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Psychiatry, Mental Institutions, and
the Mad in Apartheid South Africa

Tiffany Fawn Jones



Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa

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To all those who were institutionalized and those that were not.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
APA	American Psychiatric Association
BAD	Department of Bantu Administration and Development
BOSS	Bureau of State Security
CCHR	Citizens Commission of Human Rights, Church of Scientology
CHP	Centre for Health Policy
DI	Department of the Interior
DOH	Department of Health
DPH	Department of Public Health
ECT	Electro-Convulsive Therapy
EEG	Electroencephalography
GALA	Gay and Lesbian Archives
HIV	Human Immunodeficiency Virus
ICRC	International Committee of the Red Cross
MASA	Medical Association of South Africa
MEDUNSA	Medical University of South Africa
MP	Minister of Parliament
MRC	Medical Research Council
NP	National Party
SADF	South African Defence Force
SAMC	South African Medical Corps
SANA	South African Nursing Association
SANC	South African Nursing Council
SANCMH	South African National Council for Mental Health
SASOP	South African Society of Psychiatrists
SPNSA	Society of Psychiatrists and Neurologists of South Africa
SPSA	Society of Psychiatrists of South Africa
TB	Tuberculosis
WHO	World Health Organization

Timeline of Major Events Pertaining to Mental Health in South Africa, 1916–2002

- 1916 Mental Disorders Act No. 38
- 1920 South African National Council of Mental Health established
- 1939 World War II begins
- 1944 Mental Disorders Amendment Act incorporates a section on “temporary” patients
The administration of mental institutions is transferred from the Department of Interior to the Department of Public Health
- 1945 World War II ends
- 1946 Tara Hospital opens
- 1948 The National Party is elected and begins implementing apartheid strategies
- 1949 South African National Council of Mental Health registrars as a welfare group
- 1950 Immorality Amendment Act No. 21 prohibits all “immoral” sexual acts, including adultery, between blacks and whites
- 1951 Separate Representation of Voters Bill places coloureds on a separate voters role than whites
University of Natal accepts black students into its medical school
Bantu Authorities Act No. 68 enables the establishment of black homelands with eventual goal of self-government
- 1953 Tara Hospital initiates the first outpatient program in South Africa
- 1957 Mental Disorders Amendment Act removes the class of “social defective” and changes the name of the Commissioner for Mental Disorder to Commissioner of Mental Hygiene.
Immorality Amendment Act No. 23
Hubbard Association of Scientologists International opens offices in Johannesburg and Durban
- 1961 South Africa becomes a Republic
Mental Disorders Amendment Act includes a category for outpatients and extends free treatment to voluntary patients who cannot afford services
Interdepartmental Committee Report on the construction of mental institutions in homelands

- 1963 Smith Mitchell opens its first long-term care institution
- 1966 Society of Psychiatrists and Neurologists of South Africa officially formed
Prime Minister H. F. Verwoerd assassinated
- 1967 Commission of Inquiry to Inquire into the Responsibility of Mentally Deranged Persons and Related Matters (Rumpff Commission)
Committee of Inquiry into the Care of Mentally Deficient Persons
- 1968 Immorality Amendment Bill on homosexuality criminalizes all public homosexual activities and bans sexual devices
South Africa leaves the Commonwealth
- 1969–
- 1974 Aubrey Levin joins the South African Medical Corps of the SADF and begins “aversion therapy” on homosexuals in the military
- 1970 Bantu Homelands Citizens Act
- 1971 Bantu Homelands Constitution Act (National States Constitution Act) No. 21
- 1972 Commission of Inquiry into the Mental Disorders Act, 1916 (Act No. 38 of 1916, as amended) and Related Matters (Van Wyk Commission)
- 1973 Mental Health Act No. 18
The American Psychiatric Association removes homosexuality from its *Diagnostic and Statistical Manual of Psychiatric Disorders*
Commission of Enquiry into Scientology
- 1975 Proclamation on Rehabilitation Institutions in the Bantu Homelands
- 1976 Government rules that medical schools at universities can no longer admit black students. Sets up the Medical University of South Africa for black students
- 1976 Mental Health Amendment Act prohibits publication of any photographs, sketches or information pertaining to mental institutions
- 1977 World Health Organization reports on South African mental institutions
- 1978 American Psychiatric Association investigates and reports on Smith Mitchell facilities
- 1981–
- 1990 Stanley Platman conducts bi-annual reviews of Smith Mitchell facilities
- 1983 Royal College of Psychiatrists conducts an investigation into Smith Mitchell institutions
- 1984 Tricameral parliamentary system initiated
- 1990 Nelson Mandela is released from prison
- 1994 First democratic elections in South Africa
- 1997 Truth and Reconciliation Commission, Mental Health Workshop held
- 2002 Mental Health Care Act No. 17

Preface

When I arrived at the Esda Retirement Home in Springs, Gauteng, in 2002 to interview Dan Sable¹ about his experiences in Sterkfontein Mental Hospital where he spent most of his life, I was struck by the poor conditions in which he lived at the time. At the age of seventy, he had spent many years within mental hospitals in South Africa. He was now housed at the end of his life in yet another state institution with no one other than myself to visit him. He complained about his poor treatment and his lack of freedom within the retirement home. Entrenched with ideas about abuse within mental hospitals, I asked him about his earlier life within Sterkfontein, expecting to hear stories of mistreatment and neglect similar to his present circumstances. He began by telling me about how much he had enjoyed his stay at the mental hospital, his fond memories of the food and how he had earned R150 (\$116.17) a month, enough to buy the few things he needed.² Although he recognized some problems within the mental institution, he claimed that it was very good for him, and compared with the life he experienced in the retirement home where he currently lived, he found it far more enjoyable. I thought that Sable was an anomaly in the history of apartheid South Africa's mental hospitals, so I continued my interviews and research, setting his story aside. Numerous reports emerged in the 1970s and 1980s that discussed the mistreatment of patients in South Africa's mental hospitals and accused practitioners of being agents of the state. When I began the research for this book, I thought I would find evidence of such terrible human rights abuses in mental hospitals, especially against South Africa's black population. Moreover, my own personal experience as an ex-patriot South African in a psychiatric wing of a Canadian hospital had left a bad taste in my mouth. If I had felt abused within a Canadian hospital, what would a black patient have felt like in a South African hospital during the racial segregationist years of apartheid?

From 1948 when the National Party won its election and began implementing its strict racist policies, segregating people according to their race and ultimately inciting abuses among the majority of its population, the potential certainly existed for psychiatrists to perpetrate human rights abuses. Initially I set out to find evidence of cruelty and mistreatment.

Reading the few patient letters and files I could find, combing through the archives, people's personal collections and various psychiatric writings, I attempted to track down other individuals who had been housed in South African mental institutions—a very difficult task because the stigma of mental illness continues to prevent people from disclosing their histories. I also scanned South African government statistics about patients in mental hospitals. Some of the stories I read about or heard made me weep, but persistently I was struck by the intense focus by practitioners and government officials on white men in institutions. After months of compiling a breakdown of the number of patients in mental hospitals and an analysis of their race, gender, and occupation, I was taken aback to find that from the early twentieth century onwards, per capita, it was poor white men that were housed in mental hospitals in higher numbers than women and those called “non-whites.” Could Sable then really be representative of South Africa's mental health system during apartheid? Sable was a fellow psychiatric survivor, who although had worked for the gold mines and the railways, had ended up involuntarily in a mental hospital for most of his adult life, stigmatized with the diagnosis of schizophrenia. He was a white man, and ironically in the context of apartheid South Africa, it was this fact that had most likely resulted in his institutionalization. The majority of South Africa's female and “non-white” populations who had been deemed “mad” rarely saw the inside of a state mental hospital. Most were simply neglected. What this meant, however, was that after 1939 in South Africa, institutions and practitioners focused on the very people that the apartheid government wanted to uplift—poor white men.

Yet, worldwide we see evidence that mental hospitals were places where historically minorities, women, and anyone deemed deviant were housed. Over the past century, accusations of human rights abuse in mental institutions around the world have become more prevalent. Throughout colonial Africa, racism pervaded the practices of practitioners and Africans were often the victims of terrible abuse in mental institutions. In Soviet Russia, psychiatrists were involved in schemes to imprison individuals who expressed opposition to the government in mental institutions. In Nazi Germany, practitioners used mental patients as test subjects in scientific experiments and partook in their execution. In the United States and Canada, high incidences of women and minorities have been, and continue to be, housed in mental institutions. Scholars have also documented the abuse of indigenous peoples in mental hospitals in New Zealand and Australia. Today, cases of psychiatric abuse of minority and female patients continue to emerge.

If South Africa's focus was on treating white men, how do we account for the numerous accusations of human rights abuse against Africans that arose against practitioners during the apartheid years? When interrogating the origins of these allegations, to my surprise, I found that it was not independent international organizations, rogue practitioners, or former patients that had continuously highlighted maltreatment, but the South African division of

the Church of Scientology that had played a crucial part in spreading these charges. In the 1960s, Scientology, a zealous anti-psychiatric organization, had become increasingly concerned about what they deemed were human rights abuses in South African mental hospitals and were sending press reports to South African newspapers and around the world, hoping not only to bring attention to what they deemed were human rights abuses, but also to themselves. They were somewhat successful. Reading the published accusations of mistreatment in South Africa advanced by the Church of Scientology in newspapers, organizations such as the World Health Organization, the International Red Cross, the American Psychiatric Association, the Royal College of Psychiatrists, and individuals all conducted studies into conditions in South Africa's mental hospitals for over a decade thereafter. Although these investigations found some evidence of abuse within the institutions, for the most part they found the specific allegations initially raised by the Church of Scientology to be unfounded.³

The Church of Scientology's current publications on racism and psychiatry continue to promote their role in uncovering abuses during apartheid South Africa. When they first began publishing their criticisms, Scientologists' accusations against South Africa's psychiatrists and medical practitioners played on the growing anti-apartheid sentiment that existed throughout the world. Whereas psychiatric practitioners were far from ideal global citizens, they were not the literal communist demons, horns and all, as depicted by Scientologists. Certainly, South African mental institutions were spaces where human rights abuse occurred and where the state detained some of its opponents. Indeed, there were instances of these abuses that we should not ignore. Practitioners sometimes contributed to, and at times facilitated, mistreatment. But mental health practitioners as a group did not give blanket support to the racialized ideas of apartheid.

Today South Africa's mental health system is overloaded and understaffed. Makeshift solutions have done little to deal with the overcrowding and overall lack of services in general. It is a convoluted and ineffective system that is desperately in need of an overhaul. Moreover, the inequity of treatment and services along racial, gender, and class lines persists and reports continue to emerge of abuse within the system. Staff shortages, lack of sufficient beds, and limited funding for mental health all have contributed to these human rights violations. But if we do not have a thorough understanding of the origins and historical perceptions that are so ingrained in the system, how do we then know what the solutions are? A more nuanced understanding of South African mental health views and practices in the period leading up to and during the height of apartheid South Africa therefore is desperately needed.

Acknowledgments

The research for this book has not been an easy feat. Sources were scattered in back offices, individual garages, and makeshift archives. Much has been destroyed. Moreover, the writing of this book was often an emotional journey into the lives of those patients who were affected by South Africa's mental health system. Their experiences cannot be possibly appreciated in the confines of these pages, but it is my hope that I have at least captured their context. It is to them that this book is dedicated.

A project such as this could never have been completed without the selfless support of countless of individuals who helped along the way. First and foremost, I owe the utmost gratitude to Alan Jeeves. His thoughtful guidance, patience, and understanding during the research of this project was always much appreciated. Much thanks also to Jane Parpart, Robert Shenton, Alison Goebel, Jacklyn Duffin, Sally Swartz, Villia Jefremovas, Karen Dubinsky, Marc Epprecht, Shula Marks, Glen Elder, and Chertin Lyon whose suggestions and comments at different stages of research encouraged me to seek beyond the obvious. Their advice was always poignant and helpful. The failures of this book are, however, all my own. Thanks also to the Social Science and Humanities Research Council, Timothy C. S. Franks Travel Award, and Queen's University for funding the original research.

Over the last ten years, this research took me to various places in South Africa and North America where numerous individuals opened their homes, their offices, and their lives to me. Philip Bonner and the University of Witwatersrand History department offered me a most welcome place to hang my proverbial hat during research and I am much obliged. Stanley Platman and his wife, Vera Thomas, in Baltimore gave me access to a plethora of information about Smith Mitchell institutions from their personal archives and offered me numerous cups of tea. Lennart Eriksson opened up part of the archives of Lifecare in Randburg to me and recognized the historical importance of the Platman reports. Melvyn Freeman at the Department of Mental Health made sure that I was able to obtain recent department records not yet housed at the archives. Janis van der Westhuizen, and Eddie and Margie Hattingh opened up their homes to me while researching.

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Introduction

In 1975 the Johannesburg *Sunday Times* published a one page opinion article by Fleur de Villiers entitled “Millions Out of Madness.” Basing her expose on testimony given by Jan Robbertze, head of Clinical Psychology at the University of Pretoria and Chairman of the South African National Council for Mental Health, she claimed that a private company was making a profit from the mental illness of black individuals and operating “Dickensian workhouses” that were “an uncomfortable reminder of the bad days of Bedlam.” De Villiers argued that expenditures on patients were minimal and suggested that the company had a vested interest in keeping patients within these “human warehouses.”¹ A few months later, the Church of Scientology’s *Peace and Freedom* magazine investigated these allegations further. They claimed that thousands of Africans were forced to work and die in these mental health “labour camps,” abuse was rampant, and patient well-being was usurped by economic profit.² They then sent press reports to various news outlets in the world. This was merely the beginning of investigations of South African state and private mental hospitals. Throughout the 1970s and 1980s, reports emerged of South African mental institutions housing black political opponents to the government, excessively using electrotherapy, conducting pharmacological experiments on patients, forcing them to work as slave labor, and allowing high rates of sexual abuse by staff against patients.³ Academics, politicians, journalists, ex-political detainees, international organizations, and religious groups documented human rights abuses by mental health practitioners during apartheid South Africa. The World Health Organization, the American Psychiatric Association, the International Red Cross, individual psychiatrists, patients, and newspapers worldwide all condemned the inhumane treatment of black patients within South Africa’s mental hospitals. Their conclusions are somewhat analogous to reports of psychiatric abuse in colonial Africa, Soviet Russia, and Nazi Germany.

In 1997 during South Africa’s Truth and Reconciliation Commission, scandals about psychiatric abuse of young, gay white conscripts in the South African Defence Force (SADF) came to the fore. Aubrey Levin, now known as “Dr. Shock,” who headed up the SADF’s psychiatric wing,

2 *Psychiatry in Apartheid South Africa*

administered electroshocks to gay men while showing them nude pictures in order to “cure” them of their homosexuality. In August 2010, these stories were reiterated in newspapers worldwide when Levin, who left South Africa in 1998 to practice psychiatry in Alberta, Canada, was charged with 21 counts of sexual assault against Canadian male patients under his care. At the time of writing this, Crown lawyers estimated the number of Levin’s Canadian victims to be even higher. South Africa’s psychiatric sector has a long, sordid history of being associated with abuse.⁴

There is credibility to these accusations and certainly there are horrid instances of psychiatric mistreatment that occurred during the racist years of apartheid that are comparable to those in Soviet Russia, Nazi Germany, and other areas of Africa. Some psychiatric practitioners supported the mandate of the racist and heteropatriarchal government and most mental patients, particularly African patients, were treated abysmally. Rudimentary tales of abuse in South Africa’s mental hospitals, however, fail to account for the fact that not all South African practitioners partook in abuse and they were not simply oppressors. We need to understand that mental health practitioners’ roles were not simply the agents of the racist apartheid government. Their positions were a lot more complex.

Delivery of mental health services in apartheid South Africa was diverse, multi-layered, and often makeshift. South Africa’s mental health infrastructure consisted of disconnected components, such as state institutions, prisons, general hospitals, courts, military institutions, semi-private institutions, social welfare offices, and the community. Psychiatrists, general practitioners, superintendents, psychiatric nurses, district surgeons, social workers, and other professionals such as psychologists and indigenous healers treated mental patients on a daily basis. In addition, government officials, magistrates, prison wardens, judges, mental hospital board members, family members, patients, private psychiatrists, and privately owned facilities all had influence in their administration. The mental health sector during apartheid South Africa was not a static and cohesive unit. Individuals’ views were often ambiguous, incongruent, and contradictory. Indeed, the disparity among practitioners and the fluidity of practitioners’ beliefs, along with the disjointed mental health infrastructure, not only enabled the diffusion of state control, but also permitted practitioners to adopt ideas concurrently that were contradictory to each other—ideas that may have supported and/or challenged apartheid ideologies. This complexity of views was due to the amorphous nature of the psychiatric profession itself and the diversity of the individuals who provided services to patients. Influenced by varying spiritual beliefs, international psychiatric trends, local political events, economic shifts, and advances in pharmacology and neurology, ideas of madness continuously changed. International pressures also played a role in shaping psychiatric practices. Moreover, patients themselves affected the approaches and methods of the country’s mental health

services. Their important perspectives on the national mental health system during apartheid should be acknowledged.

Certainly South African mental health institutions were spaces where human rights abuse occurred and opponents of the state were detained. Moreover, practitioners often contributed to, and at times facilitated, these abuses. But it is not enough simply to dismiss psychiatrists as a homogenous group of actors explicitly directed by a well-organised and monolithic state. Instead, complex relationships existed between practitioners, patients, and government officials and we should place the meanings of and practices pertaining to madness within their specific historical contexts. South Africa's psychiatric views and mental health policies did not exist in a vacuum. They were highly influenced by local socio-political events and changing international trends. Indeed, South African practitioners and government officials' perspectives of the mad often followed those of their European and North American counterparts, while they also frequently adapted to local pressures. In an examination of the views and practices of practitioners and patients within a changing political structure, one sees the multiplicity of the mental health system, a multiplicity that has often been overshadowed by stories of abuse.

Whereas the reports that emerged of abuses in South Africa's mental health services importantly highlighted the failures of the system, they neglected to recognize its multifarious and contradictory nature. Nor did they appreciate the full historical context or the complex position of those within it. While not contesting the belief that human rights abuses occurred within South Africa's mental hospitals, we need to acknowledge that the South African mental health system during apartheid was far more complicated than what might at first glance appear to be simple cases of patient abuse. Unlike Soviet Russia, the apartheid government never used mental hospitals as its principle means to control its political dissidents.⁵ Nor did it use mental hospitals to specifically rid itself of those it deemed racially inferior as in the case of Nazi Germany. Instead, in South Africa, officially sanctioned mental health institutions and services for the black majority were largely lacking. Although this neglect of mental health services during apartheid was in itself a form of abuse, it was also positive in that mental health services were not simply the instruments of the apartheid government. For the most part, practitioners focused on treating white men and hospitals housed more white men per capita than women, Africans, Indians, or coloureds. White men occupied about 20 percent of the beds in the hospitals, while they only made up about 5 percent of the population. Black men and women made up about 80 percent of South Africa's population, but made up only fifty percent of the patients. Black women in particular only made up only 18 percent of the occupants in hospitals.⁶ In order to understand why this was the case, we need a more nuanced understanding of the South African mental health system in the period leading up to and during the height of apartheid.

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Table 0.1 Number of Beds and Patients in Mental Institutions by Race and Gender, 1935–1970

Type of Patient Resident on 31 Dec	1935		1940		1945		1950	
	Patients	Beds	Patients	Beds	Patients	Beds	Patients	Beds
White	4,153	3,991	4,701	4,495	6,674	6,454	7,056	7,953
Male	2,196	2,119	2,428	2,383	3,354	3,308	3,535	4,142
Female	1,957	1,872	2,273	2,112	3,320	3,146	3,521	3,811
Non-White	5,831	4,928	7,856	5,894	9,117	6,389	10,038	8,189
Male	3,970	3,406	5,226	3,953	6,120	4,464	6,737	5,625
Female	1,861	1,522	2,630	1,941	2,997	1,925	3,301	2,564
Total	9,984	8,919	12,557	10,389	15,791	12,843	17,094	16,142
No. of institutions	9		9		12		13	

Type of Patient Resident on 31 Dec	1955		1960		1965		1970	
	Patients	Beds	Patients	Beds	Patients	Beds	Patients	Beds
White	7,342	7,774	7,651	7,844	8,054	8,762	8,251	8,543
Male	3,734	4,207	3,870	3,818	4,112	4,173	4,259	3,931
Female	3,608	3,567	3,781	4,026	3,942	4,589	3,992	4,612
Non-White	11,577	9,373	12,563	7,305	13,899	8,747	15,598	11,720
Male	7,978	6,665	8,752	5,244	9,647	6,123	9,784	7,249
Female	3,599	2,708	3,811	2,061	4,252	2,624	5,814	4,471
Total	18,919	17,147	20,214	15,149	21,953	17,509	23,849	20,263
No. of institutions	13		13		15		18	

Numbers for 1935 and 1940 are compiled from statistics South Africa and include Voluntary Boarders, but do not include numbers for institutions for feeble-mindedness. Numbers from 1945–1970 are from Mental Health Commissioners' annual reports and include institutions for feeble-minded and voluntary, observation, temporary and inebriate patients. A few Commissioner's reports had addition errors in them. These have been corrected in the above table.

THE ANOMALY OF APARTHEID MADNESS?

The specific racialized and heteropatriarchal nature of apartheid South Africa does suggest that a power structure existed that would have encouraged a climate of human rights abuses by practitioners and where Africans, particularly African women, were the victims, both physically and mentally, of this oppression. Actions on the part of states to fashion and legitimate particular models of social norms are common. The very process of state formation is intrinsically tied to organizing notions of normality and morality. For example, in their analysis of the rise of the English state between the eleventh and late nineteenth century, Philip Corrigan and Derek Sayer argue that state creation is part of a “cultural revolution” that normalizes specific “forms of social order” so that they become accepted rules.⁷ The state adopts a process of what it calls “moral regulation,” that is “a project of normalizing, rendering natural, taken for granted, in a word ‘obvious’, what are in fact ontological and epistemological premises of a particular and historical form of social order.” In so doing, the state sanctions some ideas, while “suppressing, marginalizing, eroding, [and] undermining others.”⁸ Linzi Manicom, through her application of Corrigan and Sayer’s arguments to South Africa, shows how the everyday administration of the state, such as the “recording of demographic information, the application of dress codes, the bureaucratic procedures, the regulation of

labour, marriage and schooling” all allowed the state to establish political subjectivities and regulate difference.⁹ If we extend this argument to include state sanctioned regulations concerning madness, the legitimating of a set of mental health standards, legislation, categorizations, and overall policy in nation states is indeed part of the larger political process of hegemony and subjectification. One could argue further that states are directly concerned with governing the mentality of their populations.

Michel Foucault has written extensively about the influence that the state has historically had on the regulation and order in various social institutions, such as mental institutions, clinics, and prisons. In *Madness and Civilization: A History of Insanity in the Age of Reason*, he examines the confinement of large numbers of poor, mad, and homeless people in Europe in state mental institutions during the mid-seventeenth century. This period of “great confinement,” he argues, was due directly to economic and social pressures faced by the state and its need to retain social control. He asserts that a new medical discipline developed that, while couched in terms of scientific humanitarianism, was actually a means by which to enforce existing power structures and to legitimate dominant social positions.¹⁰ This power, which he later calls “disciplinary power,” is a tool used to organize and control a population as a means to create productive “docile bodies.”¹¹ Medical professionals therefore “subjectified” patients in the sense that medical and psychiatric discourse imposed certain notions of normality upon them, whereas psychiatrists also objectified patients so that they became “objects of science.”¹² In his 1991 essay on government, Foucault also shows how states fashion a patriarchal (and this can be described further as a heteropatriarchal) social structure, similar to that of a father to his family.¹³ The state becomes a disciplinarian and regulator of populations, but is not simply concerned with imposing its laws.¹⁴ Simply stated, he argues that in order to fulfill its mandate, a state will often “dispose” or remove those deemed socially deviant, such as those deemed insane or criminals, from society. States can classify and confine patients indefinitely with the semblance of concern about social and individual wellbeing, even if its goal may be to control its labor force, manage the actions of certain of its citizens, or even to simply perpetuate its ideal of a modern, sanitary living space free from vagrants.

Early studies on relationships between colonial states and psychology/psychiatry in Africa tend to emphasize the connection between the state and the mental subjectification of its population. Three key African scholars of the 1950s, Octave Mannoni, Franz Fanon, and Albert Memmi, all have examined the effect of the colonial state on the African mind. They theorized the mental abuses perpetrated by colonialists and practitioners alike in colonial West and North Africa and pointed to the psychopathological nature of colonial control and the negative mental impact of colonialism on all involved. Mannoni, for example, argued that in the African colonial state, two opposing types of psychological complexes existed—the

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“dependency complex” and the “inferiority complex,” the former of which Africans adopted during colonialism as a means to gain “security and protection” from the colonizer.¹⁵ This, he argued, resulted in a reciprocal relationship whereby “the master has a servant, the servant likewise has a master.”¹⁶ The colonizer, which included practitioners, in turn, in fulfilling the oppositional role, developed an “inferiority complex.” To compensate for their own inferiority, they willingly created dependents.¹⁷ While accepting Mannoni’s Hegelian master-slave dichotomy, Fanon, however, challenged Mannoni’s contentions of the insecure colonizer and dependent colonized as intrinsic characteristics of each group, and questioned his disregard of the socio-economic affect of colonization on the colonizers. Africans and Europeans did not possess these complexes inherently, he argued, but they were produced by the colonial system.¹⁸ Likewise, Memmi also accepted Mannoni’s basic explanation, but challenged Mannoni’s failure to account for the economic underpinnings of colonialism.¹⁹ For Memmi, the colonizer lived in a state of “inherent contradiction,” which, if left unrecognized, would “disfigure the colonizer.” The cure to this “disease” affecting the colonizer is “difficult and painful treatment, extraction and reshaping of present conditions of existence.”²⁰ If this was not done, he argued that the colonized would then force the end of colonialism.²¹

In Fanon’s later works, *Wretched of the Earth* and *A Dying Colonialism*, he implicates colonialism as being the “fertile purveyor for the psychiatric hospital.” Fanon also argued that colonial psychiatrists were representatives of the state.²² Fanon himself was a psychiatrist at the Blida-Joinville Hospital in Algeria between 1953 and 1956. He was well situated to present such a criticism. Western medical science in general was, he argued, “part of the oppressive system” and “the doctor always appears as a link in the colonialist network, as a spokesman for the occupying power.”²³

Fanon, however, was concerned with the liberation of the colonized from the constraints of colonial alienation, of which he saw psychiatry as part. He argued that it was necessary for the colonized first to recognize their own subjectivity and become liberated from themselves, be aware of their own difference, and then embrace this difference as a means for emancipation from colonial rule.²⁴ Lynette Jackson, in her book on the Ingutsheni Mental Hospital in Zimbabwe adopts this aspect of Fanon’s argument and applies it to colonial Rhodesia. She contends that the hospital indeed played a disciplinary role in Rhodesian society and became a microcosm for colonial society in general. When Zimbabwe gained its independence, the transformation of the Ingutsheni Mental Hospital became symbolic of removing the very shackles of colonization.²⁵ What we need to understand though, and what is striking is in Fanon, Memmi, and Mannoni’s arguments, is that they recognized that the colonial state fashioned psychological complexes, not only in the colonized, but in the colonizer as well. This may potentially explain why South African mental institutions focused on white men.

These authors focused mainly on the construction of racial difference, but race was not the only factor that influenced colonial policies in Africa. Changing conceptions of class, sex, gender, and sexuality were also central components of colonial segregationist policies. Governments systematically divided their landscapes into hierarchical, racialized, and gendered spaces that set up specific roles for women and men all based on a white heterosexual model. Anyone who moved outside this model was generally marginalized or sanctioned in some way.²⁶

Since the late 1960s, feminist scholars all over the world have called attention to and rejected the gendering of psychiatry. They point to how psychiatry is inherently patriarchal and skewed against women, mostly because the main diagnostic characteristics use men as the standard of normalcy, and society expects women to have more passive and less valued roles in society. Any woman who steps outside of her assigned social role can be deemed as mentally disordered.²⁷ Even the indigenous men in colonial societies played a role in inciting this view of women. Jackson, for example, has shown that in colonial Zimbabwe, any “stray woman” who was no longer being watched by their fathers or husbands was seen to be “pathological.”²⁸ We see this during apartheid South Africa as well, where the apartheid government consigned the position of black women to rural areas through the construction of “homelands” and the implementation of pass laws. When single black women began to move to urban centers, many state officials and some state practitioners declared these women as being the cause of moral decay. As the Minister of Native Affairs, E. G. Jansen, stated, “it is constantly being said that the Natives in the cities deteriorate. The undesirable conditions are largely caused by the presence of women, who in many cases leave their homes contrary to the wishes of their fathers and guardians.”²⁹ Heteropatriarchal conceptualizations dominated South African understandings of normality and mental disorder, with all notions of mental normality based on the white heterosexual male. In turn, blacks, coloureds, Indians, and women were seen as fundamentally disordered. Some feminist scholars have even argued that because psychiatry and society often depict women as irrational beings, women have become the very image of madness.³⁰

One can extend these arguments to include conceptions of homosexual men. Worldwide, governments and psychiatric practitioners often deemed gay men who exhibited what they perceived as “abnormal” or “unnatural” sexual behavior as mad. Indeed, it was only in 1973 that the American Psychiatric Association removed homosexuality from its *Diagnostic and Statistical Manual of Psychiatric Disorders* to which practitioners worldwide subscribe.³¹ In South Africa, the government classified homosexuality as both a criminal offence and a mental disorder. In the 1960s and 1970s, the apartheid government became increasingly concerned with the “spread” of homosexuality among urban white males, and some military practitioners, such as Levin, even reverted to the use of “aversion therapy” where they

administered electric shocks to young conscripts in order to “cure” them of their disordered behavior. They also used hormone therapy and conducted sex change operations.

As the 1950s African writers pointed out about the negative psychological effects of colonialism on the black African mind, feminists and queer theorists have pointed out that the very restrictions placed on women and men to maintain social morality may actually have facilitated concepts of mental disorder. The pressures placed on homosexual men certainly caused them distress. Denise Russell cautiously points out that depression in women is sometimes a reaction to their limited role within society; a sign of the dissatisfaction they feel towards their lives.³² Julie Parle, in her book on the history of colonial Natal mental health also suggests that the incidences of *indiki* or hysteria were a response by Zulu women to restraints within their own communities.³³ Some scholars, however, have moved even beyond these assertions by actually celebrating those classified as mentally ill. Scholars such as H  l  ne Cixous and Xavi  re Gauthier commemorate those women who exhibited hysterical tendencies “as champions of a defiant womanhood, whose opposition, expressed in physical symptoms and coded speech, subverted the linear logic of male science.”³⁴ Forms of mental disorder can be seen as a form of protest against the heteropatriarchal system—a means for individuals to express their frustration—although there may also be some other social factors underlying its cause. Given the stigma attached to mental illness, however, and the sub-standard conditions within mental institutions worldwide, it is unlikely that scores of women and men adopted ideas of mental illness as a form of protest. As Showalter aptly states, ideas of mental disorder as resistance come “dangerously close to romanticizing and endorsing madness as a desirable form of rebellion rather than seeing it as the desperate communication of the powerless.”³⁵

South Africa shows the difficulty of representing mental diagnoses as either a corrective mechanism or a form of resistance particularly well. As Megan Vaughan points out in her examination of whether Foucauldian accounts of medical “disciplinary power” could be applied in a colonial African context, she argues that the colonial state had no need to create an “Insane Other” in order to detain its opponents. It already had an “Other” in the form of an “African.”³⁶ In other words, Europeans, influenced by ideas of social evolutionism, saw the mad in general as being racially degenerate; that is, madness was already depicted as primordial and racialized. Scientific practitioners represented mad individuals as being “savage,” “uncivilized,” and having “black” features. Racial degeneration and madness were therefore interconnected. Yet in a world where Europeans saw Africans as inherently inferior and primitive, paradoxical and unstable ideas of madness developed because it was difficult for colonists to seek out, in the words of Anne McClintock, the “mad, the bad and the dangerous, when all were mad, bad or dangerous.” So, “if . . . colonised people, especially Africans, were figured as *inherently* bereft of reason, as

inherently mentally ‘abnormal’, how then in the colonies, were ‘normal’ Africans to be distinguished from the mentally ill?”³⁷ This is not to argue that psychiatric othering did not occur. Rather, contradictory views could be held simultaneously, so that “anachronistic spaces” remained, that is, spaces where “certain groups and certain spaces within modernity . . . were figured as existing in an earlier, more primitive, prehistoric time.” These spaces could survive together with modern ideals, but were somehow separate.³⁸ To put it in yet another way, layers of “othering” or “madness” could certainly exist within a society at a given time, so that one could be “normal abnormal” and “abnormal abnormal.”³⁹

Whereas apartheid South Africa was not a true colonial state per se, as Mahmood Mamdani has argued, the National Party’s apartheid policies were indicative, if not the epitome, of indirect rule tactics purported by colonialists such as Frederick Lugard in the early twentieth century.⁴⁰ Indeed, much of the divide and rule strategies adopted by the National Party built on existing segregationist practices initiated during the years of British colonial rule. One could certainly expect that the actions of practitioners in apartheid South Africa would have echoed those earlier practices in other colonial African countries. Like Vaughan and McClintock point out for colonial Africa, apartheid South Africa had notions of difference that were convoluted and multi-layered, and variations of earlier colonial views of madness endured throughout the apartheid years. Far from being instruments of control for the government or a means of escape for individuals, mental institutions, and those associated with them played a complex role. Contrary to popular opinion, there were only a small proportion of women and Africans who were actually admitted to psychiatric hospitals. Beds for Africans and women, particularly black women, were limited. This is somewhat different from histories related about colonial mental institutions from elsewhere in the continent and indeed the world. Because of the importance of these distinctive gender and racial ratios within South Africa’s mental institutions, an explanation for them is overdue.

Why did the racist and fascist South African government not use its institutions as a means of social control as scholars have argued existed elsewhere? And what role then did practitioners and patients actually play during apartheid? Why was apartheid South Africa different from other countries in the world where the most common people institutionalized were women and those with darker skin?

Key to understanding the reasons for apartheid South Africa’s difference in comparison to admittance trends in the rest of the world is recognizing the complexity of apartheid itself. As Philip Bonner, Peter Delius, and Deborah Posel have pointed out, apartheid was not a monolithic, well-designed plan.⁴¹ They argue that “the complex patterns of proletarianisation [initiated by apartheid policies] which accompanied . . . processes of migrancy and urbanization, and the intense social dislocation that they