

# The Confinement of the Insane

*International Perspectives, 1800–1965*

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*Edited by*

Roy Porter and David Wright



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# 1 Insanity, institutions and society: the case of the Robben Island Lunatic Asylum, 1846–1910

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*Harriet Deacon*

## Introduction

Robben Island, an island off the southern coast of South Africa barely six miles from Cape Town, the capital city of the Cape Colony in the nineteenth century, accommodated ‘lunatics’, ‘lepers’ and the ‘chronic sick’ for nearly a century after 1846. The ‘General Infirmary’ was established just eight years after the emancipation of slaves was finalized, at a time when the colonial government and a nascent middle class in Cape Town were trying to impose a new order on the undisciplined urban underclass in preparation for self-rule. The Cape’s most dangerous insane were sent to the island asylum from 1846, that, until 1875, was the only asylum in the colony. By 1921, there were a number of other asylums established: Grahamstown (1875), Port Alfred (1889), and Fort Beaufort (1894) in the Eastern Cape, and Valkenberg (1891) near Cape Town.<sup>1</sup>

While Britain and some of her colonies provided extensive provision for the insane, the Cape did not. Most of the colonial insane were cared for at home or through private boarding arrangements: only the most desperate resorted to the asylum. In 1890, the proportion of registered white insane to the white population at the Cape was 1:1,180, about three times lower than that in Ireland, New Zealand, New South Wales, Victoria and Britain (from 1:294 to

The research on which this chapter is based was supported at Cambridge University by the Sir Henry Strakosch Memorial Scholarship, and the Patrick and Margaret Flanagan Scholarship. Completion of the chapter was supported by the Robben Island Museum.

<sup>1</sup> Current scholarship on Cape asylums includes H. J. Deacon: ‘Racial Categories and Psychiatry in Africa: The Asylum on Robben Island in the Nineteenth Century’, in W. Ernst and B. Harris (eds.), *Race, Science and Medicine* (London, 2000); and ‘Madness, Race and Moral Treatment at Robben Island Lunatic Asylum, 1846–1910’, *History of Psychiatry* 7 (1996), 287–97; S. Marks, ‘“Every Facility that Modern Science and Enlightened Humanity have Devised”: Race and Progress in a Colonial Hospital, Valkenberg Mental Asylum, Cape Colony, 1894–1910’, in J. Melling and W. Forsythe (eds.), *Insanity, Institutions and Society: A Social History of Madness in Comparative Perspective* (London, 1999); S. Swartz: ‘The Black Insane at the Cape, 1891–1920’, *Journal of Southern African Studies* 21 (1995), 399–415; ‘Changing Diagnoses in Valkenberg Asylum, Cape Colony, 1891–1920: A Longitudinal View’, *History of Psychiatry* 6 (1995), 431–52; and ‘Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891–1920’, PhD thesis, University of Cape Town (1996); F. Swanson, ‘Colonial Madness: The Construction of Gender in the Grahamstown Lunatic Asylum, 1875–1905’, BA (Hons.) thesis, University of Cape Town (1994).



1:380).<sup>2</sup> There was also a much larger proportion of people classified as ‘criminal’ insane in the Cape than in Britain or New South Wales, although in New South Wales and elsewhere, police were still responsible for a large proportion of asylum committals before 1900.<sup>3</sup> Although it rose steadily after 1846, the number of insane confined in the Robben Island asylum at any one time was relatively small, only exceeding 200 in the 1890s. The total asylum population in the colony numbered only 645 in 1891; double the number of ‘lunatics’ and ‘idiots’ were kept in private houses. There was thus no ‘Great Confinement’ of the insane in the Cape Colony during the nineteenth century. Yet some of the same pressures for institutionalization operated at the Cape as in Europe: the disruption of social networks of care and a dominant-class fear of uncontrolled behaviour within an increasingly ordered urban society.

An analysis of admissions to the Robben Island asylum can illustrate the social dimensions of psychiatric practice at the Cape. Fox has suggested that patients committed to the San Francisco asylum in the early twentieth century were

a strikingly heterogeneous [group, sharing] neither a common social background, a similar mental condition, nor even a customary ‘route’ to the asylum... What united them, instead, was a type of relationship to other people. The insane were disturbing, peculiar, or incomprehensible. They were in many cases out of touch with reality and in a small number of cases violent or destructive. But they became insane not when they crossed some well-defined boundary between health and sickness, between normality and abnormality. They became insane when other individuals decided they could no longer be tolerated.<sup>4</sup>

It is clear from the Robben Island records that the Cape asylum, unlike the San Francisco asylum,<sup>5</sup> was catering mainly for the ‘dangerous’ insane. This was partly a feature of the minimal institutional provision for the insane at the Cape and partly due to the legal strictures on admitting ‘ordinary’ lunatics before 1891. And yet within this framework the island admission records highlight interesting gender and racial variations in institutional use as well as changing patterns of admission and treatment that can be related to social and economic changes in the society at large.

Throughout the nineteenth century and into the twentieth, most of the patients in Cape asylums, including Robben Island, were male<sup>6</sup> and disproportionately many were white. When the Robben Island asylum was established, it took from country gaols and the overcrowded Cape Town hospital those who were

<sup>2</sup> ‘Report of the Inspector of Asylums for 1890’, Cape Parliamentary Papers (CPP), G37–1891, 14.

<sup>3</sup> S. Garton cited in C. Coleborne, ‘Passage to the asylum’, below.

<sup>4</sup> R. W. Fox, *So Far Disordered in Mind: Insanity in California, 1870–1930* (London and Berkeley, 1978), 79.

<sup>5</sup> *Ibid.*, 137–8.

<sup>6</sup> Swartz, ‘Colonialism and the Production of Psychiatric Knowledge’, 132; Valkenberg was an exception in having more women than men, 133.

considered most disruptive to an institutional order on the mainland that placed a new stress on the performance of work by gaol inmates and the speedy cure of patients in the hospital. It took time to develop a curative ethos on the island, however. During the first fifteen years three out of five asylum inmates were black, nearly half of whom had come through the criminal justice system. During the 1860s and 1870s, the proportion of white paying patients rose fivefold as the asylum underwent reforms along humanitarian ‘moral management’ lines. After 1875, new asylums were opened on the mainland to take these middle-class patients, more of whom were women than before. Greater pessimism over the curability of black ‘lunatics’ now coincided with increasing racism in colonial society.<sup>7</sup> Within the system of colonial asylums, Robben Island was marked for the most dangerous and threatening members of society. By the early twentieth century, four out of five of the island asylum inmates were black and a third were convicts. The asylum had come full circle, its function once again to remove troublesome black male prisoners from overcrowded prisons.

### **The process of admission**

In order to analyse the process of admission to the asylum at Robben Island, a database was compiled from patient admission records. It is important to treat the statistical data with care, however. The records are incomplete before 1872, and systematically favour long-stay cases and those admitted through the Somerset Hospital, founded in 1818 as the first civilian hospital at the Cape. Early admission data have been gleaned from Old Somerset Hospital admission registers and correspondence files. Using the admissions database, the average admission rate for the period 1846–52 is 19.3 admissions per annum, while official statistics for the same period record 29.2 admissions per annum. It should be remembered too that categories such as ‘nationality’ changed over time, as did diagnostic terms and procedures.

The asylum population at Robben Island must be treated as a historically specific subset of those people who would today be defined as ‘mentally ill’ rather than as representative of the distribution of madness in the colony. Except possibly for middle-class British settlers after 1860, the major pressures for institutionalization at the Cape were poverty and fear of violence rather than the hope of a cure. There is little evidence that the establishment of an asylum in 1846 produced or reflected a change from home care to the use of the asylum as a therapeutic resource. Africans,<sup>8</sup> Dutch-Afrikaans settlers<sup>9</sup> and

<sup>7</sup> On racism in colonial psychiatry see Swartz, ‘The Black Insane’.

<sup>8</sup> Although people who have been born in Africa, or lived most of their lives there, and certainly those who lived there before 1652, could all be termed Africans, in this paper I have used the term ‘African’ specifically to refer to those black indigenous inhabitants of the Cape who were probably not identified as Khoisan, ‘Malay’ or ‘coloured’.

<sup>9</sup> The Dutch-speaking white settler community at the Cape came from a range of continental European countries, but predominantly from the Netherlands and Germany. Most immigrated to the Cape before 1806. Although there was considerable intermixing with the local slave and

Muslims<sup>10</sup> all continued to be reluctant to use the asylum. Admissions were dominated by those considered dangerous, by the friendless and the poor. I shall therefore start by examining the pressures for institutionalization and the alternatives to the asylum before exploring the processes through which the insane were identified and admitted to the asylum. Then I shall examine the social constitution of the asylum population.

### **The making of an asylum population**

When the Robben Island asylum was opened in 1846 it provided an extra seventy hospital beds for lunatics in addition to the thirty or more in the Somerset Hospital in Cape Town. These places were soon filled by patients who had been in gaols, in the pauper asylum at Port Elizabeth and in home care. Few of these people had any alternative source of care. In 1861 the asylum keeper commented that if the lunatic men had ‘any one to come for them . . . they would be sent away’.<sup>11</sup>

Ex-slaves, indigenous Khoisan<sup>12</sup> and Africans made up nearly 60 per cent (n = 87) of all first admissions given nationalities who were admitted to the Robben Island asylum in the period 1846–61.<sup>13</sup> Annual reports give a breakdown of lunatic numbers by race and nationality after 1859. In that year there were 156 lunatics, of whom 70 per cent (n = 110) were described as ‘Hottentot’,<sup>14</sup> ‘African’ (some of these were probably Dutch colonials) or ‘Kafir’,<sup>15</sup> and 23 per cent (n = 37) were from the United Kingdom.<sup>16</sup> Recent European immigrants, ex-slaves, African refugees from the frontier wars, and others without strong family networks were more likely to require state aid

Khoisan population, by the end of the nineteenth century those who saw themselves as ‘white’ had developed a strong racialized identity as Afrikaners.

<sup>10</sup> In Cape Town at this time, Muslims were what nineteenth-century settlers called ‘Malays’, black descendants of slaves who had come from East Asia and parts of Africa, many of whom converted to Islam after their arrival at the Cape and intermarried with local settler and indigenous populations. A number of Cape Town Muslims were able to rise above the extreme poverty of the urban underclass.

<sup>11</sup> Pierce, minutes of evidence, ‘Report of the Commission of Inquiry into the General Infirmary and Lunatic Asylum on Robben Island’, CPP, G31–1862, 109.

<sup>12</sup> Some of the indigenous people who lived off the land around Cape Town and in the interior, mainly to the west and north, were hunter-gatherers and others were pastoralists. The Dutch called the former ‘Bushmen’ and the latter ‘Hottentots’. Although later scholars have attempted to get away from the pejorative uses of these words by inventing new terms (San and Khoi or Khoekhoe respectively), which I have used in this paper, the distinction between the two is not always sustainable (hence the use of the term Khoisan).

<sup>13</sup> The sample is small, and the large number of ex-slaves listed in the registers may be partly because they were admitted on government order. However, the general picture from official statistics is similar.

<sup>14</sup> See explanation of the term ‘Khoisan’.

<sup>15</sup> A term used by settlers in the nineteenth century to refer to Xhosa-speaking Africans from the eastern Cape.

<sup>16</sup> ‘Report on the General Infirmary, Robben Island for the year 1859’, CPP, G11–1860, 4.

in times of distress. Emancipation and the transition to a market economy before mid-century, which reduced traditional family and employers' support for the mentally ill, and encouraged the use of the asylum in Britain,<sup>17</sup> may have increased the pressure on poor families to send cases to Cape Town for institutional care. Most of the Africans entering the Robben Island asylum were men – unemployed or migrant workers referred by employers or the criminal justice system rather than their own communities.<sup>18</sup> Similarly, Victorian asylums in Australia admitted few aboriginal patients.<sup>19</sup> In twentieth-century colonial Africa, governments still considered the care of the African insane to be the concern of their communities rather than the state.<sup>20</sup>

There were options outside the asylum that even the poor could utilize in the absence of family care. The Dutch Reformed Church, to which most Dutch-Afrikaans settlers belonged, provided boarding-out care for non-violent lunatics. There were Cape Dutch home remedies for hysteria and epilepsy<sup>21</sup> and some patent medicines, very popular among the Dutch-Afrikaans community, like 'Dr Forsyth's Chemic Health Restorer', were said to cure 'nervousness'.<sup>22</sup> For those without church or financial resources there were other options. The insane orphan Maggie K was kept at the Salvation Army Rescue Home for some time before being taken to the police by a friend of the family.<sup>23</sup> In 1883 a Woodstock resident called a 'Malay doctor' to attend to her servant girl who had 'gone mad or was in a fit'. 'Brutus', the doctor, chanted and sang in the 'vernacular' to ward off the presence of the Devil who, he said, had been in the room the previous night.<sup>24</sup> 'Vertical' charity thus assisted some of the mad just as it assisted the poor in general.

Institutional provision for the insane in the Cape Colony was limited and in demand. The Robben Island Surgeon-Superintendent, Dr Edmunds, attested in 1871 to the 'numerous applications' for admission.<sup>25</sup> Even in the 1880s, the asylums at Robben Island and Grahamstown were usually so full that cases had to be kept in gaols for many months where they were 'aggravated by becoming the butt and amusement of the prisoners'.<sup>26</sup> These cases included convicts who

<sup>17</sup> A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700–1900* (London, 1993), 26–32.

<sup>18</sup> On the paths of black people into asylums see Swartz, 'The Black Insane', 408.

<sup>19</sup> Coleborne, 'Passage to the asylum', below.

<sup>20</sup> M. Vaughan, *Caring their Ills: Colonial Power and African Illness* (Cambridge, 1991), 120.

<sup>21</sup> D. G. Steyn et al. (eds.), *Volksgeneeskuns in Suid-Afrika: 'n Kultuurhistoriese Oorsig, Benewens 'n Uitgebreide Versameling Boererate* (Pretoria, 1966), 258; L. Pappé, *Florae Capensis Medicae Prodromus: An Enumeration of South African Plants used as Remedies by the Colonists of the Cape of Good Hope* (Cape Town, 1868), 16, 46.

<sup>22</sup> *The Lantern*, 18 May 1878.

<sup>23</sup> Sub-Inspector Barnes to Resident Magistrate of Cape Town, 10 July 1898, Cape Town Municipality Papers: Lunacy 1878–1910, 1/CT 12/53, Cape Archives, Cape Town (CA).

<sup>24</sup> *The Lantern*, 25 August 1883.

<sup>25</sup> 'Report on the General Infirmary, Robben Island for the year 1871', CPP, G18–1872, 8.

<sup>26</sup> 'Reports of the Civil Commissioners, Resident Magistrates and District Surgeons for 1882', East London, CPP, G91–1883.

had become insane as well as non-criminal cases.<sup>27</sup> Dangerous or violent cases usually got precedence for admission to the island because of the shortage of asylum provision. The Old and the New Somerset Hospitals in Cape Town were also used to house lunatics. One Jan du P, from the country town of Paarl, having threatened his family with a knife, thinking that he was being poisoned, was kept in the Old Somerset Hospital for twelve years with ‘chronic mania’ before his transfer to Valkenberg in 1891.<sup>28</sup> The more modern New Somerset Hospital was used for patients like Miss S, who in 1864 was transferred from the Old Somerset Hospital where it was deemed ‘quite impossible . . . to pay proper attention to lunatic females’ of her class.<sup>29</sup>

The wealthy insane had a wider choice of options than the poor: home care, boarding-out, private asylums and state institutions. Initially, however, the island asylum had a poor public image that discouraged all but the most desperate applicants. There was also a general aversion to hospitals among the middle classes at the Cape. Growth in middle-class use of asylums abroad and their increasing association with cure made the institutional option more popular during the latter half of the nineteenth century. Walter E, a colonial-born Englishman who worked as a clerk in the attorney general’s office, was sent to Robben Island in 1855 and again in 1880. He was described as ‘an imbecile . . . harmless and quite childish’, but had delusions of persecution by ‘Malays’. After Walter E’s discharge from the island, Dr Beck suggested a ‘complete change’ to cure his ‘loss of memory and general nerve depression’. But when he returned from his holiday abusive, threatening suicide and sexual assault, he was sent to Robben Island again before being transferred to Valkenberg in 1891.<sup>30</sup>

Private care of the wealthier insane continued to play an important role even after middle-class facilities were made available in Cape asylums. Most of the propertied insane were admitted to the Valkenberg and Grahamstown asylums, who cultivated a more elitist image than the Robben Island asylum.<sup>31</sup> During the 1880s some private practitioners dissuaded relatives from sending patients to Robben Island or the Somerset Hospital.<sup>32</sup> Cape Town doctors continued to treat some ‘better class’ lunatics privately in 1879, patients for whom the ‘existing arrangements’ on Robben Island were said to be ‘quite unfit’.<sup>33</sup> As

<sup>27</sup> R. Southey to Edmunds, 19 Feb. 1868, letters despatched by Colonial Office, CO 6861, CA.

<sup>28</sup> Valkenberg Asylum casebook 1, 1891–4, University of Cape Town (UCT) Manuscripts Collection, Cape Town.

<sup>29</sup> J. Laing to Colonial Secretary, 23 Dec. 1864, letters received by Colonial Office, CO 827, CA.

<sup>30</sup> Valkenberg Asylum casebook 1, 1891–4, UCT Manuscripts Collection, Cape Town.

<sup>31</sup> Report on Robben Island in ‘Reports on the Government-aided Hospitals and Asylums and Report of the Inspector of Asylums for 1892’, CPP, G17–1893, 135.

<sup>32</sup> D. Moyle, ‘Laying down the Line: The Emergence of a Racial Psychiatric Practice in the Cape Colony During the Nineteenth Century’, unpublished paper, Psychology Department, UCT, 1988, 10.

<sup>33</sup> Dr J. F. Manikus, Minutes of Evidence, ‘Report of the Commission appointed to inquire into and report upon the best means of moving the asylum at Robben Island to the mainland’, CPP, G64–1880, 21.

late as 1898, the *Cape Argus* reported that poorer patients were sent to the asylum sooner, as rich families 'will do anything rather than send [their insane relatives] to a hospital'.<sup>34</sup> In 1890, only thirteen of the thirty-nine propertied insane placed under curatorship by the Supreme Court were accommodated in asylums – the rest were kept in private homes.<sup>35</sup>

Although most of those recognized as insane were not sent to asylums, private asylums never loomed as large at the Cape as they did in England.<sup>36</sup> In 1845, Harriet O complained that there were no private houses for the treatment of the insane in Cape Town. Her father was forced to go either to the Somerset Hospital or to Robben Island.<sup>37</sup> In 1905, only a Miss Durr's in Mowbray was licensed under the 1897 Act as a private lunatic asylum. It housed three uncertified European women patients as voluntary boarders.<sup>38</sup> Informal boarding houses were more common. Thomas McS, an English hotel keeper in Caledon, was boarded with a family after the death of his mother in 1890, three years after he began to get violent. He was admitted to Valkenberg in 1891. Ebenezer K, declared 'of unsound mind' in the Supreme Court in 1843, was boarded out for ten months before going to England where he was in fact certified sane.<sup>39</sup> Sending the insane 'home' to England was not general practice. In 1889, Robben Island surgeon-superintendent Ross had to make a special case of C, a 'dipso-manic with strong leading delusions', whom he wanted to send to relatives in England at government expense.<sup>40</sup>

The 1891 census provides the first accurate estimates of the relative balance between different forms of provision for lunatics. It shows that 1,281 lunatics were being maintained in private dwellings, as opposed to 120 in jails and approximately 645 in Cape asylums.<sup>41</sup> Males were significantly over-represented among those certified as insane, but whites were only slightly over-represented. While the male–female ratio approached unity in the colony,<sup>42</sup> men represented nearly two-thirds of the insane. While whites represented about a third of the

<sup>34</sup> Quoted in the *South African Medical Journal* (1898), 48.

<sup>35</sup> Report of the Inspector of Asylums in 'Reports of the Medical Committee . . . for 1890', CPP, G37–1891, 10.

<sup>36</sup> See W. L. Parry-Jones, *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London, 1971).

<sup>37</sup> Memorial from Harriet O, 6 Dec. 1845, memorials received by Colonial Office, CO 4026, doc.468, CA.

<sup>38</sup> Report of the Inspector of Asylums in 'Reports on the Government-aided Hospitals . . . for 1905', CPP, G32–1906, 54.

<sup>39</sup> Valkenberg Asylum casebook 1, 1891–4, UCT Manuscripts Collection, Cape Town; and 'Supreme Court', *Cape Town Mail*, 28 February 1846.

<sup>40</sup> W. Ross to Under Colonial Secretary, 11 March 1889, Colonial Office, letters received, CO 1438, CA.

<sup>41</sup> Report of the Inspector of Asylums in 'Reports on the Government-aided Hospitals and Asylums and Report of the Inspector of Asylums for 1892', CPP, G17–1893, 126, 134.

<sup>42</sup> Census of 1891, CPP, G6–1892, 22.

Table 1.1 *The number of lunatics and idiots in the colony in 1891, as recorded in the 1891 census*

	Asylums	Outdoor lunatics	Outdoor idiots	Gaols
Male	396	244	450	
Female	249	253	334	
White	350	131	266	
Black	295	366	518	
Total	645	497	784	120

colonial population in 1891,<sup>43</sup> they comprised two-fifths of the insane. In a situation of scarcity of asylum accommodation, admission was granted more often to white men (whose insanity threatened white supremacy and raised the spectre of degeneration and hereditary insanity) and black men (whose insanity threatened white society by disrupting employment relations or the taboo on sexual contact with white women).<sup>44</sup>

Cape asylums were also admitting only a small proportion of those who were recognized by their communities and the authorities as insane, and admitting these patients very selectively (see Table 1.1). Although the number of asylum patients had nearly doubled in the previous decade,<sup>45</sup> it still represented only about half of the number outside asylums and gaols. Nearly two thirds of certified mental patients in private dwellings ('outdoor' lunatics and idiots) were classified as 'idiots' – cases who were probably considered less violent or dangerous than 'lunatics'. This trend was reversed within the asylums, where most inmates were certified as 'lunatics'. Yet more of the black and slightly more of the female insane were 'outdoor lunatics' and more of the white and male insane were institutionalized.<sup>46</sup>

### Admission procedures

Defining someone as insane was a necessary condition for admission into the asylum. The doctor was only called to ratify the definition if the person had already been labelled as insane in social terms and had also become socially or

<sup>43</sup> Census of 1891, CPP, G6–1892, 15 (in that section of the colony defined by the 1875 census, and thus excluding recently annexed territories).

<sup>44</sup> H. J. Deacon, 'A History of the Medical Institutions on Robben Island, 1846–1910', PhD thesis, University of Cambridge (1994), chapter five; Swartz, 'Colonialism and the Production of Psychiatric Knowledge', 113–16.

<sup>45</sup> Report of the Inspector of Asylums in 'Reports on the Government-aided Hospitals and Asylums and Report of the Inspector of Asylums for 1892', CPP, G17–1893, 126.

<sup>46</sup> Moyle, 'Laying Down the Line', 11.

economically problematic.<sup>47</sup> The relative scarcity of complaints about wrongful detention at the Cape testifies to the use of the asylum mainly for those cases who were seriously mentally ill, for whom there were few viable alternatives or whose families approved of their detention. The ‘Lunacy Panic’ about wrongful detention of alleged lunatics in England during the 1850s,<sup>48</sup> which caused a flurry of legislation in India,<sup>49</sup> hardly touched the Cape.

At the nineteenth-century Cape, where in legal terms until 1891 all lunatic admissions had to be either criminal or potentially so, the boundaries between the lunatic and the criminal lunatic were vague. Because gaols were used to accommodate paupers and the insane as well as the criminal, and to police ‘vagrancy’ too, there was little pressure to sharpen the boundaries between the various groups. A prisoner called Rachel N in the House of Correction in Cape Town in the mid-1870s became too violent to control and was sent to the Somerset Hospital lunatic wards on the order of the Under-Colonial Secretary. ‘Convalescent’, she was returned to the House of Correction six months later to complete her sentence of imprisonment.<sup>50</sup>

Not all lunatic cases stood trial: brought to the gaols for some offence or ‘nuisance’, some were certified insane by the local doctor or district surgeon and sent to the asylum when there was a vacancy. Michael P, reportedly a source of ‘annoyance’ and ‘violence’ to his friends in Cape Town, was several times imprisoned in the Cape Town gaol, where he ‘forced conversation upon other prisoners of the most beastly and unnatural description’. A medical board asked to determine whether he was insane, decided that as a temporary measure he should be sent to the Robben Island pauper wards.<sup>51</sup> Henry I, a similar case, had run after the young women in his master’s house, lit a fire in the stable and scribbled nonsense on the fence. He was sent to Grahamstown Asylum in 1880 as a criminal lunatic without trial.<sup>52</sup> The separation of criminal and ordinary lunatics only became an issue in the 1890s, when numbers of the latter increased, and a large proportion were sent to Robben Island from where, it was argued, they could not easily escape.

<sup>47</sup> See Swartz, ‘Colonialism and the Production of Psychiatric Knowledge’, 76–97 for a discussion of the certificates required by the committal process at the Cape during this period. See Coleborne, ‘Passage to the asylum’, below, for a discussion of New South Wales’ certificates.

<sup>48</sup> T. Turner, ‘Not Worth Powder and Shot: The Public Profile of the Medico-Psychological Association, c.1851–1914’, in G. Berrios and H. Freeman (eds.), *One Hundred and Fifty Years of British Psychiatry 1841–1991* (London, 1991), 3.

<sup>49</sup> W. Ernst, *Mad Tales from the Raj: The European Insane in British India, 1800–1858* (London, 1991), 45–6.

<sup>50</sup> Under-Colonial Secretary to Surgeon of Old Somerset Hospital, 16 Dec. 1876, Old Somerset Hospital Papers, letters received: 1876–1888, HOS 1, CA.

<sup>51</sup> Report by the Superintendent of Police, memorial of P, March/April 1859, memorials received by Colonial Office, CO 4110, doc. P36, CA.

<sup>52</sup> Case of Henry I, n.d., Health Branch: Criminal lunatics 1893–9, CO 8050, CA.



Until the first quarter of the nineteenth century in England, notions of culpability were centred around obvious signs of behavioural disturbance (e.g. violence), and required proof that the insane did not know wrong from right, for if they did they were not insane and could control their actions. After 1825, the defence of partial insanity, or monomania (delusion), began to be accepted in English courts and was accompanied by a far greater amount of medical testimony because the signs of insanity were only discernible by expert eyes.<sup>53</sup> In the colony, these ideas took root as well. Elliot, a lunatic on Robben Island in 1848, had been accused of stealing clothing in Cape Town and had subsequently destroyed the clothing given to him in the asylum. Although he had been rejected by the legal system as insane, his lack of violence and his apparent consciousness of his misdeeds were commented on by Dr Hall, who said, ‘we cannot avoid thinking that some degree of knavery is mixed up with his lunacy, which a little gentle discipline would in all probability correct’.<sup>54</sup> The idea of partial insanity was also clumsily suggested in evidence before the Robben Island Commission in 1861. The assistant lunatic keeper, appropriately named Mr Nutt, complained that the lunatics who refused to work, fought each other and stole from the boat, knew that they were doing wrong: ‘They are not quite right [he said], but some are only a little wrong.’<sup>55</sup>

Psychiatric assessment of dangerousness and the use of the diminished responsibility defence are now crucial in the sentencing of those who are deemed mentally disordered in South Africa.<sup>56</sup> In dealing with the forensic patient, the relevance of the crime to sentencing and duration of asylum care remains a serious issue today.<sup>57</sup> ‘Dangerousness’ played an important role in justifying asylum admission during the nineteenth century. Besides family applications, the courts and police networks were the major screening mechanisms for asylum admissions during the nineteenth century, and often invoked the notion of dangerousness. Whether criminal or not, a large proportion of the patients sent to Robben Island were perceived as dangerous. In the period 1846–1910, 406 out of 1,141 first admissions (36 per cent) entered in the database are listed as dangerous. Suicidal cases made up about 9 per cent of first admissions in this period.

<sup>53</sup> J. P. Eigen, ‘Delusion in the Courtroom: The Role of Partial Insanity in Early Forensic Testimony’, *Medical History* 35 (1991), 27, 29.

<sup>54</sup> Report by J. Hall on Robben Island, 19 April 1848, minutes of evidence, ‘Report of the Commission of Inquiry’, CPP, G31–1862, 133–4.

<sup>55</sup> Nutt, minutes of evidence, ‘Report of the Commission of Inquiry’, CPP, G31–1862, 169–70.

<sup>56</sup> Henning cited in A. Cohen, ‘The Psychiatric Assessment of Dangerousness at Valkenberg Hospital’, MA thesis, UCT (1991), 27, suggests that in South Africa today, although most Attorneys General feel that the duration of a patient’s detention in an asylum should be directly related to the seriousness of their crime, the therapeutic policy of the Department of Health relates length of detention to cure.

<sup>57</sup> Cohen, ‘The Psychiatric Assessment of Dangerousness’, 28.

Because of the bias towards long-stay patients in the pre-1872 records, and the scarcity of accommodation for the mentally ill in this period, one might expect that dangerousness would be a major criterion for admission to Robben Island before 1872. Indeed, fourteen (nearly a third) of the forty-nine patients sent from Somerset Hospital to Robben Island in 1846, the year the latter hospital opened, were described as ‘violent’ or ‘treacherous’.<sup>58</sup> The cases of Joseph O and Cornelia S, both held in the lunatic wards of the Old Somerset Hospital in 1845, and earmarked by the authorities for transfer to Robben Island, illustrate the influence of assessments of dangerousness in sending patients to the Island. The relatives of both cases did not want them transferred, as Robben Island was too far away, and was already stigmatized. Joseph O was an epileptic who had been cared for at home by his daughter for six years until he became violent, when he was put into the Old Somerset Hospital. Cornelia S was a ‘peaceful’ lunatic who had been kept in the Old Somerset Hospital for fifteen years, visited by her sister whose husband could not afford to keep Cornelia at their home. Cornelia was allowed to remain in the Old Somerset Hospital while Joseph, who was considered too disruptive for the pauper wards, was transferred to the island.<sup>59</sup>

For the whole period before 1872, however, only a tenth of first admissions to Robben Island were described as dangerous in the Somerset Hospital registers (see Table 1.2). On the Island in 1848, the surgeon-superintendent reported that ‘with two or three exceptions the lunatics [were] tranquil’.<sup>60</sup> In 1861 the chaplain, Revd J. A. Kuster complained that he visited the lunatics only once a month, as ‘[s]peaking with them affects my nerves very much, there being much disturbance from the noisy ones’.<sup>61</sup> Noisy or disruptive behaviour, in the wards, at work, or in church, was reported as the major disciplinary problem in the asylum, although every year there were a few cases of violent assault.<sup>62</sup> This suggests that, although always important as a justification for admission or transfer, the notion of ‘dangerousness’ was used far less before 1872 than thereafter in admission registers for the island asylum. This may have been because in 1879,<sup>63</sup> the first mental health legislation concerned with institutionalization

<sup>58</sup> H. Bickersteth to Acting Secretary to Government, 23 June 1852, in ‘Report of the Select Committee on and documents connected with, the Robben Island Establishment’, CPP, A37–1855, 41.

<sup>59</sup> Memorial of H.O., 6 Dec. 1845, memorials received by Colonial Office, CO 4026, doc.468, CA; memorial of J.S., 3 Dec. 1845, memorials received by Colonial Office, CO 4024, doc.127, CA.

<sup>60</sup> Report on Robben Island, 19 April 1848, minutes of evidence, ‘Report of the Commission of Inquiry’, CPP, G31–1862, 133.

<sup>61</sup> Revd J. A. Kuster, Minutes of evidence, ‘Report of the Commission of Inquiry’, CPP, G31–1862, 49.

<sup>62</sup> For example, J. Verreaux, minutes of evidence, ‘Report of the Commission of Inquiry’, CPP, G31–1862, 191.

<sup>63</sup> See A. Kruger, *Mental Health Law in South Africa* (Durban, 1980), pp. 12–13 for a discussion of the Act.

Table 1.2 *Proportion of first admissions to the Robben Island Lunatic Asylum recorded as dangerous, 1846–1910*

Date	'Dangerous' lunatics
1846–1871	10% (n = 45)
1872–1890	61% (n = 234)
1895–1910	41% (n = 127)

at the Cape was passed to provide a legal basis for the detention of 'criminal' and 'dangerous' lunatics.

By the time the detention of 'ordinary' lunatics was provided for in the 1891 Act,<sup>64</sup> Robben Island was earmarked for dangerous and criminal lunatics anyway. As more mainland asylums opened, a greater proportion of 'dangerous' and 'criminal' patients were sent to the island asylum. By 1881, Grahamstown asylum accommodated a significantly smaller proportion of 'maniacal and dangerous' cases than did Robben Island.<sup>65</sup> In the period 1872–90, two-thirds of first admissions to the Robben Island asylum were characterized as dangerous. This proportion dropped to two-fifths in the period 1895–1910 (see Table 1.2). By this time more of the Robben Island patients were criminal lunatics (34 per cent rather than 28 per cent) whose detention was already justified by the court and legislative changes that had increased the range of patients who could be admitted, including 'ordinary' and 'voluntary' patients, which reduced the burden on dangerousness as a justification for admission.

Men were consistently more likely than women to be designated 'dangerous' in the Robben Island registers, in line with contemporary gender stereotypes. Although there was a long association in colonial discourse between blackness and dangerousness too, and black mental patients are perceived as especially dangerous in Britain and America today,<sup>66</sup> 'dangerous' admissions at the Robben Island asylum were not disproportionately black. This may have been because far more of the black admissions came through the criminal justice system, and their detention was already justified on those grounds (see above).

### The definitions of insanity

The process of defining madness was not uniform. Disagreement over who was insane illustrates the fluid nature of boundaries of deviance. There were cases

<sup>64</sup> *Ibid.*, p. 14. <sup>65</sup> *Cape of Good Hope Blue Book for 1881*, 228.

<sup>66</sup> P. Moodley and G. Thornycroft, 'Ethnic Group and Compulsory Detention', *Medicine, Science and Law* 28 (1988), 324–28; M. Sabshin, H. Diesenhaus and R. Wilkison, 'Dimensions of Institutional Racism in Psychiatry', *American Journal of Psychiatry* 127 (1970), 787–93.

at Robben Island thought not to be insane, either by their families or by the staff. In 1860, for example, the attendant Pierce felt that the violent actions of a Mr S, employed in the colonial auditing department in Grahamstown, towards a fellow lodger who had stolen something from him, were used against him in 'some foul play' resulting in his admission to Robben Island.<sup>67</sup> S had no trial, and was apparently sent to the island without being told what had happened.<sup>68</sup> He was not considered insane, but nevertheless spent some time on the island.

There were more fundamental debates about the meaning of insanity, however. In 1873, the island chaplain, Baker, commented on a case of 'religious mania' as follows:

[De V is now] quite sane, may be a little 'eccentric', and doubtless too practically religious to be regarded as 'quite right' by ordinary people. I counselled him not to bring religion *openly* to bear on trifling matters of daily routine or domestic life. I wish many were like him.<sup>69</sup>

He admitted nevertheless that the Bible could be misused, commenting in 1869 that

From conversations . . . with one or two of the patients, I have been convinced that it would be better not to give the Bible generally to them, but a book of suitable readings from the Scriptures, with forms of prayer. They morbidly turn to unprofitable expressions, and find food for their diseased minds [in the full Bible text].<sup>70</sup>

Baker was tolerant of 'eccentricities', as long as they coincided with his moral viewpoint. His emphasis on religious instruction and morality as the only good way of living gave his psychological counselling a particular emphasis. He recognized the need to speak less 'plainly' to 'a sensitive Lunatic',<sup>71</sup> but did not agree with the surgeon-superintendent, Dr Biccard, who quoted, in 1876, 'a medical man of 12 years' experience' who made it a rule 'never to discuss or allow to be spoken of, matters of Religion and Politics in his Asylum'. Only convalescents should be allowed to attend church, said Biccard.<sup>72</sup> In other ways, Baker's view of the insane was more inclusive than the medical definition, possibly due to the fact that he was more concerned with the content of utterances than with the pathological form.

In general, Baker and the other island chaplains seem to have relied on the usual visual and audible indications of the 'ordinary features of insanity', such

<sup>67</sup> Pierce, minutes of evidence, 'Report of the Commission of Inquiry', CPP, G31-1862, 108.

<sup>68</sup> G. M. S., minutes of evidence, 'Report of the Commission of Inquiry', CPP, G31-1862, 224.

<sup>69</sup> Baker, 11 Nov. 1873, Chaplains' Diaries, AB 1162/G2, University of the Witwatersrand Manuscripts Collection (UWMC), Johannesburg.

<sup>70</sup> Baker, 10 Sept. 1869, Chaplains' Diaries, UWMC, AB 1162/G2.

<sup>71</sup> Baker, 30 April 1877, Chaplains' Diaries, UWMC, AB 1162/G3.

<sup>72</sup> F. L. C. Biccard to Under-Colonial Secretary, 6 July 1876, letters received by Colonial Office, CO 1027, CA.

as a lack of ‘rational’ conversation, over-excitement, and strange appearance or lack of composure.<sup>73</sup> In 1870 he urged a Miss P to be calm, in spite of her excitement at being discharged, in order that this not be interpreted as insanity.<sup>74</sup> In 1874, using a popular etiology, he linked the violence of some of the lunatics on a Sunday to the presence of a new moon.<sup>75</sup> In 1876, he was concerned about the over-hasty discharge of a certain Mrs S, who he felt ought to be removed from the ‘society of insane people’ but that ‘from her expressions about her husband and her feeling towards myself, etc., I fear she should not retake the full status of a wife’.<sup>76</sup> Baker supported the asylum doctors’ decisions regarding institutionalization, however. For example, Baker wrote to the brother of a patient, Dr P. J. van B, whose family was agitating for his release on the grounds of temporary insanity, noting that the patient had ‘conducted himself as a gentleman’. But Baker then wrote in his journal that he had ‘made no remark as to mental disease – nothing to be used as proof of sanity’ in their attempts to free the patient against medical advice.<sup>77</sup>

### Medical diagnoses

Nineteenth-century doctors’ definitions of who was insane tallied closely with social definitions. Almost all they added to the process was a medical diagnosis. During the early nineteenth century in Europe, doctors’ classifications of the insane centred around gross behavioural signs, and simple putative causes: major categories were mania, melancholia, phrenzy, dementia and lethargy.<sup>78</sup> The Robben Island doctors used a similar classification, centred around mania, dementia, melancholia and idiocy or imbecility. More detailed diagnoses were given as the century wore on. S. Swartz has suggested that nineteenth-century medical certificates for the insane in the Cape were legal documents justifying institutionalization, rather than medical diagnoses with implications for treatment. She indicates that in the latter part of the century, these justifications hinged on evidence that the patient was becoming childish (dementing); that a patient was passive (lazy, lethargic, mute, withdrawn) or violent and hyperactive; and/or that patients were immoral (including all sexual behaviour such as masturbation).<sup>79</sup>

Many asylum patients in Britain before mid-century suffered serious bouts of psychosis, were suicidal or suffered from serious mental disability. By the

<sup>73</sup> Baker, 28 Dec. 1869, Chaplains’ Diaries, UWMC, AB 1162/G2.

<sup>74</sup> Baker, 29 July 1870, Chaplains’ Diaries, UWMC, AB 1162/G2.

<sup>75</sup> Baker, 20 Oct. 1874, Chaplains’ Diaries, UWMC, AB 1162/G3.

<sup>76</sup> Baker, 11 Aug. 1876, Chaplains’ Diaries, UWMC, AB 1162/G3.

<sup>77</sup> Baker, 5 July 1872, Chaplains’ Diaries, UWMC, AB 1162/G2.

<sup>78</sup> G. E. Berrios, ‘Historical Background to Abnormal Psychology’, in F. Miller and P. J. Cooper (eds.), *Adult Abnormal Psychology* (Cambridge, 1988), 30.

<sup>79</sup> Swartz, ‘Colonialism and the Production of Psychiatric Knowledge’, 78–9.

Table 1.3 *First diagnoses of first admissions to the Robben Island Lunatic Asylum who were given diagnoses, 1846–1910 (percentage)*

Date	Mania	Dementia	Idiocy		Melancholia	General <sup>b</sup>	Other	Total
			Imb. <sup>a</sup>					
1846–61	52.7 (n = 137)	19.6 (n = 51)	1.6 (n = 4)	0.4 (n = 1)	24.6 (n = 64)	1.2 (n = 3)	100 (n = 260)	
1862–71	28.0 (n = 52)	30.6 (n = 57)	6.5 (n = 12)	3.2 (n = 6)	30.6 (n = 57)	1.1 (n = 2)	100 (n = 186)	
1872–90	53.5 (n = 204)	26.8 (n = 102)	9.7 (n = 37)	6.6 (n = 25)	2.4 (n = 9)	1.0 (n = 4)	100 (n = 381)	
1895–1910	52.8 (n = 161)	13.4 (n = 41)	7.2 (n = 22)	13.8 (n = 42)	9.5 (n = 29)	3.3 (n = 10)	100 (n = 305)	

<sup>a</sup>Idiocy and imbecility were not formally distinguished although the general trend was towards defining more severe cases as idiots.

<sup>b</sup>I have invented this category to describe non-specific diagnoses such as ‘insanity’ or ‘lunacy’.

mid- to late nineteenth century, British alienists admitted more patients with less serious disorders.<sup>80</sup> It is difficult to ascertain reliably the extent of severe dysfunctional behaviour from the diagnoses in the Robben Island admission registers, however, as there are no surviving case books detailing behaviour.<sup>81</sup> The frequency of the appellation ‘dangerous’ (see above) does perhaps indicate that aggression and behavioural dysfunction were very common. Throughout the period, the most common diagnoses for the Robben Island admissions were ‘mania’ of various types, and ‘dementia’ (see Table 1.3). The less disruptive forms of insanity (‘idiocy’, ‘imbecility’ and ‘melancholia’) were diagnosed slightly more frequently as the century wore on, perhaps indicating a greater willingness among doctors to venture out of general descriptions such as ‘insanity’ or a greater preponderance of mental deficiency and depression among patients. As diagnoses became more sophisticated and ‘scientific’, general descriptions like ‘insanity’ or ‘lunacy’ were used less often. Diagnoses of epilepsy remained constant, representing about 10 per cent of first admissions throughout the period 1846–1910, often coupled with other diagnoses.

Delusions were a clear identifier of the insane, by doctors and lay people alike. It has been argued that delusions cannot tell us much about the social fabric of life for the population at large, but delusional content may nevertheless reflect

<sup>80</sup> See L. Smith, *Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England* (London, 1999).

<sup>81</sup> Swartz, ‘Changing Diagnoses in Valkenberg Asylum’, 451 has suggested that because diagnoses and descriptions of symptoms changed so often in asylum records, information about first diagnoses in admission registers does not represent the complexity of the system of psychiatric diagnosis. This means that while we can compare diagnostic patterns to social prejudices, we cannot simply translate nineteenth-century diagnoses into modern ones.

general social tensions.<sup>82</sup> The 1880s was a time of increasing concern about the ‘Malay’ (Muslim) threat in Cape Town, as the white middle classes believed that the smallpox epidemic of 1882 was exacerbated by the burial practices of the Muslim community. Muslims were associated with magic, poisoning and dirtiness.<sup>83</sup> One man who was sent to Robben Island in 1886 complained that he could not fish because the ‘Malay men’ hid under the water and took the fish off his line.<sup>84</sup> Another patient refused to apologize for beating his wife and children because he said ‘a Malay had bewitched him’.<sup>85</sup> The idea of being ‘Malay tricked’ was also a feature of delusional content among Valkenberg patients.<sup>86</sup>

### Causes of insanity

Lay and medical explanations of insanity commonly emphasized the inability of the insane person to cope with the trials and temptations of life, or the adverse effects of excess. This ‘social’ explanation of insanity was older than, and existed alongside, physical explanations (referring to brain lesions) and later physiological ones (referring to brain function) advanced by alienists in Europe and America.<sup>87</sup> But the assignment of etiology was not a priority for the asylum doctor. Only just over a quarter of admissions to the Robben Island asylum between 1872 and 1890 are given etiologies, while the register is complete in most other respects. Of the cases given etiologies, 37 per cent (n = 39) were deemed hereditary, 31 per cent (n = 33) due to physical causes and 26 per cent (n = 28) to moral causes. The latter included ‘adverse circumstances’, ‘disappointed affections’, ‘religious enthusiasm’ and ‘temper’.<sup>88</sup> ‘Physical’ etiologies, that also had moral or social dimensions, included climate, ‘deviant’ sexual behaviour such as masturbation or promiscuity, and alcohol abuse.<sup>89</sup> By the late nineteenth century, doctors saw heredity as the primary etiology. Dodds suggested in 1891 that female insanity was due mostly to hereditary factors or ‘other bodily diseases’.<sup>90</sup> Dr Greenlees of the Grahamstown Asylum

<sup>82</sup> J. C. Burnham, ‘Psychotic Delusions as a Key to Historical Cultures: Tasmania, 1830–1940’, *Journal of Social History* 13 (1980), 373.

<sup>83</sup> J. V. Bickford-Smith, *Ethnic Pride and Racial Prejudice in Victorian Cape Town: Group Identity and Social Practice, 1875–1902* (Cambridge, 1995), 71–4.

<sup>84</sup> Case of Jan, n.d., Health Branch, Criminal lunatics 1893–1899, CO 8050, CA.

<sup>85</sup> Case of Bekker, 25 Nov. 1895, Attorney General’s Papers, Lunatics 1894–5, AG 1932, CA.

<sup>86</sup> Swartz, ‘The Black Insane’, 404–5.

<sup>87</sup> Berrios, ‘Historical Background’, 29.

<sup>88</sup> These etiological terms were not invented by colonial doctors (see Sankey cited in R. Russell, ‘Mental Physicians and their Patients: Psychological Medicine in the English Pauper Lunatic Asylums of the later Nineteenth Century’, PhD thesis, University of Sheffield (1983), 41).

<sup>89</sup> For an example of self-diagnosis see A. Simons to W. J. Dodds, 22 December 1894, Valkenberg Asylum casebook 1, 1891–4, UCT Manuscripts Collection, Cape Town.

<sup>90</sup> Report of Inspector of Asylums in ‘Reports of the Medical Committee . . . for 1891’, CPP, G36–1892, 10.

argued that heredity was a more important cause of insanity among whites in the Colony than in England.<sup>91</sup> There was a marked drop in diagnostic interest at Robben Island after 1890, due probably to the large number of supposedly ‘incurable’ black and criminal cases. Etiologies were given to only 11 per cent (n = 34) of first admissions in the period 1895–1910, compared to 28 per cent (n = 106) in the period 1872–1890.

Throughout the period 1846 to 1910, alcoholism was advanced as a cause of insanity in just over a tenth (n = 18) of all cases given etiologies. This is the second largest category after ‘heredity’. In evidence from the 1850s, it is clear that although addiction to drink was seen as a cause of insanity, being drunk was not conflated with being insane, and the insane alcoholic could be cured by abstinence. K was said by his brother to have ‘destroyed’ his ‘mental faculties’ through drink in 1849;<sup>92</sup> Birtwhistle suggested in 1850 that Hugh G be sent on a sea voyage to avoid temptation from drink.<sup>93</sup> In 1855 Birtwhistle said that Mr V, admitted to Robben Island with ‘mania’, had merely been ‘suffering from the effects of drink’ when examined by Dr Frankel on the mainland, and was not therefore showing further signs of insanity.<sup>94</sup> Epileptic cases, said the chaplain in 1876, would be improved by ‘the withholding of intoxicating drinks’.<sup>95</sup> Alcohol was nevertheless provided for patients as part of their asylum diet because it was a central part of nineteenth-century medical treatments.<sup>96</sup> In the 1860s, a patient with *delirium tremens* was turned away from the Somerset Hospital with the advice to go home and drink some whisky.<sup>97</sup>

### **The social profile of the Robben Island patient**

This section examines the social profile of first admissions to the Robben Island asylum between 1846 and 1910, focusing on the period 1872–1890, for which there is most information. This period differs from earlier and later periods at the asylum because non-criminal cases make up a large proportion of the intake, and white lunatics predominate. The figures in Table 1.4 show that the Robben Island admissions were disproportionately likely to be middle-aged

<sup>91</sup> Quoted in R. C. Warwick, ‘Mental Health Care at Valkenberg Asylum 1891–1909’, BA (Hons.) thesis, UCT (1989), 57.

<sup>92</sup> Memorial of K, 29 October 1849, memorials received by Colonial Office, CO 4047, doc., 3, CA.

<sup>93</sup> J. Birtwhistle to Colonial Secretary, 23 Oct. 1850, Robben Island Letterbook, RI 1, CA. See also Birtwhistle to Colonial Secretary, 2 Nov. 1854, Robben Island Letterbook, RI 1, CA.

<sup>94</sup> Birtwhistle to Colonial Secretary, 18 March 1855, Robben Island Letterbook, RI 1, CA.

<sup>95</sup> Chaplain’s Report in ‘Report on the General Infirmary, Robben Island for the year 1876’, CPP, G20–1877, 6.

<sup>96</sup> W. Edmunds in P. E. Wodehouse to the Duke of Newcastle, 7 Aug. 1863 in ‘Correspondence between the Colonial Government and the Authorities at Home Relative to the Robben Island Institution 1863–1865’, CPP, A9–1865, 18.

<sup>97</sup> P. Landsberg, minutes of evidence, ‘Report of the Select Committee appointed to take into consideration the papers laid on the table referring to Somerset Hospital’, CPP, A27–1865, 20.



Table 1.4 *Social profile of first admissions to the Robben Island Lunatic Asylum, 1846–1910*

Date	Total in sample	White %	Male %	Paying %	Mean age	Median age
1846–61	261	37.8	61.8	0.8	33.5	30.0
1862–71	186	56.5	68.5	4.8	33.8	32.0
1872–90	384	60.8	65.0	24.0	35.2	34.5
1895–1910	310	19.4	63.9	7.1	34.9	32.0

males between 1862 and 1890. Paying patients represented about a quarter of first admissions between 1872 and 1890.

Different admission or diagnostic patterns for racial and gender-defined groups at the Robben Island asylum could be caused by the race or gender-bias of colonial officials or doctors, or by systematic differences between these groups in terms of family circumstance, culture and incentives or opportunities for seeking care. The relative role of these factors in diagnosis could be established by looking at individual case records. These are however absent from the Robben Island archive, the only detailed case records coming from records of those transferred to Valkenberg or Grahamstown or the Old Somerset Hospital. An analysis of the patient profile can nevertheless inform our understanding of the way in which the asylum was used by psychiatrists, their clients and the community.

Fox shows that admissions to the San Francisco Asylum (1906–29) were mostly lower-class, single adult males.<sup>98</sup> Black admissions to Robben Island were largely single adult males but among white admissions there was an increasing tendency to use the asylum for middle-class, married white females in the period from 1860 to 1890. Both black and white women continued to be underrepresented at Robben Island compared to the colonial population, however, possibly for different reasons. Black women, especially Africans, were not fully urbanized and therefore avoided contact with white employers or agents of the state. More white families could afford private care to avoid the stigma of institutionalization, and they were more likely to keep mentally ill women at home.

Recent historians of gender and psychiatry have argued that women have suffered the brunt of psychiatric intervention as they are represented in greater numbers both in Victorian asylums and in the more diffuse psychiatric patient population today.<sup>99</sup> This feminization of psychiatry is not evident in South

<sup>98</sup> Fox, *So Far Disordered in Mind*, 105.

<sup>99</sup> E. Showalter, 'Victorian Women and Insanity', *Victorian Studies* 23 (1980), 161.

Africa: neither at Robben Island during the nineteenth century, nor today.<sup>100</sup> During the nineteenth century the gender ratio in Cape asylums remained stubbornly favourable to men. In the early twentieth century, the preponderance of male patients at Robben Island can be partly ascribed to the increasing proportion of criminal insane patients (largely men), and possibly also to the increasing proportion of black patients, for which group there may have been some gender specific recruitment because of the initial predominance of males among African migrant labourers in the urban areas. By the 1890s only Valkenberg Asylum attracted a significant proportion of long-stay female patients whose middle-class families found the asylum acceptable.<sup>101</sup>

External factors and the allocation of institutional beds in segregated asylums can also influence gender ratios, however. The dominant use of the Victorian asylum for pauper cases (women were more likely to be recipients of poor relief), and the provision of more ward space for women in asylums built after the 1830s were important factors in creating the consistently high ratios of women to men in Victorian asylums.<sup>102</sup> And although admission ratios are valuable in detecting inequalities, they do not tell the whole story. As Fox has pointed out, inequalities in admission ratios, or the lack of such inequalities, does not automatically imply the absence of gendered inequalities associated with psychiatric care.<sup>103</sup> In fact, he shows that in San Francisco between 1906 and 1930, although gender ratios on admission approached unity, women admitted to the state asylums suffered from longer attacks, were more likely to have had previous commitments and attacks, and were overrepresented in the age group sixty-five and over, compared to men.<sup>104</sup> Both variation in length of stay (women stayed longer) and allocation of bed spaces (men had more bed spaces) played a role in the gendering of psychiatric provision at Robben Island.

Compared to the general population, proportionally fewer black people than white were admitted to Robben Island asylum. As in the past, black South Africans today have different admission figures for certain psychiatric conditions,<sup>105</sup> there are racial differences in the type and form of some mental diseases,<sup>106</sup> and some have argued that there are different intra-racial profiles depending on experiences of urbanization and what has been termed 'transculturation'.<sup>107</sup> In modern South Africa where racial differences are bound closely to class and cultural divides, different patterns of aid-seeking,<sup>108</sup>

<sup>100</sup> Swartz, 'Colonialism and the Production of Psychiatric Knowledge', 21.

<sup>101</sup> *Ibid.*, 35, 45, 46. <sup>102</sup> Showalter, 'Victorian Women and Insanity', 162, 164.

<sup>103</sup> Fox, *So Far Disordered in Mind*, 105, 124. <sup>104</sup> *Ibid.*, 127–29, 131.

<sup>105</sup> Freed and Bishop cited in L. Swartz, 'Aspects of Culture in South African Psychiatry', PhD thesis, UCT (1989), 39.

<sup>106</sup> Bartocci cited in Swartz, 'Aspects of Culture', 41.

<sup>107</sup> Cheetham *et al.* cited in Swartz, 'Aspects of Culture', 47.

<sup>108</sup> Swartz, 'Aspects of Culture', 40.

different cosmologies,<sup>109</sup> complex culturally based communication failures between psychiatrist and patient and other variables can systematically influence psychiatric profiles of the various racial categories. Leslie Swartz argues that different incentives and opportunities for admission may by themselves produce different psychiatric profiles for various racial groups in South Africa today.<sup>110</sup> He has also criticized modern cross-cultural studies in South African psychiatry for treating black and white patients as culturally separate.<sup>111</sup> In assessing degree and amount of mental illness among Xhosa speakers in South Africa using the Present State Examination (PSE) in translation as a standard diagnostic tool may be problematic.<sup>112</sup> Many studies continue, explicitly or implicitly, to use racial stereotypes (e.g. the African personality), or a passive, static representation of African culture, in order to explain the extent and type of mental illnesses among black people.<sup>113</sup> Similar patterns of racism within psychiatry have been documented in Britain, where schizophrenia, for example, is more commonly diagnosed among blacks and the Irish.<sup>114</sup>

Cultural factors would certainly have affected the admission process at Robben Island. Fox argues that in early twentieth-century San Francisco, insane foreigners were relatively unlikely to have family in the area who could refer them to the asylum and were therefore more likely to be picked up by police. But by comparing police referrals for foreigners and for locally born cases without family in the area, Fox can conclude that cultural factors played a large role in determining which people were taken in by police. Foreigners wandering about the city in inappropriate areas would be picked up and, if unable to give a good account of themselves in English, appearing confused or hostile, would often be sent to the courts on a charge of insanity.<sup>115</sup> In the nineteenth-century Cape, recent arrivals to urban areas, especially those who did not speak English, sometimes ended up in the asylum.<sup>116</sup> Recent arrivals from rural African communities in the eastern Cape may have experienced similar problems, as they did in Argentina and Australia.<sup>117</sup> Cultural ‘boundaries’ were not always contiguous with nineteenth-century racial categories, however. Cultural similarities between rural Cape ‘coloured’ and

<sup>109</sup> H. Ngubane cited in Swartz, ‘Aspects of Culture’, 22.

<sup>110</sup> Swartz, ‘Aspects of Culture’, 40. <sup>111</sup> *Ibid.*, 52.

<sup>112</sup> Gillis *et al.* cited in Swartz, ‘Aspects of Culture’, 36.

<sup>113</sup> Swartz, ‘Aspects of Culture’, 17, 23.

<sup>114</sup> M. Lipsedge and R. Littlewood, *Aliens and Alienists: Ethnic Minorities in Psychiatry* (London, 1989).

<sup>115</sup> Fox, *So Far Disordered in Mind*, 87–89.

<sup>116</sup> For example, see the report of a Russian detained at Robben Island who could not speak any English, Health Branch Correspondence, 1901, CO 7258, CA.

<sup>117</sup> J. Ablard, ‘The limits of psychiatric reform in Argentina, 1890–1946’, below, notes a similar pattern for long-distance peasant admissions to asylums in Buenos Aires; see also Coleborne, ‘Passage to the asylum’, below, on Chinese immigrants to Australia.