebos with side effects?” *Journal of the Canadian Medical Association*, 182, 18, 2014. See also Juned Siddique et al, “Comparative Effectiveness of Medication versus Cognitive Behavioral Therapy in a Randomized Controlled Trial of Low-income Young Minority Women with Depression”, *Journal of Consulting and Clinical Psychology*, 80, 6, 2012, and Pam Harrison, “Depression Outcomes Similar With Antidepressants, CBT”, *Medscape*, December 2015, accessed July 2018.

It was possible for universalism and discrimination to co-exist in this environment. In the Grahamstown Asylum, the strictures of moral treatment and the need to provide good-quality care informed the selection of the asylum's site and the development of its physical facilities: successive medical superintendents pressured the colonial government to provide funding and assistance in creating a suitable environment for the care of the Cape's lunatics, of all races. But inside this concern around creating a good asylum was a conscious decision to create an unequal environment for a considerable part of the patient population. These decisions were based on ideas that black Africans were simpler, needed less, *deserved* less than their European rivals and the deprivation and dispossession of physical comfort and dignity that resulted worsened over time.

Therefore, in the system of privilege and oppression that operated within the Grahamstown Asylum, medical authorities were at the pinnacle of the pyramid. Ward staff and attendants followed. Below them, the patient body. Supreme among patients were white paying patients, followed by white non-paying patients, followed by black non-paying patients. There were very, very few black paying patients in the Grahamstown Asylum, or in any Cape asylums. Every member of the patient population had been legally determined to be a lunatic by two medical examinations, a magistrate and the examinations of Asylum doctors; evidence of their insanity had been given by friends, family and associates, and ratified by doctors, policemen and lawyers. Their status in the outside world was that of 'lunatic', a position – at least in Westernised societies – which carried with it low status and loss of the privileges owed to sane individuals. For black lunatics in the Colony, the loss was profound, as colonial society already believed them to be inferior, undifferentiated members of a misunderstood and exploited majority. It is ironic that the colonial project, so obsessed with the sifting out of minute tribal and cultural differences between all subjects, white and black, should ultimately decide that for black colonial subjects the group trumped the individual. Colonial medical science and anthropology created false images of black Africans are simultaneously intensely multifarious and completely without identity except at a group level.

Inside the asylum, this continued alongside their loss of the status as sane. Indeed, insanity may have been less relevant inside the Asylum than race or class: if a patient was not unruly or unpleasant, their position inside the Asylum and thus their experience of their time spent in

that space – outside their experience of mental illness – was dictated largely by their race and social class. Robert Hullah and T Duncan Greenlees, as well as WJ Dodds – and most other medical superintendents in the Cape and Natal asylum systems - understood their asylums to be places where racial segregation was crucial to psychological recovery and comfort for white patients. Moral treatment, ostensibly for everyone, in truth meant making efforts to improve the condition of white patients while being concerned only with providing barely-adequate custodial care for black patients.

That Cape asylums certainly intended to provide moral treatment and therapeutic care is not at issue: their basic tenets reflected those of the British and European moral treatment movement. But their understanding of mental illness among both black and white colonial subjects meant that, however stringent the instructions to attendants to be kind or committed each asylum doctor was to discovering physical causes for insanity, discrimination would creep in. Race determined to a large degree *how* a lunatic would become an asylum patient and how their particular mental illness would be understood and slotted into the framework of colonial psychiatry. The ways in which this was done in the Grahamstown Asylum resembled the same processes at the Natal Government Asylum and Valkenberg, and can therefore be taken as typical of the processes prevalent in Cape asylums. Demographically, all Cape asylums followed certain patterns that were also global: their white patient bodies were young or middle-aged, often unmarried, and often able to recover. Black patient bodies in colonial asylums were likewise young or middle aged and usually unmarried, but recovery proved more elusive, and cure was rare. This was directly due to the treatment they received in asylums. In the Grahamstown Asylum, lack of paying status meant harder work and less varied diet, less agreeable accommodation, and simply less care and attention. Asylum life for black patients, very few of whom had any hope of becoming fee-paying patients, was monotonous, uncomfortable and often onerous.

The Grahamstown Asylum arose from noble impulses. It was intended to provide care for the afflicted and respite for the families and friends of those individuals who could not live safely at home or at large. Almost immediately it became entangled in the Cape Colony's tangled machinery of control and prejudice. While the Cape had no "Great Confinement" *a la* Foucault's 17th-century France, an element of control-by-institutionalisation was introduced

by the Lunacy Acts. Moral therapy met uneasily with this practice; the underlying philosophy of moral therapy was kindness, not just custody. But the Lunacy Acts and the socio-political environment in which they were devised, as well as that in which they were implemented, conspired to create a system in which some people admitted to the Asylum were considered inferior to others. If there was a true prevailing commitment to ensuring that every person in the Grahamstown Asylum was treated kindly, of course, this should not have been a problem and however troublesome they were would not have made a difference.

But the eastern half of the nineteenth-century Cape Colony was not the United Kingdom: deeply-entrenched racialised distrust and prejudice in the region created strong streams of social discrimination and consequently psychiatric theory, in service to the “civilising mission”, that were deleterious to the provision of good – indeed, moral – treatment for black inmates of the Asylum. The admixture of prejudice, universalism and moral therapy also created an environment in which the Asylum’s staff was caught between the instructions about how to treat patients that were laid out in their handbooks and the attitudes their superiors, peers and the socio-politically dominant white society around them showed towards some of the inmates in their care. It is not surprising, then, that the world inside the Asylum quickly grew to resemble that on the outside. No institution, however all-encompassing, is entirely impermeable and the Grahamstown Asylum was, by design, firmly entrenched in its surroundings, very like the other colonial asylums. As I have outlined, inside the Grahamstown Asylum, practices on even the most quotidian level were dictated by the doctrine of *kindness* towards everyone but *adequate resources* only for some. This philosophy was well-intentioned, but its practice was skewed by prevailing social and racial values; as a result, the concrete effects of the practice of this philosophy remained far from ideal. The echo in modern South Africa is uncomfortably strong.

The Grahamstown Asylum’s DNA is encoded into the challenges facing mental healthcare in the Eastern Cape in particular and South Africa in general. This is not to say the Grahamstown Asylum has been revived and recreated anew, only that it appears to have arisen again all the same. In these spheres we see practices that should by rights be long gone and not mourned: differential approaches to the provision of healthcare for the wealthy and poor, a willingness to rob one group of rights to save money, whether or not with the

intention of using that money for the betterment of another group, and a disregard for the comfort, wellbeing, happiness and even survival of the deprived. This thesis should be a window into a past that has closed, not a snapshot of the early stages of an ongoing event. As a nation we have officially dispensed with the dogmas that created the unequal colonial and apartheid-era systems in which these hospitals were created and equipped. What use is this change of philosophy really if, on the ground, little concrete change is in evidence? Real change remains elusive, as long as the interests of the elite few are privileged over the needs of the many. New modalities of disorder and diagnosis have arisen in the place of the racially-discriminatory theories of the colonial era, but the traces of the underlying issues of prejudice, inequality and preferentialism nevertheless still show through. The systematised racism, disenfranchisement and social dysfunction that had their roots in the colonial era and came to full flower during the Apartheid regime created a desperately unequal society in twentieth-century South Africa, one which a return to democracy in the 1990s has not done enough to change. A minority of the population has access to well-resourced, well-staffed psychiatric clinics and outpatient care; most South Africans are left with the option of consulting overburdened public institutions.

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