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**CONTRADICTIONS AND CONSTRUCTIONS:  
PSYCHIATRIC PERCEPTIONS IN APARTHEID SOUTH  
AFRICA, 1948-1979**

**by**

**Tiffany F. Jones**

**Submitted in partial fulfilment of the requirements  
for the degree of Master of Arts**

**at**

**Dalhousie University  
Halifax, Nova Scotia  
September, 2000**

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This thesis is dedicated to my husband, Michael Heal, who cheered me on from the sidelines every step of the way. Thanks Michael for all your support, understanding and assistance with everything that I never seemed to have time for.

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## ABSTRACT

South African psychiatrists perpetuated apartheid notions of racial difference between 1948 and 1977. However, support of apartheid ideology by South African psychiatrists was not necessarily uniform. Rather, some psychiatrists supported apartheid ideology, some opposed it, while others did both. Yet most of the assertions by South African psychiatrists who challenged apartheid ideology inadvertently ended up perpetuating apartheid policies and increasing the gap between services for 'White' and 'non-White' patients. In the early years of apartheid, psychiatric innovations of community psychiatry, which promoted more 'open-door' and community-orientated practices, opposed apartheid notions of racial segregation through its focus on prevention. Yet, community psychiatry also neglected the needs of long-term patients – the majority of whom were 'non-White'. The assassination of the state President, H. F. Verwoerd in 1966, by a 'criminally insane' individual, highlighted the psychiatric profession's inability to deal with the 'criminally insane' and long-term patients. In opposition to those psychiatrists promoting community psychiatry, some psychiatrists called for stricter policies concerning mental patients, the majority of whom were 'non-White'. In the 1970s, assertions of cross-cultural psychiatry rejected the biological and racial basis for 'mental illness' and challenged apartheid racism. However, cross-cultural psychiatry also supported apartheid notions of segregation through its stereotypical view of African culture. Thus, much of the psychiatric perceptions during the height of apartheid were ambiguous and contradictory, and ended up supporting the apartheid state. This was because the apartheid state itself was not completely uniform or free of contradictions.

## LIST OF ABBREVIATIONS

BMA	British Medical Association
CCHR	Citizens Commission on Human Rights
DMD	Defective Mental Development
DOH	Department of Health
ECT	Electroconvulsive Therapy ('Shock Treatments')
MASA	Medical Association of South Africa
MEDUNSA	Medical University of South Africa
MP	Member of Parliament
MSRC	Medical Students' Representative Council at the University of Natal
NP	National Party
SAMA	South African Medical Association
SAMJ	South African Medical Journal
TB	Tuberculosis
TRC	Truth and Reconciliation Commission
WHO	World Health Organization

## ACKNOWLEDGEMENTS

There are many people that I would like to acknowledge who assisted me in the research and writing of this thesis. First and foremost, I would like to acknowledge the assistance of my supervising professor, Dr Jane Parpart, whose encouragement, patient ear and thoughtful insight has enabled me to move beyond my own personal boundaries. Her perceptive, and often piquant, advice has kept my interest in South African history constant. In addition, her tireless suggestions with respect to writing style and grammar has been much appreciated. Secondly, I would like to thank Dr Philip Zachernuk for teaching me the value of questioning, arming me with historiographical knowledge and offering me astute advice on every aspect of my work over the past few years. Both Jane and Phil have set an exceptional example to which I aspire. I would also like to thank Dr Sandra MacLean for gracefully accepting to be part of my committee on short notice and dedicating her time to the reading of and commenting on this thesis.

This thesis could not have been completed without the inexhaustible assistance from the Dalhousie University Document Delivery Department who obtained numerous obscure documents, articles and microfiche at my request. I would also like to extend my appreciation to *Freedom Magazine* and the CCHR at the Church of Scientology for forwarding me numerous articles and reports at short notice. In addition, I am greatly appreciative to the Dalhousie University History Department and the Faculty of Graduate Studies for providing me with funding and administrative support throughout this process. Special thanks also to Suzy Waldman, Anahid Achekian, my family and friends for their unwavering support.

## INTRODUCTION

The recent report of the Truth and Reconciliation Commission (TRC) in South Africa charged mental health professionals with collaborating with the apartheid government in human rights violations:

...until very recently, the profession failed to draw attention to the incontrovertible link between apartheid and mental health or to comment on the destructive effect of apartheid policies on the mental health of those they oppressed.<sup>1</sup>

The 'sins' of the mental health profession in South Africa were largely those of omission, although there is some evidence of more direct involvement in unethical conduct leading to human rights abuses.<sup>2</sup>

Although the TRC's investigation has been essential to the process of reconciliation, it has focussed on human rights violations of mental health practitioners as a whole (psychiatrists and psychologists) and is not an in-depth study of psychiatric perceptions and practices during apartheid. Moreover, it bases its investigation on a dualist notion of 'collaborator' versus 'resistor'. Therefore, it fails to recognise the varying and complex roles that psychiatrists played during apartheid. This is not to infer that South African psychiatrists categorically rejected racist apartheid ideologies (indeed many often enthusiastically accepted and augmented them), but rather that their position cannot simply be categorised either as 'collaborator' or 'resistor'.

In their article on resistance in colonial Mozambique, Leroy Vail and Landeg White argue that the terms 'resistance' and 'collaboration' do not accurately reflect the

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<sup>1</sup> Truth and Reconciliation Commission, *Truth and Reconciliation Commission of South Africa Report*, 4 (Basingstoke and Oxford: Macmillan Reference, 1998), p. 139.

<sup>2</sup> *Ibid.*, p. 142.



varied 'African' reactions to capitalism and colonialism. Rather, they argue that many different *forms* of resistance existed during colonialism.<sup>3</sup> Similarly, Frederick Cooper and Ann Stoler argue that the categories of 'colonizer' and 'colonized' were not uniform or stagnant, but were fluid, contested and riddled with tensions.<sup>4</sup> Likewise, in apartheid South Africa, the categorisations of 'apartheid' and 'resistor' were neither fixed nor absolute. As Deborah Posel aptly points out, apartheid was not a clear-cut and well-defined ideology. No monolithic master plan for apartheid actually existed and '[u]ncertainties, conflicts, failures, and deviations, although often less visible than the continuities and triumphs of Apartheid, were fundamental to its development'.<sup>5</sup> Thus, apartheid ideology and resistance movements were complex, contradictory processes that resulted in many complicated and conflicting relationships.

This thesis explores the contradictions and complex relationships in which South Africa's psychiatrists were involved during the height of apartheid between 1948 and 1979. It suggests that while many South African psychiatrists supported apartheid notions of racial difference, others challenged them, while some psychiatrists managed to do both. However, it also argues that those South African psychiatrists who often explicitly (and sometimes unintentionally) challenged apartheid practices, inadvertently ended up supporting apartheid ideology. Nevertheless, this thesis also contends that the

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<sup>3</sup> My italics. Leroy Vail and Landeg White, 'Forms of Resistance: Songs and Perceptions of Power in Colonial Mozambique', in Donald Crummey (ed.), *Banditry, Rebellion and Social Protest in Africa* (London: J. Currey, 1986), pp. 193-227.

<sup>4</sup> Frederick Cooper and Ann L. Stoler, 'Introduction: Tensions of Empire: Colonial Control and Visions of Rule', *American Ethnologist* 16: 4 (1989), pp. 609-621.

<sup>5</sup> Deborah Posel, *The Making of Apartheid 1948-1961: Conflict and Compromise* (Oxford: Clarendon Press, 1991), p. 5.

assertions of the psychiatric field that simultaneously supported and opposed apartheid ideologies are in themselves important because they highlight the contradictions that existed within the psychiatric field and, in turn, within the apartheid state.

### ***Theoretical Foundation and Historiography***

This thesis is premised on the idea that psychiatry is historically conditioned, i.e. political, social, economic and cultural conditions constrain and influence psychiatric beliefs. Many historians have established the connection between historical circumstances and psychiatry. However, in a recent book on the history of psychiatry, Edward Shorter argues that he wants 'to rescue the history of psychiatry from the sectarians who have made the subject a sandbox for their ideologies'. He contends that 'zealot-researchers have seized the history of psychiatry to illustrate how their pet bugaboos – be they capitalism, patriarchy, or psychiatry itself – have converted protest into illness, locking into asylum those who otherwise would be challenging the established order'. Rather, he argues that '[a]lthough these trendy notions have attained great currency among intellectuals, they are incorrect, in that they do not correspond to what actually happened'. He argues that psychiatric illness is not socially constructed but is rather a 'scientific' reality. Psychiatric history, he contends, 'can be mapped, understood, and treated in a systematic and scientific way'.<sup>6</sup> While Shorter is correct in stating that psychiatry did not always translate protest into illness, his quick dismissal of

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<sup>6</sup> Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), p. viii.

the historical conditioning of psychiatry is worrying – particularly because his comments are meant to include psychiatric beliefs worldwide. By neglecting psychiatry in countries other than North America and Europe and disregarding any 'non-Western' forms of psychiatry, Shorter adopts a flagrantly Eurocentric approach. He infers that psychiatric trends were similar throughout the world despite vast differences in historical circumstances. Moreover, Shorter underestimates the impact that historical events have on psychiatric views by basing his argument on the idea that a 'scientific truth' exists. Subsequently, he overlooks the repercussions of historically influenced prejudices such as racism, gender bias, ageism and homophobia on psychiatric studies in both 'Western' and 'non-Western' countries.

Shorter's argument is meant as a rejection of Foucaudian studies on psychiatry that have been increasingly popular since Michel Foucault published his first work in the 1960s. While Foucault's theories may have some limitations, his work cannot simply be dismissed. Foucault has been invaluable to those writing psychiatric history – particularly those undertaking studies of discourse and power. His discussion of power relations, and of the subjectification of human beings in particular (i.e. the means by which a 'subject', who participates in his/her own repression, is created), has formed the theoretical foundation of numerous works on the history of mental health in modern Europe and elsewhere. Foucault's early work, *Madness and Civilization: a History of Insanity in the Age of Reason*, challenges the notion that the emergence of the asylum and the development of the 'science' of mental health at the end of the eighteenth century,

were simply positive and progressive events in the history of humanity's self-understanding. He suggests that because of a general concern for creating order and control, medical professionals invented a regressive systematised 'science' that both objectified and subjectified the patient. In doing so, they created the antithesis of 'normal' – the 'Other'.<sup>7</sup> In a later essay entitled 'The Subject and Power', Foucault studies the 'objectivising of the subject' whereby the human subject is inevitably placed in complex web of power relations – with one exercising power over the 'Other'.<sup>8</sup> Power is, according to Foucault, 'a total structure of actions brought to bear upon possible actions'.<sup>9</sup>

While Foucault rightly recognises the changing nature of power and its association with discourse, he problematically views this power as unified, homogenous and intrinsically connected with the government under which it works. He bases his arguments, as Jock McCulloch suggests, on the assumption that intentions unequivocally result in outcomes, and ignores the fact that reforms often result in unanticipated circumstances.<sup>10</sup> Consequently, he sees mental institutions, and those working for them, as entirely and unilaterally dominant. Therefore, he ignores the potential of both tacit and explicit forms of resistance resonating from either within or external to the mental health profession. Foucault's later works on institutions and power do recognise resistance of the modern power structure. However, his arguments with respect to resistance and

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<sup>7</sup> Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Random House, 1965), pp. 201-206.

<sup>8</sup> Michel Foucault, 'The Subject and Power', in Hubert L. Dreyfus and Paul Rabinow (eds.), *Michel Foucault: Beyond Structuralism and Hermeneutics* (Chicago: The University of Chicago Press, 1982), pp. 208-209, 220.

<sup>9</sup> *Ibid.*, 220.

<sup>10</sup> Jock McCulloch, *Colonial Psychiatry and 'the African Mind'* (Cambridge: Cambridge University Press, 1995), p. 44.

mental health discourse are poorly developed. He particularly fails to account for gender, class or cultural differences within psychiatric discourse. Furthermore, as Megan Vaughan points out, his concept of power in his later work is based on the notion that power originates from individuals' everyday activities and their unknowing participation in the repressive regime.<sup>11</sup> These discussions are still based on a dichotomy of resistor versus oppressor.

In *Curing their Ills: Colonial Power and African Illness*, Megan Vaughan investigates Foucault's arguments as they apply to colonial Africa. She specifically highlights the differences between Foucault's study and her own. She suggests that Africa was not a 'colonial equivalent' of the 'great confinement' in modern Europe and explores how Foucault's process of subjectification did not characterise colonial psychiatry. Rather, she argues that while Foucault is concerned with the creation of the insane 'Other', in colonial Africa the 'Other' already existed in the form of the 'African'.<sup>12</sup> Therefore, she maintains that colonial mental health professionals had no need to create a 'mad Other' as a means for social control, and 'psychiatric categories became secondary to the [racial and] "ethnic" categories'.<sup>13</sup> In addition, Vaughan challenges Foucault's view of the dominant subjective power.<sup>14</sup> Rather, she suggests that Africans themselves often

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<sup>11</sup> Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (California: Stanford University Press, 1991), pp. 9-10.

<sup>12</sup> *Ibid.*, p. 101.

<sup>13</sup> *Ibid.*, pp. 118 and 202.

<sup>14</sup> Vaughan acknowledges Foucault's later works that discuss resistance. However, Vaughan suggests that, in Foucault's discussion of power, 'effective resistances to power is...ruled out...since the discourses of resistance are necessarily permeated with the very ideas of "freedom" and "liberation" which themselves help constitute the modern power/knowledge regime.' *Ibid.*, pp. 9-10.

participated in and shaped biomedical practices, as well as challenged medical discourse. Furthermore, she points out that biomedical beliefs (which includes psychiatry) in British colonial Africa were not uniform and often challenged colonialism.<sup>15</sup> Therefore, she argues that colonial power did not extend as far as Foucault describes in Europe.<sup>16</sup>

Vaughan's arguments, as they pertain to colonial Africa, are valid in their revision of Foucault's notion of the all-powerful discourse. She rightly argues that while one must recognise the effect that medical discourse had in objectifying and subjectifying individuals in colonial Africa, one must also recognise that medical discourse has not gone unchallenged.<sup>17</sup> However, because of the somewhat broad nature of Vaughan's study, her analysis of contradictions within the South African psychiatric field is limited. Therefore, her study does not adequately examine the views of many South African psychiatrists who held beliefs which contradicted those of the colonial state.<sup>18</sup>

Vaughan's study is meant as a broad analysis of colonial Africa. Except for a brief discussion of South Africa prior to 1948, apartheid South Africa is significantly absent from her discussion. Indeed, very few historical studies on psychiatry in apartheid South Africa exist. Recently, Hilary Sapire and Robert Edgar published *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth Century South African Prophet*. It tells the story of Nontetha, a female prophet who was treated as both a political dissident as well as a 'mentally insane' patient, and institutionalised in a

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<sup>15</sup> *Ibid.*, p. 25.

<sup>16</sup> *Ibid.*, pp. 203-206.

<sup>17</sup> *Ibid.*, p. 206.

<sup>18</sup> *Ibid.*, p. 8.

psychiatric hospital during the 1920s and 1930s. Although their study focuses on a period earlier than with which this thesis is concerned with, and their discussion focuses on a somewhat unusual case within South African psychiatric history, their arguments are somewhat helpful in my own research. They adopt Vaughan's revision of Foucauldian analysis, arguing that while one must recognise the effect that medical discourse had in repressing individuals, one must also take note of the resistance to this discourse. While they examine the role psychiatry played in the 'regulation of South African society, and its place in a continuum of disciplinary and custodial institutions' prior to apartheid,<sup>19</sup> they, like Vaughan, also recognise that psychiatric institutions became neither disciplinary nor regulatory institutions as Foucault describes of nineteenth century England.<sup>20</sup> Their study also emphasises the tensions (although somewhat briefly) that existed between the psychiatric community and the government during this period.<sup>21</sup>

The arguments of Vaughan, Edgar and Sapire are useful as a theoretical base of analysis of psychiatrists' perceptions in the various stages of apartheid South Africa. Their adoption of Foucault's analysis of the power gained through subjectification and the recognition of resistance to subjectification, which includes the complex position in which psychiatrists were placed, forms the backdrop for my study on psychiatric perceptions during apartheid South Africa. This thesis, however, moves beyond Vaughan, Edgar and Sapire's analyses in two ways. Firstly, it furthers their discussion of

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<sup>19</sup> Robert R. Edgar and Hilary Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth-Century South African Prophet* (Johannesburg: Witwatersrand University Press, 1999), p. xxi.

<sup>20</sup> *Ibid.*, p. 123.

<sup>21</sup> *Ibid.*, pp. 122-126.

psychiatry in South Africa chronologically so that it examines psychiatry beyond 1948, a period in which racial views were formalised and new psychiatric trends developed. Secondly, it examines the views of South African psychiatrists in more detail in order to allow us to gain a larger understanding of the complex and changing roles of psychiatrists within the apartheid state. This in turn will enable us to discern how the contradictory nature of psychiatrists often reflected the complexity and contradictions of apartheid.

### ***Organisation of Thesis***

This thesis is divided into three time periods and three chapters accordingly; 1948-1966, 1966-1973 and 1970-1979. It is important to note that these time periods are not absolute and that many of the themes discussed in one may overlap with the other. Chapter One examines the intersection of community psychiatry and apartheid ideology between 1948 and 1966. It argues that contradictions both within and between apartheid ideology and community psychiatry resulted in increased racial differentiation of psychiatric services. The chapter begins with a brief description of the rise of psychiatry in Europe, North America and South Africa prior to the election of the National Party in South Africa in 1948, in order to show that psychiatric conditions in South Africa between 1948 and 1966 arose out of pre-existing, established conditions. It then describes the contradictory nature of apartheid ideology and its effect on psychiatric practices. It also discusses the contradictory nature of community psychiatry and its intersection with apartheid policies. The chapter ends with a discussion of how



paradoxes within the South African psychiatric field manifested themselves within psychiatric diagnoses.

Chapter Two describes how between 1966 and 1973, the assassination of the state President, H.F. Verwoerd, by a 'madman' by the name of Demitrio Tsafendas in 1966, increased the profile of psychiatry. Psychiatry's new prominent position enabled South African psychiatrists to promote community psychiatry more vigorously. Paradoxically, however, Tsafendas' trial also highlighted the fact that the majority of judges, politicians and the public viewed psychiatrists as enabling criminals to escape just punishment. Consequently, many psychiatrists felt impelled to call for stricter regulations for the 'criminally insane'. This chapter argues that psychiatrists' promotion of community psychiatry contradicted their calls for stricter policies and resulted in the increased division between short-term patients (the majority of whom were 'White') and long-term patients (the majority of whom were 'non-White').

Chapter Three traces the origins of 'cross-cultural' psychiatry in the 1970s. During the 1960s and 1970s, the apartheid government embraced a new discourse of 'multi-ethnicism' which promoted the government's creation of the 'ethnic homelands'. Chapter Three argues that the apartheid government's decision to contract out the care of long-term patients (the majority of whom were 'non-White') to a private company by the name of Smith Mitchell reflected the government's new extended focus on racial segregation. However, the segregation of long-term patients from short-term patients (i.e. 'non-White' patients from 'White' patients) merely transferred many of the problems within state institutions to the private sector. Conditions within private institutions were

significantly sub-standard. This chapter describes how an anti-psychiatric group of the Church of Scientology internationally publicised the atrocious conditions within private mental hospitals and accused the South African psychiatric field of human rights abuses. In response to both the apartheid government's increased segregation and anti-psychiatric accusations, psychiatrists adopted a more culturally-relative approach to psychiatry. 'Cross-cultural' psychiatry, as it was called, focused more on 'African' perceptions of psychiatry and 'traditional' healers. This chapter argues, however, that the new 'cross-cultural' psychiatry was riddled with inconsistencies and contradictions that reflected the contradictions inherent within apartheid.

### ***Brief Description of the South African Psychiatric Field***

For the purposes of this thesis, 'psychiatric field' is a collective term for certified, government-sanctioned psychiatrists. With the exception of approximately one 'Coloured' psychiatrist in the late 1970s, all South African psychiatrists were classified as 'White' – the majority of whom were male.<sup>22</sup> The South African psychiatric field can be divided into two main groups: state psychiatrists and private psychiatrists. State psychiatrists usually worked within state-funded hospitals (which includes state mental hospitals, provincial hospitals and 'homeland' hospitals) and received a salary from the South African government. Universities throughout South Africa also appointed many state psychiatrists as professors of psychiatry. In addition, some state psychiatrists held positions within the Department of Health (DOH) or as Members of Parliament (MPs),

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<sup>22</sup> Editorial, 'Medical Journals and International Hate' *SAMJ* 55: 15 (1979), p. 572.

often while continuing their duties at hospitals. One psychiatrist was appointed by parliament as Commissioner of Mental Health, who, along with a committee, oversaw mental health issues. Consequently, the line dividing government officials and state psychiatrists was often blurred. Because of the large workload and the moderate income associated with state psychiatry, many psychiatrists chose private psychiatric practice.

Private psychiatrists worked for licensed private institutions and/or established their own private practice. Information regarding psychiatrists in private practice is difficult to obtain. Therefore, this thesis does not specifically examine private psychiatric perspectives. Although further research into private psychiatric views is needed, it is possible to presume that the line between state and private psychiatry was somewhat blurred. Indeed, the South African psychiatric field was made up of a relatively small number of psychiatrists and was a close-knit group. Many private psychiatrists trained at the same European institutions (or in the 1960s and 1970s, were trained by state psychiatrists at South African universities) and were professionally connected to state psychiatrists through patients, organisations, journals and psychiatric conferences. Therefore, it is likely that the majority of private psychiatrists were frequently affected by and shared many of the views of their colleagues in state institutions.

The exact number of registered state and private psychiatrists between 1948 and 1979 is not entirely clear. Little empirical data was recorded with respect to psychiatric staff and mental facilities during apartheid – especially in those facilities catering to 'non-Whites'. Nevertheless, based on a survey conducted by Kevin Solomons in 1976 of mental health facilities in South Africa, it is estimated that there were thirty-eight

registered psychiatrists working within South Africa in 1945.<sup>23</sup> The number of private psychiatrists is not known. By 1976, the number of state psychiatrists is indicated to have increased to 168. These numbers, however, are not representative of the actual number of psychiatrists, because the later numbers include part-time psychiatrists at private institutions and psychiatrists working at provincial hospitals – many of whom trained undergraduate and post-graduate psychiatric students, or were students themselves.<sup>24</sup> Because complaints about the lack of psychiatric staff were constant throughout apartheid, it is possible to assume that the numbers of state psychiatrists did not increase dramatically.<sup>25</sup>

Although psychiatrists in South Africa were part of a limited educated medical elite whose views were given great credence by the government and public, their standing was not as high as that of their medical colleagues. Indeed, many psychiatrists complained of a lack of support by and repute within the public, government and general medical community. The lack of support was compounded by the fact that administration of mental health services in South Africa was separate from that of the general medical field. The national government oversaw mental health services while the provincial government had jurisdiction over general medical hospitals. This led to discrepancies in funding and subsequent treatment of patients. These issues will be explored further in Chapter One.

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<sup>23</sup> Kevin Solomons, 'The Development of Mental Health Facilities in South Africa, 1916-1976', in Francis Wilson and Gil Westcott (eds.), *Economics of Health in South Africa Volume II: Hunger, Work and Health* (Johannesburg: Ravan Press, 1980), p. 277.

<sup>24</sup> *Ibid.*, pp. 277-278.

<sup>25</sup> See Chapter One.

### ***Brief Background of the South African Medical Journal***

The majority of the published psychiatric works upon which this thesis is based were obtained from the *South African Medical Journal (SAMJ)*. This journal, published by the Medical Association of South Africa (MASA, known as the South African Medical Association or SAMA before 1926) was the main voice of registered psychiatrists during apartheid. Before 1892, all medical practitioners fell under the administration of the British Medical Association (BMA). However, after the first South African medical congress in 1892, the South African Medical Association slowly established itself as an independent association. The South African War in 1903 interrupted the SAMA's establishment and it reverted back to a branch of the British Medical Association (BMA). It was only in 1926, when a committee established the Medical Association of South Africa (MASA), that MASA took over the publication of the *South African Medical Journal*.<sup>26</sup> The *SAMJ* was mainly a medical journal for general practitioners that occasionally published articles on psychiatry. However, as psychiatry became a more established field and psychiatrists demanded integration with general medicine, the *SAMJ* published significantly more psychiatric articles on a regular basis.

The connection between MASA and the *SAMJ*, however, seriously undermined the impartiality of the journal during apartheid. Recently, the Health and Human Rights Project, which was initiated jointly by the Trauma Centre for Victims of Violence and the

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<sup>26</sup> Theodore James, 'The First Fifty – A Review of the South African Medical Congresses', *SAMJ* 49: 32 (1975), pp. 1313-1316.

University of Cape Town, argued that MASA's main concern was 'in maintaining the security of the State above human rights considerations'.<sup>27</sup> Furthermore, it accused MASA of 'placing international esteem and status above the recognition that much was not well with the health of South Africans'.<sup>28</sup> MASA itself acknowledged the fact that it was 'a part of the white establishment... and for the most part and in most contexts, shared the worldview and political beliefs of that establishment'.<sup>29</sup>

This link with the 'white establishment' meant that the *SAMJ* did not represent psychiatric practitioners who chose not to publish, or were denied publication, or those 'traditional' healers who were not accepted in the 'western' psychiatric community. Indeed, most of the published psychiatric articles within the journal were written by psychiatrists who worked in state-funded institutions. Furthermore, the *SAMJ* also excluded the voices of patients. While the views of patients were sometimes reported in psychiatric writings, patients' words had usually been filtered twice by the psychiatrist: first at the initial hearing and secondly through the writing process.

These problems in representation do not mean, however, that the publications contained within the journal are invalid. On the contrary, what was published, and what was not, speaks volumes about the political, social, and economic conditions at the time. Unfortunately, a detailed analysis of psychiatric patient discourse and unregistered psychiatrists is not only beyond the scope of an MA thesis but is also hindered by the

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<sup>27</sup> Truth and Reconciliation Commission, *Health Sector Hearings* (Cape Town, 18 June 1997), p. 78 [electronic copy], accessed 22 February, 2000: available from <http://www.truth.org.za/HRVtrans/health/health02.htm>

<sup>28</sup> *Ibid.*, pp. 78-79.

<sup>29</sup> TRC, *Truth and Reconciliation Commission of South Africa Report*, 1998, p. 146.

confidential nature of the subject matter. Therefore, this thesis is merely a rudimentary study of psychiatry in apartheid South Africa, meant to form the basis of future studies. While I include other sources such as government reports, anti-psychiatric organisations' reports, newspaper articles and House of Assembly debates, further research into psychiatric patients' perspectives and 'non-Western' psychiatric views is definitely needed.

### *Methodology*

Because this thesis conducts some general qualitative discourse analysis on published psychiatric writings between 1948 and 1979, it is important to discuss the use of discourse analysis as a tool of historical research. Discourse – particularly psychiatric discourse – constructs not only who we are, but also how we understand ourselves in relation to others. Therefore, discourse analysis opens up a vast arena of accepted notions that reveal far more about individuals and their relationships with others than is initially seen when just viewed at face value. As Cheryl de la Rey argues, 'when the researcher analyses a text, dominant conceptions are revealed, taken-for-granted meanings are disrupted and the ways in which these discourses support or challenge institutions and the distribution of power in a society may be exposed'.<sup>30</sup> Although de la Rey's argument supports a purely dualistic notion of 'supporter' versus 'challenger', her argument is nevertheless important because it emphasises the wealth of information

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<sup>30</sup> Cheryl de la Rey, 'On Political Activism and Discourse Analysis in South Africa', in A. Levett, A. Kottler, E. Burman, and T. Parker (eds.), *Culture Power and Difference: Discourse Analysis in South Africa* (London: Zed Books, 1997), p. 192.

available within discourse. South African psychiatric discourse, with its emphasis on categorisation and diagnosis, not only reveals the context in which psychiatrists viewed their patients, but also discloses prevalent racial distinctions. An analysis of psychiatric discourse in turn reflects larger social notions of race. It is a window through which to view a microcosm of the larger apartheid structure. As Saul Dubow aptly states in a discussion on scientific racism in South Africa, 'the discourse of intellectual debate, with its well-defined conventions and norms, provides a valuable overall context in which studies of popular racism can be situated'.<sup>31</sup>

There is one major pitfall when conducting discourse analysis of psychiatry that needs to be recognised. When analysing discourse, there is a danger of reifying the subjects about which one writes; i.e. in writing about discourse, one creates a system of statements – an object that objectifies the subject. In order to avoid reification, it is necessary not to treat the discourse and representations of the patients as reality, thereby imitating the techniques of the data one analyses, and in turn reifying the subject. One can further avoid reification, as Lucy Yardley rightly argues, by reflecting on one's own views and disclosing how one's own views and theoretical bias affect the research.<sup>32</sup>

### ***Terminology***

Throughout this thesis, I have used terms such as 'non-European', 'European', 'Bantu', 'Native', 'White', 'non-White', 'Black', 'Coloured', 'Asian' and 'Indian' that

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<sup>31</sup> Saul Dubow, *Scientific Racism in Modern South Africa* (Cambridge: University of Cambridge, 1995), p. 6.

<sup>32</sup> Lucy Yardley, 'Introducing Discursive Methods', in *Material Discourses of Health and Illness* (London: Routledge, 1997), p. 27.



psychiatrists, politicians, journalists and individuals used themselves. Racial categories and terms changed during apartheid and offer insight into the existing perceptions during each period. For example, during the early years of apartheid, the terms 'European', 'non-European', 'Bantu' and 'Native' were popular. By 1979, however the terms 'Black', 'White', 'Coloured', 'Indian' and 'non-White' had superseded these terms. This movement away from designations that described individuals in terms of their cultural origins (or in the case of 'non-Europeans' the lack thereof) toward more set racial classifications is indicative of the increased concern over racial segregation. It also mirrors South Africa's move away from its political association with Europe (such as its withdrawal from Commonwealth membership) towards a more autonomous state. The use of relevant terms is important because it allows the reader to gain a greater understanding of the changing racial perspectives that existed during various stages of apartheid. I also use medically accepted terms that psychiatrists used to describe different forms of 'mental illness'. Words such as 'lunatic', 'imbecile', 'feeble-minded', 'insane', 'mad', 'retarded', 'neurotic', 'schizophrenic', 'depressive', 'psychotic', 'disordered', 'insane', and most recently, 'mentally ill', depict different degrees and types of 'mental illness', but also embody specific historically conditioned notions of a 'mentally ill' individual. For example, the movement away from somewhat obscure and ill-defined psychiatric terms such as 'lunatic', 'feeble-minded' and 'mad' towards specific biological designations such as 'schizophrenic', 'depressive' and 'mentally ill' is reflective of psychiatry's move towards a more established and biologically based viewpoint (which incidentally corresponds with the South African government's increased concern over racial segregation). In

allowing the words to stand, I am able to offer the reader further insight into the mindset of the writers during the period in which I write. I am also able to extricate myself from the responsibility of using present-day terms that may objectify the individuals about whom I write.

## CHAPTER ONE: PSYCHIATRIC PERSPECTIVES, APARTHEID IDEOLOGY AND COMMUNITY PSYCHIATRY, 1948-1966

Psychiatric views are intrinsically connected to the political, economic and social climate in which they are practised. In *Curing Their Ills*, Megan Vaughan has established that psychiatric views in colonial Africa differed significantly from those that Foucault describes in nineteenth century Europe.<sup>1</sup> In *African Apocalypse*, Robert Edgar and Hilary Sapire have argued that Nontetha's treatment as both a political opponent and mental patient was due to a 'key moment in history' when segregationist thought, nationalist protests and formidable economic conditions caused the government to institutionalise an individual whom they saw as subversive.<sup>2</sup> The impact of historical conditions on psychiatry cannot be overstated. In this chapter, I examine the effect that emerging formal policies of racial segregation between 1948 and 1966 had upon South African psychiatric views and practices. Indeed, after the National Party (NP) narrowly won the election over the United Party in 1948, psychiatric views changed significantly. Not only did psychiatrists have to deal with a new formalised racism, but they also encountered burgeoning policies that increased the incidence of 'mental illness' within South Africa – particularly within the 'non-European' population.<sup>3</sup>

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<sup>1</sup> Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (California: Stanford University Press, 1991), p. 115.

<sup>2</sup> Robert R. Edgar and Hilary Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth-Century South African Prophet* (Johannesburg: Witwatersrand University Press, 1999), p. 118.

<sup>3</sup> Recently, the TRC highlighted the effect that apartheid had on psychiatry. It stated that South Africans 'have had to deal with a psychological stress which has arisen as a result of deprivation and dire socio-economic conditions, coupled with the cumulative trauma arising from violent state repression and intra-community conflicts'. TRC, *Truth and Reconciliation Commission of South Africa Report*, 5 (Basingstoke and Oxford: Macmillan Reference, 1998), p. 127. As John Dommissie points out, recognition of the psychological effects of apartheid is only a recent phenomenon. Historically, scholars ignored the effects of apartheid on the physical and mental health of South Africans and indirectly supported mental health practices in South Africa by failing to show their abhorrence of the effects. Dommissie is especially critical of the international mental health community, which failed to censure the Medical Association of South Africa. John Dommissie, 'Apartheid as a Public Mental Health Issue', *International Journal of Health Services* 15: 3 (1985), pp. 501-510.

Vaughan, Edgar and Sapire have established the contribution of the psychiatric field towards ideas of racial difference. However, they also acknowledge that the contribution of psychiatrists towards racial policies was not always uniform or intentional. It would be incorrect to assume that psychiatrists were homogeneous or were merely the political pawns of the government under which they worked. During early apartheid South Africa, for example, the National Party's attempt to formalise racial segregation caused many psychiatric views to contradict apartheid policies through their adoption of a new community-oriented approach to psychiatry, which had developed in the 'Western' psychiatric field.<sup>4</sup> Its preoccupation with prevention and changing socio-economic conditions directly challenged apartheid policies. However, this is not to imply that psychiatrists utterly rejected apartheid ideologies. Rather, community psychiatry, as it was called, tended also to support apartheid policies of segregation through its focus on community. Therefore, the effects of community psychiatry were not felt by 'non-European' patients, and the gap between 'non-European' and 'European' services widened.

### ***Background of Psychiatry in Europe, North America and South Africa before 1948***

South African psychiatric views cannot be understood without situating them within the context of early psychiatric developments in Europe and North America. Indeed, the South African psychiatric field primarily took its cue from European and North American psychiatrists throughout its early stages of professional development.

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<sup>4</sup> 'Western' psychiatry means North American and European psychiatry. It is not clear as to the extent that South African psychiatrists were influenced by ethnopsychiatric studies in other African countries. However, in my own studies, I found that very rarely did South African psychiatrists refer to psychiatric studies in neighbouring countries. They rather turned to Europe and North America to substantiate their own research.

What follows is not meant as a comprehensive description of psychiatric trends before 1948, but is merely a general background of psychiatric trends that influenced the development of psychiatry in South Africa.<sup>5</sup>

Before the seventeenth century, European societies had openly accepted the 'insane' into their midst. However, as Michel Foucault argues, during the mid-seventeenth century, numerous marginalised mental asylums were constructed and large numbers of 'insane' were institutionalised. Foucault attributes this expansion and marginalisation of the 'insane' to a rise of absolute monarchical power and a desire to control the poor. Mental asylums in Europe served as prison-like structures in which monarchs and the bourgeoisie placed large numbers of lower-class contestors, in an attempt to simultaneously maintain absolute power and social control. Foucault terms this period the 'great confinement'.<sup>6</sup> The dismal image of the shackled, abused and forgotten psychiatric patient in dungeon-like facilities originated in this period. During the eighteenth century, however, with the dissolution of absolutism, the 'great confinement' Foucault describes began to dissipate. Furthermore, in the nineteenth century, increased industrialisation resulted in a rise of social problems such as poverty,

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<sup>5</sup> There are many books concerning psychiatry in Europe and North America before 1948. The ones I found most helpful were Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Pantheon Books, 1965), Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Chicago: Aldine Publishing Company, 1962), Joan Busfield, *Managing Madness: Changing Ideas and Practice* (London: Hutchinson, 1986), Gerald N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (Princeton: Princeton University Press) and Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997). For further information concerning psychiatry in South Africa before 1948, see Sally Swartz, 'Colonizing the Insane: Causes of Insanity in the Cape, 1891-1920', *History of the Human Sciences* 8: 4 (1995), pp. 39-57 and Robert R. Edgar and Hilary Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth-Century South African Prophet* (Johannesburg: Witwatersrand University Press, 1999).

<sup>6</sup> Foucault, *Madness and Civilization*, pp. 38-64. See Goffman for a similar analysis of institutions in North America.

overpopulation, ill-health and exploitation. These conditions initiated an expansion of social consciousness.<sup>7</sup> The general medical community advocated a reform in health services. This in turn induced many psychiatrists to contest the 'custodial' nature of psychiatry.<sup>8</sup> However, although many general medical services were reformed, very few mental institutions adopted the new reformist approaches to psychiatry. As Joan Busfield argues, the continuance of the custodial nature of mental institutions was mostly due to the unwillingness of government officials to provide adequate economic support to the poor. Mental institutions became an important form of support for individuals needing relief.<sup>9</sup> Therefore, little incentive existed for governments to make reforms to mental health services, and many mental institutions continued to act as custodians of the 'insane' well into the twentieth century.

It was only during the mid-nineteenth century that the South African government began to establish official mental institutions. Previously, the South African government had kept its few mental patients (the majority of whom were 'European') in wings of hospitals, prisons or on the convict station of Robben Island. The first official mental asylum was established in South Africa on Robben Island in 1846 during British occupation.<sup>10</sup> At the end of the nineteenth century, the government established seven

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<sup>7</sup> Busfield, *Managing Madness*, p. 225.

<sup>8</sup> *Ibid.*, p. 234.

<sup>9</sup> *Ibid.*, p. 273. Similarly, Gerald N. Grob argues that American psychiatric practices did not undergo reforms. He argues that 'institutional psychiatry appeared to be the vestigial remnants of a premodern age, and the mental hospital a welfare-like institution far removed from the mainstream of medical practice.' Grob, *The Mad Among Us*, p. 31.

<sup>10</sup> M. Minde, 'The History of Mental Health Services in South Africa: Part I. In the Days of the Dutch East India Company', *SAMJ* 48: 29 (1974), p. 1271 and 'History of Mental Health Services in South Africa: Part II. During the British Occupation', *SAMJ* 48: 38 (1974), p. 1629.

more mental asylums throughout South Africa. In 1910, South Africa had eight mental institutions that accommodated approximately 1,692 'European' and 1,932 'non-European' patients.<sup>11</sup> Although these institutions were based on European and North American models, they differed in a few significant ways. Firstly, the relative number of mental institutions and patients was considerably less than those in North America or Europe. This was probably because mental institutions in South Africa had been established some time after the European 'great confinement' of the seventeenth and eighteenth centuries. Secondly, these institutions were specifically segregated by race – with 'Europeans' obtaining superior treatment and significantly better accommodation than 'non-Europeans'. This is not to suggest that the conditions in 'European' wards were ideal, for they were far from being so. Rather, it attests to the appalling conditions that 'non-Europeans' had to endure within mental institutions.

From the late nineteenth to the mid-twentieth century, the introduction of Freudian psychoanalysis offered a means by which psychiatrists across the world could challenge the custodial nature of mental institutions. Many South African psychiatrists adopted psychoanalysis as a form of treatment. However, as Edward Shorter points out, psychoanalysis created a dilemma within the psychiatric field. Because psychoanalysis was particularly time-consuming and the numbers of patients admitted to psychiatric hospitals continued to rise, psychiatrists practised little psychoanalysis. Psychoanalysis became the therapy of the less-seriously ill and wealthy, and very few lower class or

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<sup>11</sup> M. Minde, 'History of Mental Health Services in South Africa: Part VII. Services Since Union', *SAMJ* 49: 11 (1975), p. 406.

seriously ill patients benefited from it.<sup>12</sup> Therefore, many mental hospitals, including those in South Africa, continued to implement custodial practices for the masses.

### ***Apartheid Ideology and South African Psychiatry between 1948 and 1966***

In order to fully understand the effect that apartheid had on the psychiatric field, it is necessary to have a sense of exactly what apartheid was and how it interacted with psychiatric views. In 1948, apartheid (literally meaning 'apartness') formed the platform for the National Party during the election. It was an ill-defined concept that denoted a desire for the extension of existing racial segregation. The success of the Nationalists' apartheid campaign was a strong blow to the previous governing party under Jan Smuts, which had proposed lessening racial segregation. With no specific strategy behind it, apartheid ideology was based on an ambiguous notion of ethnic individualism. However, it was strongly imbued with racism and soon became a means by which to facilitate the superiority of Afrikaners and the 'European' population in general. Apartheid was formalised by a series of haphazard legislative policies that the National Party, led by D. F. Malan, implemented soon after its victory. In 1950, the government instituted the Population Registration Act and the Group Areas Act. These acts respectively categorised and segregated individuals by their race. The Group Areas Act restricted 'non-European' individuals to certain areas and numerous 'petty apartheid' laws restricted 'non-Europeans' from using the same amenities as 'Europeans.' The Mixed Marriages Act of 1949 and the Immorality Act of 1950 supported the segregation of individuals further by restricting marriages and sexual relations between racial groups. Furthermore, Dr. H.

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<sup>12</sup> Shorter, *A History of Psychiatry*, p. 190.



F. Verwoerd, the Minister of Native Affairs and Malan's successor, developed a 'native policy' and implemented the Native Laws Amendment Act of 1952 that extended control over the 'Bantu' population, implemented pass laws and created 'reserves' or 'homelands' for different ethnic groups.

Much of the justification for the formalisation of racial segregation during the early twentieth century was based on what Saul Dubow terms 'Christian-national ideology' – an ideology based on theological and cultural rationalisations for ethnic difference, supported by biological notions of race.<sup>13</sup> Much of its theory was ironically drawn from contrasting earlier racial beliefs of the Dutch Reformed Church and evolutionist thought based on Social Darwinism.<sup>14</sup> I will not explore the details regarding early racial policies of the Afrikaans churches. Rather, I am more interested in the 'scientific' basis of apartheid ideology as it is directly connected to views within the South African psychiatric field.

Social Darwinist theory allowed the apartheid government to base its policies on the pretext that it was insuring not only the rise of Afrikaner nationalism, but safeguarding the constant evolution and superiority of the 'White' race. The apartheid government therefore also became increasingly concerned with any form of perceived degeneration or devolution of the 'European' population. The fear of degeneration was not new. Sally Swartz has rightly argued that the fear of degeneration existed as early as

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<sup>13</sup> Saul Dubow, *Scientific Racism in Modern South Africa* (Cambridge: Cambridge University Press, 1995), p. 246.

<sup>14</sup> There has been much discussion about the definition of Social Darwinism. However, for this thesis, I am relying on Saul Dubow's definition: 'Social Darwinism may be understood as a broad philosophy or ideology which describes social evolution in terms of laws of natural selection and stresses the importance of biological inheritance. This may be seen as a rationalisation of competitive individualism or as a claim for collective social action in defence of, say the "nation."' Dubow, *Scientific Racism*, p. 120f.

the eighteenth century.<sup>15</sup> However, just a decade before the 1948 election, the Depression had severely affected the economic circumstances of many 'White' families in South Africa and the numbers of 'poor whites' had shocked and embarrassed the government. With the vision of the 'poor whites' during the 1930s Depression still fresh in the minds of Nationalists, many feared that the 'White' race would not maintain its superiority.

The image of degeneration was strongly connected to 'mental deficiency', as can be seen in many psychiatric studies during this period. Psychiatrists became concerned with examining the reasons why 'mental disorders' and the level of 'mental defect' among the 'White' population seemed to have risen. For example, in a study of admissions of high grade mental defectives in Alexandra Institution (a 'European'-only institution administered by the government), H. W. Smith examined the many reports that were 'often made, officially and otherwise, that the average intelligence of the European inmates of the Alexandra Institution...has for some unknown reason been in a process of decline.'<sup>16</sup> While Smith found that the average intelligence had dropped, he attributed this to the increasing services available to those with higher IQs. Nevertheless, Smith's study shows the general fear of mental degeneration that 'Whites' believed could occur while living in the so-called 'uncivilised' African continent.

The belief that 'mental disorder' was increasing and the intelligence quotient was decreasing represented the overall fear of racial degeneration through miscegenation and

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<sup>15</sup> Swartz, 'Colonizing the Insane', pp. 39-57.

<sup>16</sup> H. W. Smith, 'Decline in Requests for the Admission of High Grade Mental Defectives to the Alexandra Institution', *SAMJ*, 29: 38 (1955), p. 891.

racial mixing. Arguably, this fear is represented no more aptly than in Doris Lessing's novel *The Grass is Singing*.<sup>17</sup> Her main character, Mary Turner, embodies the epitome of the 'White', 'civilised' woman who ultimately declines mentally because of her movement away from the urban centre and her exposure to 'Native' men. Although the book is set in Southern Rhodesia, Mary's descent into insanity is reflective of the existing fears within the South African 'European' community. Lessing parallels Mary's insanity with her decline into an 'uncivilised' nightmare of rural life. Mary ultimately becomes unhealthy, disorderly and wretched – all depictions of her insanity and her subsequent mental degeneration. Her movement from the city to a farm and her struggle against 'becoming native' are indicative of the fear felt by many 'White' South Africans during this period – many of whom feared the close proximity of 'natives'. When Mary first arrives on the farm, she struggles against the poverty and harsh environment, attempting to make the house, which acts as a symbol of her 'mental order', as habitable as possible. However, as time passes, she begins no longer to care about her house, allowing it to degrade, as well as incorporating many 'native' materials. Charlie Slatter, Mary's neighbour, describes the final status of the house:

Charlie looked at Mary's ear-rings, and at the sofa-cover, which was of the material always sold to natives, an ugly patterned blue that has become a tradition in South Africa, so much associated with 'kaffir-truck' that it shocked Charlie [*sic*] to see it in a white man's house. He looks round the place, frowning. The curtains were torn; a windowpane had been broken and patched with paper; another had cracked and not been mended at all; the room was indescribably broken down and faded.<sup>18</sup>

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<sup>17</sup> Doris Lessing, *The Grass is Singing* (London: Michael Joseph, 1950).

<sup>18</sup> *Ibid.*, p. 218.

Lessing also shows Mary's decline through her eventual relationship with Moses, a 'native houseboy', an individual whom at first she detests but then becomes increasingly reliant upon. When Charlie notices this uxorious-like relationship, he demands that Mary's husband take Mary away. Charlie does this out of his responsibility to obey 'the dictate of the first law of white South Africa which is: "Thou shalt not let your fellow whites sink lower than a certain point; because if you do, the nigger will see he is as good as you are."<sup>19</sup> The fear of miscegenation was connected to the fear of racial degeneration. Tony, a visitor from England describes it as follows:

It was 'white civilization' which will never, never admit that a white person, and most particularly a white woman, can have a human relationship, whether for good or for evil, with a black person. For once it admits that, it crashes, and nothing can save it. So above all, it cannot afford failures, such as the Turners' failure.<sup>20</sup>

Contrary to views about the degeneration of 'Europeans', the apartheid government suggested that 'Bantu' degeneration occurred through movement to the urban 'White' areas. Indeed, many Nationalists argued that segregation policies would protect 'Bantus' from both cultural and social degeneration. Central to this notion of 'Bantu' degeneration was the view that 'undesirable Bantu women' (which included most single women) who moved to urban centres caused moral deterioration. As E. G. Jansen, the Minister of Native Affairs 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

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<sup>19</sup> *Ibid.*, p. 221.

<sup>20</sup> *Ibid.*, p. 30.

guardians.<sup>21</sup> Therefore, the government only allowed women who were married to men permitted to live in the area, or those women who had permanent jobs, to remain in urban areas. Policies that attempted to ensure that most unemployable and single women remained in rural areas were reflected in the lack of available psychiatric services for 'African' women during apartheid. In 1956, female 'Native' beds made up only 14 percent of all beds available for psychiatric patients.<sup>22</sup> Those women who did have a 'mental disorder' were expected to return to the rural areas for support.

Many psychiatrists supported this view of social degeneration further, by arguing that the movement of 'Bantu' individuals to urban centres caused mental deterioration. For example, R. W. S. Cheetham argued that increased industrialisation and technological advances resulted in an increase in mental illness. He contended that because scientific advances were made at an alarming rate, individuals' anxiety increased. 'Cultural patterns and behaviour' he argued, 'have departed radically from traditionally sound and fundamental concepts... more and more material gain only serves to enhance the underlying emotional insecurity.'<sup>23</sup> Furthermore, he suggested that 'the loss of identity with one culture and an attempt to adapt to another, particularly when rapid and extensive, has a damaging effect on mental health.'<sup>24</sup> Similarly, H. Moross argued that

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<sup>21</sup> Quoted in Deborah Posel, *The Making of Apartheid 1948-1961: Conflict and Compromise* (Oxford: Clarendon, 1991), p. 81.

<sup>22</sup> Ironically, however, the rate of women entering urban centres continued to rise (mostly without the government's knowledge) and the lack of mental facilities for 'Bantu' women only contributed to an increase of the social degeneration that the apartheid government sought to avoid. Ross, *Concise History*, p. 119.

<sup>23</sup> R.W.S. Cheetham, 'Society, the Legislator, Mental Health and Ourselves', *SAMJ* 38: 31 (1964), p. 717.

<sup>24</sup> *Ibid.*

urbanisation of 'non-Europeans' contributed to their 'mental health' problems. He argued that:

South Africa faces special mental health problems in its multi-racial and multi-cultural community. The complexity of these problems is heightened by urbanization of the non-White races in a time of changing values – especially by the effects of urbanization on tribal laws, customs and taboos.<sup>25</sup>

Many psychiatrists such as Cheetham and Moross believed that if the 'Bantu' simply returned to their 'traditional' way of life, mental illness among them would not exist. They believed that 'non-Europeans' had a 'traditional' community-oriented means of coping with the mentally ill and encouraged 'Africans' to continue taking care of their 'mentally disordered.'

Indeed, the apartheid government bolstered this view further by encouraging a two-tier health system. For example, the government suggested that psychiatrists refer their mental patients to private licensed institutions.<sup>26</sup> While private licensed institutions existed for psychiatric patients, they mostly were for 'Europeans'.<sup>27</sup> As Ilana Edelstein *et al.* argue, the National Party encouraged individuals to take care of their own medical needs. If they were unable to do so, the government expected community-sponsored programs to offer assistance. At the same time, however, the government unofficially took care of the health and welfare of civil servants (made up mostly of 'White' Afrikaners). This led to a cleavage between formal and informal policies that excluded

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<sup>25</sup> H. Moross, 'Thoughts on the Planning of Mental Health Services for South Africa', *SAMJ* 34: 9 (1960), p. 171.

<sup>26</sup> Ian R. Vermooten, 'Facilities Available for Treatment in Mental Hospitals: With Brief Reference to Extra-Mural Work done by Government Psychiatrists', *SAMJ* 27: 38 (1953), pp. 815-817.

<sup>27</sup> HAD (9 September 1958), col. 3266.

the majority of the population and promoted a strong private health sector for the wealthy.<sup>28</sup> The apartheid government therefore promoted a private practice for those who could afford it, or who were covered under medical plans (i.e. mostly 'Europeans'), and an alternative state-funded practice for those who could not afford it or had no form of medical coverage (i.e. 'non-Europeans'). For many psychiatric patients, private psychiatry was simply not an option. Rather, they were expected to use sub-standard, state-funded institutions or 'traditional' community services.

At the same time, however, the apartheid government recognised the need for treating some 'mentally disordered' 'non-Europeans' – particularly those already living in urban centres. Indeed, in an attempt to solve the demand for lower wage labour in the urban centres, the apartheid government had allowed 'non-Europeans' who had been born in urban areas or had worked for the same employer for ten years (or different employers for fifteen years) to permanently settle in urban centres.<sup>29</sup> To deal with 'non-European' urban patients, psychiatrists such as Cheetham and Moross argued that the government should encourage 'non-Europeans' to pursue training in psychiatry. They contended that 'non-European' psychiatrists would be better suited to deal with 'non-European' patients. Moross stated that the 'White practitioner, no matter how familiar he is with non-White culture, will always be handicapped by communication problems; the non-White who has

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<sup>28</sup> Ilana Edelstein, Vaughan Weber and Yogan Pillay, 'The Role of the Private Sector', in Don Foster, Melvyn Freeman and Yogan Pillay (eds.), *Mental Health Policy Issues for South Africa* (Pinelands: Medical Association of South Africa/Multimedia Publications, 1997), p. 132.

<sup>29</sup> Ross, *Concise History*, p. 119.

a foothold in both cultural camps may succeed better than the one who must approach from without.<sup>30</sup>

However, apartheid policies concerning 'Bantu' education were ambivalent. Before 1948, 'Bantu' education had been administered through missionaries and government involvement was limited to paying teachers' salaries. Very few opportunities for post-secondary education had existed for 'non-European' students. However, as Jonathan Hyslop argues, the apartheid government's restructuring of the education policies during the 1950s actually enabled larger numbers of 'Black' youths to obtain an education that had not been as easily accessible through the missionary system. At the same time, the government's transformation of 'Bantu' education was an attempt to 'respond to the crisis of reproduction of the [urban] labour force' upon which it was reliant, while also attempting to address the 'more radical level of oppositional political activity, marked by the emergence of the Mandela-Tambo-Sobukwe generation of leadership of the ANC.'<sup>31</sup> The government also used the education system as a means to promote its apartheid message by controlling textbooks, curriculum and teacher training. On a post-secondary level, the apartheid government did set up specific universities for 'non-European' individuals so that by the 1980s, as Robert Ross points out, 'the number of black university students was sixty times that of the late 1940s.'<sup>32</sup> However, from 1959 the government passed the Extension of University Education Act that compelled anyone

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<sup>30</sup> H. Moross, 'The Development of Community Resources for Mental Health Care', *SAMJ* 38: 20 (1964), p. 416.

<sup>31</sup> Jonathan Hyslop, "'A destruction coming in': Bantu Education as Response to Social Crisis', in Philip Bonner, Peter Delius and Deborah Posel (eds.), *Apartheid's Genesis, 1935-1962* (Braamfontein: Ravan Press, 1993), p. 393.

<sup>32</sup> Ross, *Concise History*, pp. 121-122.



who wanted to attend university to obtain special consent from the Ministry of Native Affairs, which often denied applications. Therefore, the result of post-secondary education changes during apartheid had virtually no impact for 'non-European' students interested in becoming psychiatrists. Although the apartheid government had established a much-anticipated faculty of medicine at the University of Natal that accepted 'non-European' students in 1951, the conditions at the university (often controlled by state psychiatrists), did not encourage 'non-European' enrolment in postgraduate psychiatry. At first, the university did not offer specific courses in psychiatry. Rather, it only offered psychology in the third year of the undergraduate curriculum and provided minimal clinical training at the Fort Napier Mental Hospital in Natal.<sup>33</sup> When it did offer the first class in psychiatry in 1956, this did not take off very well.<sup>34</sup> The university treated 'non-European' psychiatric students as second-class citizens. It transformed neglected military barracks that had been erected during World War Two into residences for 'non-European' students, while 'European' students lived in well-designed residences on campus.<sup>35</sup> All 'non-European' students, regardless of their level of knowledge, had to take preliminary courses for a year before beginning the regular medical curriculum. The preliminary year was meant to provide students with a broad general education. This meant that their undergraduate medical education alone took seven years. Furthermore, the university did not allow 'non-European' students to examine 'European' patients. This severely limited

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<sup>33</sup> G.W. Gale, 'The Durban Medical School: A Progress Report' *SAMJ* 29: 19 (1955), p. 437.

<sup>34</sup> M. Minde, 'History of Mental Health Services in South Africa: Part XIV. Psychiatric Education' *SAMJ* 51: 7 (1977), p. 212.

<sup>35</sup> Solly Ratemane quoted in *Truth and Reconciliation Commission. Human Rights Violations: Health Sector Hearings* (Cape Town, 17 June, 1997), p. 42 [electronic copy], accessed 22 February, 2000: available from <http://www.truth.org.za/HRVtrans/health/health01.htm>

the students' access to modern clinical experience.<sup>36</sup> Thus, in 1966, there were still no 'Coloured', 'Indian' or 'Black' registered psychiatrists, and services for 'non-Europeans' were significantly sub-standard or non-existent.

### ***Material Conditions within Mental Institutions***

The lack of mental services for 'non-Europeans' was not necessarily a negative thing. Indeed, material conditions were so appalling that psychiatric treatment was often more detrimental than helpful. Conditions within mental institutions reflected the racist and contradictory nature of apartheid policy. Although the government relied on a healthy workforce in order to maintain its economic growth, it made no changes to mental health legislation throughout the early years of apartheid. In 1948, the 1916 Mental Disorders Act No. 38 (which had been based on Britain's Mental Disorders Act) still regulated the treatment of the 'mentally disordered'. The Act opened negatively with a chapter on requirements for involuntary detention of mental patients and contained fixed descriptions of different grades of 'mentally diseased' or 'mentally disordered' individuals.<sup>37</sup> In 1944, the South African government had briefly amended the Act so that responsibility for the 'mentally disordered' fell under the jurisdiction of the Department of Health rather than the Department of Interior. It had also replaced the term 'moral imbecile' with the term 'socially defective person'.<sup>38</sup> These amendments seemingly reflected a movement away from the custodial mental 'asylum' towards a more therapeutic mental hospital. Indeed, mental institutions also changed their names from

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<sup>36</sup> *Ibid.*, and Gale, 'The Durban Medical School', p. 437.

<sup>37</sup> *Ibid.*, p. 408.

<sup>38</sup> A. Kruger, *Mental Health Law in South Africa* (Durban: Butterworth, 1980), p. 24.

mental 'asylums' to mental 'hospitals'. However, the government made these amendments mostly to ensure that certain psychopaths could be detained in custodial-like mental institutions and had no expectations of their recovery.<sup>39</sup>

In 1950, South Africa had approximately 16,142 beds available for patients at 13 state mental institutions across the country – 7,953 beds for 'Europeans' and '8,189' beds for 'non-Europeans'.<sup>40</sup> This meant that mental institutions catered to one in every 326 'European' individuals, while they only accommodated one in 1,204 'non-Europeans'. Most state mental institutions catered to both 'European' and 'non-European' populations, although patients were segregated into separate wards or buildings.

Facilities for the 'mentally disordered' in general were significantly sub-standard – particularly those for 'non-Europeans'. Mental hospitals were usually run-down and very rarely renovated. 'Non-European' wings were less cared for than the 'European' wings. Many hospitals had inadequate heating and sanitary services. Fort Napier Hospital in Natal, for example, was originally erected as military barracks by the British in 1861. The South African government used it for housing German prisoners of war during World War One and it was thereafter left vacant. In 1927, the government decided to use it as a mental hospital for both 'Europeans' and 'non-Europeans', with few renovations.<sup>41</sup> By 1958, the government had done little to improve the facilities at Fort Napier and Dr. A. Radford, MP for Durban-Central, described Fort Napier Hospital as follows:

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<sup>39</sup> Minde, 'History of Mental Health Services: Part VII', p. 409.

<sup>40</sup> Kevin Solomons, 'The Development of Mental Health Facilities in South Africa 1916-1976' in Francis Wilson and Gill Westcott (eds.), *Economics of Health in South Africa Volume II: Hunger, Work and Health* (Johannesburg: Ravan Press, 1980), p. 299.

<sup>41</sup> Minde, 'History of Mental Health Services: Part VII', p. 325.

In 1861, just under the time when the Monuments Commission will go and put a label on it, the British Government built some barracks in Maritzburg. They built them of wood and iron. That is Fort Napier Hospital. And that is the place where Europeans are housed; in the bitter cold; it is not possible to warm them, because you cannot have fires and there is no other means of heating; the mortality and morbidity from chest complaints among these old people must, I think be fairly high. Not only is it wood and iron, Sir, but it is in great danger of falling down. Parts of it are propped up by gum-poles, not just a little support here and there, not just 18-foot and 16-foot poles here and there, but 20 feet to 25 feet long stuck at an angle to stop it from blowing over.<sup>42</sup>

Similarly, Fort Beaufort Mental Hospital in the Cape was also run-down. It too had been created out of abandoned military barracks. In 1894, the colonial government transformed the military barracks at Fort Beaufort into an exclusive institution for 'non-European' South Africans. Since its establishment, however, Fort Beaufort was very overcrowded and mortality rates were high. In 1913, a parliamentary Select Committee recommended that the government scrap it because of its unrelenting problems. However, because of the incessant demand for accommodation, the hospital continued to operate under inhuman conditions. In 1936, the Orenstein Committee argued that patients were unable to recover because of the excessive overcrowding in the institution. Serious health conditions such as tuberculosis and diseases caused by vitamin deficiency were prevalent because of the gross overcrowding and inadequate diet at Fort Beaufort. In 1946, large amounts of pellagra (a disease caused by vitamin B deficiency often resulting in a form of 'mental illness'), scurvy and beriberi were reported because of inadequate diet.<sup>43</sup>

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<sup>42</sup> HAD, (9 September 1958), col. 3265.

<sup>43</sup> M. Minde, 'History of Mental Health Services in South Africa: Part III. The Cape Province', *SAMJ* 48: 53 (1974), p. 2232.

Insufficient medical attention was not limited to Fort Beaufort Mental Hospital but was common in most mental hospitals that catered to 'non-European' patients. In 1955, M. Minde, then the physical superintendent of the Umgeni Waterfall Institution in Grahamstown, found that 62 percent of 'Bantu' patients transferred from other mental institutions had untreated intestinal parasites. Patients from Fort Napier Hospital in Natal and Sterkfontein Hospital in the Transvaal were the worst affected.<sup>44</sup> Similarly, A. Moffson, Medical Officer at Weskoppies Hospital in Pretoria, found that 28 'Bantu' patients out of 400 patients admitted to Weskoppies Hospital died from physical conditions such as lung infections and pulmonary tuberculosis.<sup>45</sup>

All mental hospitals also experienced a shortage of psychiatric staff. In 1950, there were only 49 certified psychiatrists, many of whom were in private practice. These numbers did not expand very rapidly [See Table 1].

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<sup>44</sup> M. Minde, 'Intestinal Parasites in Bantu Mental Patients' *SAMJ*, 36: 28 (1962) p. 561.

<sup>45</sup> A. Moffson, 'A Study of 400 Consecutive Male Bantu Admissions to Weskoppies Mental Hospital', *SAMJ* 29: 29 (1955), p. 689.

	Medical Staff Employed by State Mental Hospitals	No. of Registered Psychiatrists in South Africa
1935	45	
1940	50	26
1945	43	38
1950	51	49
1955	55	62
1956	59	
1957	51	
1958	67	
1959	57	
1960	65	70
1961	64	
1962	67	
1963	76	
1964	78	
1965	73	86
1966	74	

**Table 1: Number of Medical Staff Employed in State Mental Hospitals and Numbers of Registered Psychiatrists between 1935 and 1966.<sup>46</sup>**

Because of the low number of state psychiatrists, underqualified medical officers often filled positions designated for psychiatrists. By 1966, thirty-three positions existed for psychiatric staff. Psychiatrists filled only thirteen of these positions, while other medical staff filled sixteen. Four posts remained vacant.<sup>47</sup> A 1961 editorial article entitled "Why South Africa is Short of Psychiatrists" stated that the negative attitude afforded to psychiatry by the general medical community discouraged individuals from studying psychiatry. It contended that many senior members of the medical profession and university officials were to blame for the negative stigma attached to psychiatry. Consequently, it argued that the general medical field and universities still treated psychiatry as 'the stepchild of medicine' and medical students viewed it 'as one of the relatively minor subjects of secondary status in the curriculum.'<sup>48</sup> Indeed, psychiatry had

<sup>46</sup> All numbers obtained from the South African Department of Statistics, Pretoria.

<sup>47</sup> HAD (19 August 1966), col. 1049.

<sup>48</sup> Editorial, 'Why South Africa is Short of Psychiatrists', *SAMJ* 35: 8 (1961), p. 147.

a negative stigma attached to it. General hospitals often discouraged the admittance of psychiatric patients, and in some cases, they forbade it completely.<sup>49</sup>

University officials and physicians were not the only ones who attached a negative stigma to psychiatry. Many psychiatric support staff had the same view. General mental health staff were in critical demand. The numbers of psychologists, psychiatric social workers and specialised psychiatric nurses were drastically low. Mental health staff at institutions were grossly overworked and underpaid. Consequently, an exceptionally high staff turnover rate existed. 'European' nurses, assisted by 'non-European' nursing assistants, treated all patients, but a stigma existed about working within the field that discouraged individuals to pursue training in psychiatry and mental health services.<sup>50</sup> Therefore, the staff appointed to psychiatric institutions often had limited training in psychiatry or in nursing in general. In 1958, Dr. Fisher brought a petition to parliament signed by 1000 friends and relatives of patients at Valkenberg Hospital, a 'European' mental hospital in the Cape. It argued that the working conditions within the hospital were 'such that not the best type of person is being attracted to these institutions.'<sup>51</sup> Nevertheless, 'European' mental hospitals employed the most highly qualified staff. This meant that most 'non-European' institutions employed

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<sup>49</sup> Editorial, 'Psychological Illness in South Africa', *SAMJ* 27: 38 (1953), p. 812.

<sup>50</sup> In 1965, Charlotte Searle argued that an inherent prejudice against mental health work existed among the English-speaking people in Natal. She stated that the nineteenth century perceptions that mental health work was for the 'lower levels of the servant class, who in the mass were described as coarse, harsh, passionate, indifferent, untrustworthy and intemperate, [and] who have no higher conception of their office than that of gaoler' continued to the 1960s. Charlotte Searle, *The History of the Development of Nursing in South Africa 1652-1960: A Socio-Historical Survey* (Cape Town: Struik, 1965), p. 118.

<sup>51</sup> HAD, (9 September 1958), col. 3254.

the less experienced psychiatric staff and therefore 'non-European' patients received a significantly lower standard of care than did 'European' patients.

Language barriers further compounded the inadequate treatment of 'non-European' patients. Because many psychiatrists did not speak languages other than English and Afrikaans, they often were unable to communicate effectively with their patients. This meant that psychotherapy in 'non-European' institutions was virtually non-existent. Little background on 'non-European' patients was ever gathered and many psychiatrists (or their equivalent) diagnosed patients with little knowledge of current or past circumstances. This is particularly evident in the large discrepancy in the case studies presented in the *South African Medical Journal*. Psychiatrists gave detailed family backgrounds and situational analysis for 'European' patients, while 'non-European' case studies merely noted visible symptoms. Psychiatrists paid little attention to environmental factors or the histories of their 'non-European' patients. Thus, either psychiatrists released most 'non-European' patients prematurely or they continued to confine them in the mental hospitals for most of their lives. Indeed, many 'non-European' institutions continued to implement outdated 'locked-door' policies and had serious overcrowding problems. Radford describes what he saw at Fort Napier Mental Hospital in 1958:

...I saw myself something between 200 and 300 male Natives going to bed. They were happy, I will say that... They had mats to lie on. That is quite all right, and they had blankets. They were clean... But, Sir, as I walked out, the superintendent locked the door, as he locked every door before and behind him – every door in these places is locked, it reminded me of the days of my youth when my father used to kraal his sheep, pushing them in.<sup>52</sup>

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<sup>52</sup> *Ibid.*, col. 3265.



Similarly, in 1958, Radford described the conditions for 'non-Europeans' purposely using the words of a 1936 departmental committee report to show that mental hospitals had not improved significantly:

In the case of non-Europeans the position in some of the dormitories is really appalling. Patients are sleeping in absolute contact with one another, not only shoulder to shoulder but feet to shoulder, when patients are placed both transversely and longitudinally in the same dormitory. They really make a solid layer of humanity, so that there is scarcely room to put a foot between sleeping patients.<sup>53</sup>

In 1950, there were 1,849 more 'Bantu' patients in mental hospitals, while 'European' wards had an excess of 897 beds. Overcrowding increased significantly so that in 1965 there were 4,624 more 'Bantu' patients than beds [See Table 2]. This meant that only the critically-ill 'Bantu' patients would be admitted to mental hospitals. Often, because the accommodation situation was so inadequate, many 'Bantu' patients were crammed into mental institutions, housed in police cells or left untreated.<sup>54</sup>

	1945		1950		1955		1960		1965	
	Patients	Beds	Patients	Beds	Patients	Beds	Patients	Beds	Patients	Beds
Registered 'European' Patients	6,774	6,454	7,056	7,953	7,342	7,774	7,651	7,844	8,054	8,662
Registered 'Bantu' Patients	9,117	6,389	10,038	8,189	11,577	9,373	12,563	7,305	13,979	8,747
Total Patients	15,891	12,843	17,094	16,142	18,919	17,147	20,214	15,149	22,033	17,409
Number of hospitals					13		13		15	

Table 2: Number of Patients and Beds in State Mental Hospitals from 1945 to 1965<sup>55</sup>

<sup>53</sup> *Ibid.*, col. 3258.

<sup>54</sup> Alice Cox, 'Psychological Illness in South Africa: The Problems of Treatment and Care. The Psychiatrist's Point of View', *SAMJ* 27: 38 (1953), p. 814 and Editorial, 'Geestesongestelheid in Suid-Afrika', *SAMJ* 32: 26 (1958), p. 352. Those placed in police cells lost all their rights to freedom and were placed under the authority of the Department of Justice rather than the Department of Health. HAD, (9 August 1966), col. 384.

<sup>55</sup> Solomons, 'The Development of Mental Health Facilities', p. 299.

### *Community Psychiatry and the South African Psychiatric Field*

These conditions, however, did not remain uncontested by the South African psychiatric field. Indeed, highly influenced by 'Western' psychiatric trends, in the 1950s South African psychiatrists began to promote reformist ideas of community psychiatry. Community psychiatry was an attempt by psychiatrists to move services beyond the institutional walls to the community. It originated during World War II when European and North American countries recruited large amounts of young physicians into the psychiatric field and trained them to deal with 'mental disorders' caused by environmental stress. These psychiatrists recognised that patients affected by combat who were treated in community settings did not deteriorate. Indeed, many were restored to normal much more quickly. After the war, 'Western' psychiatrists transposed their ideas of community-oriented treatment to civilian psychiatry.<sup>56</sup> This development, coupled with the development of psychotropic drugs in the 1950s, promoted the view that 'mentally ill' individuals could live relatively normal lives outside of the mental institution. Many advocated the use of more 'open-door' practices and argued for a more integrative approach with general medicine that would allow patients easier access to psychiatry. Community psychiatry was seen to be 'a revolution in psychiatric practice.'<sup>57</sup> It was, as Joan Busfield suggests, meant to 'provide services for every stage of the illness, and for prevention as well as cure: primary care facilities, acute hospital beds, hospital beds for chronic patients who still needed medical or psychiatric care, residential hostels, half-way

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<sup>56</sup> Grob, *The Mad Among Us*, p. 191-192.

<sup>57</sup> Editorial, 'Mental Health Services', *SAMJ* 35: 21 (1961), p. 424.

houses, day hospitals, social work support as well as the health and welfare services more generally.<sup>58</sup>

Community psychiatry depended strongly on psychotropic drugs in order to assist patients with their transition back into the community. Following their European and North American counterparts, South African psychiatrists had quickly rejected psychoanalysis and displaced it with the idea that the 'mentally disordered' brain was a chemical and biologically affected entity. Indeed, psychiatrists began gradually to use the term 'mental illness' rather than 'mental disorder', which reflected this move towards a biological definition of 'madness'. In South Africa during the 1950s and 1960s, the introduction of psychosomatic drugs to the psychiatric field had seemed to be the answer to many of the problems that psychiatrists faced within mental asylums. As early as 1958, M. Minde acknowledged the power of the first tranquillising drugs. Although they could not cure patients of their 'mental illness', he argued that they could drastically change the way that psychiatry was practised:

During the last few years the psychiatrist has been given another potent weapon in the shape of the tranquillizing drugs, which though not able to cure many cases of mental disease, are valuable in controlling and modifying many of its worst features, and have turned what were previously the most disturbed wards in the hospital into havens of peace and quiet.<sup>59</sup>

Psychiatrists used many of the earlier tranquillising drugs in conjunction with other psychoanalytic and therapeutic treatments. However, drugs did play a large role in the transition from the asylum to community psychiatry. Drugs not only calmed patients

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<sup>58</sup> Busfield, *Managing Madness*, p. 342.

<sup>59</sup> M. Minde, 'The Mental Hospital and the Community', *SAMJ* 32: 28 (1958), p. 710.

down so that they seemed more 'normal' and more easily integrated into the community, but as psychotropic drugs became available in South Africa, psychiatrists saw them as the answer to the overcrowding and staff problems in the institutions. L. S. Gillis, for example, argued in 1962 that drugs could eventually eliminate the long-term patient thereby enabling more beds to open up in general and psychiatric hospitals, although he was somewhat sceptical as to how quickly this would happen. He argued that the new psychotropic drugs enabled 'an absolutely unprecedented diminution of patients in mental hospitals (European), and the solution of overcrowding problems for non-Europeans.'<sup>60</sup> For A. McE. Lamont, anti-psychotic drugs were a dramatic improvement. Although he acknowledged the side effects of many of the psychiatric drugs, he mostly glorified the drugs by arguing that many psychiatric and psychotic symptoms merely 'melted away' after drug administration.<sup>61</sup> In 1966, a *South African Medical Journal* editorial also spoke highly of the introduction of drugs. It contended that drugs used for depressive states were mostly effective and 'may produce impressive results.'<sup>62</sup> Drugs, it argued, could offer patients not only relief from depression but could also offer solutions to sleeplessness and anxiety.<sup>63</sup> Drugs were not only meant to cure a patient, but enable a patient to become a productive member of society.

However, pharmacological drugs were still relatively new and community psychiatry was not a well-defined concept. Some psychiatrists associated community

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<sup>60</sup> L. S. Gillis, 'Social and Community Psychiatry in South Africa', *SAMJ* 36: 8 (1962), p. 142.

<sup>61</sup> A. McE. Lamont, 'Man's Hidden Madness or Defence Against Insanity', *SAMJ* 44: 24 (1970), p. 711.

<sup>62</sup> Editorial, 'Drugs for Depression', *SAMJ* 40: 9 (1966), p. 182.

<sup>63</sup> *Ibid.*

psychiatry with the increase of services in a community, moving existing services out of the institution into the community. Others saw it as including preventative measures. This meant challenging socio-economic conditions that increased the incidence of 'mental disorder'. While the former explanation supported apartheid notions of segregation by emphasising that the mental health of an individual was the responsibility of his/her racial group, it also countered the apartheid government's need for social control. Furthermore, the latter explanation directly contradicted the large amounts of mental stress on 'non-Europeans' caused by apartheid, while supporting the mental health of the 'non-European' labour force. Therefore, South African psychiatrists found themselves torn between promoting the well-being of psychiatric patients while maintaining their non-activist stance with a government that particularly damned any opposition to its policies.

'Western' psychiatrists shared this dilemma as well. As Gerald Grobb describes:

Community psychiatry was identified with social and political activism. To conflate the two, however, raised serious intellectual problems. How could a medical specialty such as psychiatry reconcile its claims to professional autonomy and legitimacy with a commitment to democratic politics in which partisanship and competing ideologies played a vital role.<sup>64</sup>

Community psychiatry in practice also had some serious pitfalls. Firstly, by moving the treatment of patients away from the mental institutions into the community, psychiatrists could easily neglect the needs of many patients. For example, a major assertion of community psychiatry was a more holistic approach to medicine.

Psychiatrists argued that psychiatry needed to be integrated with the general medical field

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<sup>64</sup> Grob, *The Mad Among Us*, pp. 250-251.

so that psychiatric services would be more readily available to the masses. By placing psychiatry in the hands of general practitioners, South African psychiatrists believed that accommodation and staff problems would also be addressed. Although the promotion of psychiatry within the general health field significantly opened up psychiatric access to patients, it neither addressed the problem of the more seriously ill patients, nor did it examine the socio-economic conditions which caused many of the illnesses. Community psychiatry only affected those less-serious cases. Chronic long-term patients often remained institutionalised in custodial institutions.<sup>65</sup> As I pointed out earlier, because of gross overcrowding problems, psychiatrists usually admitted only critically-ill 'non-European' patients. This meant that the innovations of community psychiatry did not reach 'non-European' patients. Instead, psychiatrists only offered community-orientated services to a limited 'European' patient community, while explicitly neglecting 'non-European' patients. Community psychiatry, therefore, promoted a more segregated and tiered psychiatric system.

### ***Contradictions in Psychiatric Diagnoses***

The contradictions within (and between) psychiatric beliefs and apartheid ideology can be seen in the diagnostic method of South African psychiatrists. Community psychiatry acknowledged that socio-economic conditions had an effect on the development of 'mental disorder', while apartheid ideology attributed 'mental disorder' to racial differences. An awareness of socio-economic effects on 'mental disorder', in conjunction with ideas of racial difference, resulted in the creation of a contradictory

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<sup>65</sup> Busfield, *Managing Madness*, pp. 329-330.

hierarchical classification system in which 'mental disorders' were rated in terms of both severity and race.

South African psychiatrists deemed defective mental development (DMD) and depression as higher on the ladder and therefore more common in the 'European' population, while they associated schizophrenia as lower on the ladder and more common in 'non-Europeans'. Part of the hierarchical distinction between DMD, depression and schizophrenia was based on services available and the ease of cure. DMD services were virtually non-existent for 'non-European' patients, and depression was easily cured. On the other hand, schizophrenia was, as one psychiatrist called it, the 'therapeutic failure' of psychiatry.<sup>66</sup> Schizophrenia had a very low recovery rate and made up the majority of the long-term patients. The hierarchical structure of 'mental disorders' was further augmented by legislation governing 'mental disorders'. The Mental Disorder Act of 1916 defined a 'mentally disordered' person as:

any person who in consequence of *mental disorder* or *disease* or *permanent defect* of reason or mind is incapable of managing himself or his affairs; or is in consequence of such disorder or disease or defect a danger to himself or others; or who in consequence of such disorder or disease or defect requires supervision, treatment and control...<sup>67</sup>

It did not have descriptions of types of 'mental disorders', but did classify patients into set classes based on intelligence, determined by pre-set questions designed specifically for the 'European'-based notion of 'normal'. The description of mental patients as individuals with 'disorders', 'disease' and 'defects' meant that a 'normal' individual was orderly,

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<sup>66</sup> M. Minde, 'The Mental Hospital and the Community', p. 710.

<sup>67</sup> Quoted in Union of South Africa, *Report of Penal and Prison Reform* (Pretoria: Government Printer, 1947), p. 117.

healthy and faultless – terms open to interpretation and rarely used to describe 'non-European' individuals. 'Non-Europeans' were generally seen as 'disorderly', 'unhealthy' and 'deficient'. It would be logical therefore to assume that psychiatrists saw 'non-Europeans' as more prone to 'mental disorder' than 'Europeans'. However, this was not necessarily the case. Rather, psychiatrists were more likely to diagnose 'Europeans' with 'mental disorders'.

	1962	1966	1967	1968
<b>Defective Mental Development*</b>				
'Whites'	3,691	3,314	4,105	4,123
'Coloureds'	566	589	865	869
'Asiatics'	55	23	61	36
'Bantu'	972	861	1,241	1,122
<b>TOTAL</b>	<b>5,284</b>	<b>4,787</b>	<b>6,272</b>	<b>6,150</b>
<b>Manic-depressive psychoses and involuntional melancholia</b>				
'Whites'	299	307	294	305
'Coloureds'	89	57	58	60
'Asiatics'	15	13	16	14
'Bantu'	277	225	233	216
<b>TOTAL</b>	<b>680</b>	<b>602</b>	<b>601</b>	<b>595</b>
<b>Schizophrenia and paranoid conditions and paranoia</b>				
'Whites'	2,413	2,475	2,303	2,254
'Coloureds'	1,459	1,574	1,614	1,570
'Asiatics'	215	139	140	122
'Bantu'	7,361	7,733	7,705	6,805
<b>TOTAL</b>	<b>11,448</b>	<b>11,921</b>	<b>11,762</b>	<b>10,751</b>
*Both with and without epileptic psychoses. Numbers of patients diagnosed with depression are not available.				

**Table 3: Breakdown of Number of Patients Diagnosed with DMD, Manic-Depressive Psychoses and Schizophrenia by Race<sup>68</sup>**

<sup>68</sup> All numbers obtained from the South African Department of Statistic, Pretoria.



The most prevalent diagnosis for 'Whites' was defective mental development. DMD is an organic (rather than functional) psychosis that was often associated with the insufficient development of brain tissue and is often characterised by confusion or in severe cases, delirium. This diagnosis included individuals whose mental facilities had ceased to function correctly for various organic reasons, but did not include other organic psychoses such as senile and arteriosclerotic psychosis, toxic psychosis, or psychosis caused by syphilis. In 1962, psychiatrists diagnosed 30 percent of patients in mental hospitals with DMD (both with and without epilepsy), 69 percent of whom they classified as 'Whites'.<sup>69</sup> This predominance of 'Whites' with DMD was probably because defective mental development was most often the concern of psychologists, many of whom were more apt to use psychotherapy, occupational therapy, mental testing and other forms of innovative practices. Because many innovative practices were never applied to 'non-European' patients, the numbers of 'non-European' patients to receive treatment for DMD was minimal. Furthermore, because the early symptoms of DMD were similar to those of schizophrenia, the majority of psychiatrists instead diagnosed 'non-Europeans' with schizophrenia.

South African psychiatrists also found significantly less depressive states in 'non-Europeans' than in 'Europeans'. In 1950, H. Walton argued that suicide rates were considerably higher in 'European' than in 'Bantu' and 'Coloured' groups. Similarly, Peter Kellett found that in Durban the majority of suicide patients admitted to the Addington

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<sup>69</sup> Quoted in Toker, 'Mental Illness in the White and Bantu Populations of the Republic of South Africa', *American Journal of Psychiatry* 123: 1 (1966), p. 58 and Alastair McE. Lamont, 'Predictability of Behaviour Disturbance in Patients Presenting with Psychiatric Symptoms', *SAMJ* 40: 5 (1966), p. 88.

General Hospital between October 1964 and January 1965 were 'European'.<sup>70</sup> Both Walton and Kellett found significant differences in racial groups on the way suicide was played out. 'Europeans' tended to use barbiturate drugs while, as Walton described, the 'non-European, probably because of ignorance and because drugs are less available, chose more drastic methods.'<sup>71</sup> The image of the 'ignorant' and somewhat 'barbaric' 'non-European' was present in Walton's overriding argument. He argued that '[t]he Coloured patient's attempt is far more frequently a gesture of anger, or of resentment when neglected by a loved person, than a serious attempt at self-destruction.'<sup>72</sup> This idea of the 'angry' and 'resentful' native was common among psychiatrists. Alistair McE. Lamont, in an article on affective disorders in 'Cape Coloured persons', argued that there were no cases of depression or manic-depression among his study group, while a higher incidence of depression existed in 'European' patients.<sup>73</sup> He attributed this higher rate of depression in 'Europeans' to a general 'Coloured' personality:

When compared with the European, the Coloured patient is more volatile emotionally, and he is more carefree. Society has less to offer him in reward for an industrious and conscientious existence. He is less hampered by rigid conventions. Thus Coloured persons, who are constitutionally predisposed to affective types of psychotic reaction, are less liable to harbour repressed charges with feelings of guilt... It is submitted that because there is less likelihood of feelings of guilt associated with sexual and other topics in the development of the Coloured individual's personality, that the depressed forms of manic-depressive psychosis are rarely encountered in members of that race.<sup>74</sup>

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<sup>70</sup> Peter Kellett, 'Attempted Suicide in Durban: A General Hospital Study', *SAMJ* 40: 5 (1966), p. 90.

<sup>71</sup> H. Walton, 'Attempted Suicide in Cape Town', *SAMJ* 24: 45 (1950), p. 933.

<sup>72</sup> *Ibid.*

<sup>73</sup> Alistair McE. Lamont, 'Affective Types of Psychotic Reaction in Cape Coloured Persons', *SAMJ*, 25: 3 (1951), pp. 40-42.

<sup>74</sup> *Ibid.*, p. 41.

Lamont's image of the sexual promiscuous and innately 'guilt-free' 'Coloured' reflects the apartheid racist view of the 'Coloured' population. Many 'Europeans' viewed 'Coloureds' as 'untrustworthy', 'cheeky' and very similar to the 'Natives.' The government saw 'Coloureds' as a homogenous group that had its own unique (and stagnant) culture. This can be seen further in Lamont's two case studies; one of a 59 year old 'Coloured' female who worked as a domestic servant for many years who was, he argues, 'more affected by European cultural standards' than usual, and one of a 'Coloured' male who was admitted because of restlessness, suicidal thoughts and delusions. Both patients, despite their connection (or lack thereof) to European culture, felt 'persecuted,' rather than feeling guilt in any form. Similarly, in a later study on male 'Bantu' admissions to Weskoppies hospital in Pretoria, Lamont and Blignault argued that '[n]ot a single case with delusional ideas of unworthiness or guilt presented' and that cases of depression were virtually insignificant.<sup>75</sup> Indeed, whether or not one experienced 'guilt' was central to feelings of 'depression'. Guilt feelings, however, were also directly connected to criminal behaviour. For example, J. J. de Villiers argued that individuals who did not experience guilt' were 'criminally minded.'<sup>76</sup> These issues of crime, guilt and race will be discussed further in Chapter Two of this thesis.

The majority of those patients who did not 'experience feelings of guilt' and were not diagnosed with depression or DMD were diagnosed as schizophrenic. Indeed, in 1962, over half of all patients admitted to South African State Hospitals were diagnosed

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<sup>75</sup> Alistair McE. Lamont and Willem J. Blignault, 'A Study of Male Bantu Admissions at Weskoppies during 1952', *SAMJ*, 27: 31 (1953), pp. 637-639.

<sup>76</sup> J.J. de Villiers, 'Correspondence: Mental Disorder, Crime and Sin', *SAMJ* 24: 23 (1950), p. 456.

as schizophrenic, two-thirds of whom were 'Bantu' patients.<sup>77</sup> Similarly, A. Moffson, medical officer at Weskoppies, found that the rate of schizophrenia was more than double in the 'Bantu' population compared to 'Europeans'.<sup>78</sup> While recognising the many different symptoms of schizophrenia, Moffson argued that patients with schizophrenia had 'an apathy or indifference to the events of reality and a splitting of thought from its appropriate affective response'.<sup>79</sup> This definition of schizophrenia was based on two basic concepts; indifference to 'reality' (which is often closely associated to a form of conscience) and 'appropriate affective response'. While psychiatrists some decades later would recognise that these concepts were open to interpretation, early apartheid psychiatrists generally saw them as set 'scientific' concepts. Therefore, if a patient exhibited any differentiation from what they perceived as the 'norm', psychiatrists often diagnosed them as schizophrenic.

Schizophrenia differed in many aspects from the diagnosis of depression. There existed very limited treatment for schizophrenic patients – especially for 'non-European' patients. When psychiatrists administered Electroconvulsive Therapy (ECT) for treatment, it often had a very low success rate. M. Minde estimated that incurable 'schizophrenics' – most of whom were 'non-Europeans' – made up approximately two-thirds of any mental hospital's patients. Similarly, Moffson argued that schizophrenia in 'Bantus' was more of a problem than in 'Europeans' because of the low remission rate. The reason for these low remission rates was probably because of the limited resources

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<sup>77</sup> Quoted in Toker, 'Mental Illness in the White and Bantu Populations', p. 58.

<sup>78</sup> Moffson, 'A Study of 400 Consecutive Male Bantu Admissions', p. 689.

<sup>79</sup> A. Moffson, 'Schizophrenia in Male Bantu Admissions to Weskoppies Hospital' *SAMJ* 28: 32, p. 662.

available for 'Bantu' patients. But it was also because mental hospitals rarely offered alternative methods of treatment such as psychotherapy to 'Bantu' patients. In addition, to the belief that 'non-Europeans' had a higher violence quotient, the risk of violent behaviour was seen as much higher than in 'Europeans'. Furthermore, schizophrenia was also strongly associated with crime (although interestingly less so with sexual crimes).<sup>80</sup> Therefore, psychiatrists would have been less likely to release 'non-European' patients.

However, in contrast to their notion that racial difference caused the significant difference in numbers of 'European' and 'non-European' patients diagnosed with depression, DMD and schizophrenia, many psychiatrists also recognised that 'disorders' were not always caused by biological differentiation. Indeed, many psychiatrists recognised that depression could be caused by social stresses such as 'the loss of a loved one or financial reverses... competition in work, loss of prestige, demotion, and plain overwork.'<sup>81</sup> Furthermore, Eugene Toker and L. S. Gillis argued that the high incidence of schizophrenia in the 'Bantu' population was because of their low socio-economic circumstances.<sup>82</sup> This belief in class difference was in line with Henderson and Gillespie's textbook, printed in the United States, that found 'a disproportionate number of cases of schizophrenia amongst those of low socio-economic status both in Britain and in the U.S.A.'<sup>83</sup> P. J. Fischer, a South African psychiatrist, supported Toker and Gillis'

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<sup>80</sup> Lamont, 'Predictability of Behaviour Disturbance in Patients', p. 87.

<sup>81</sup> Editorial, 'Depression – A Problem in Diagnosis', *SAMJ* 36: 8 (1962), p. 139.

<sup>82</sup> Toker, 'Predictability of Behaviour Disturbance in Patients', p. 55 and L. S. Gillis, 'The Prevention of Mental Illness – Myth of Mandatory', *SAMJ* 40: 38 (1966), p. 923.

<sup>83</sup> Sir David Henderson and Ivor R. C. Batchelor, *Henderson and Gillespie's Textbook of Psychiatry for Students and Practitioners* 9<sup>th</sup> Ed. (London: Oxford University Press, 1962), p. 256.

socio-economic view. He argued that symptoms not only presented themselves differently between 'cultures' but within them as well. Therefore, schizophrenic symptoms would exhibit themselves differently depending on how 'Westernised' the 'Bantu' patient was; i.e. how much more 'urban' the patient was than 'rural'. Fischer argued that 'urban Bantus' would be more likely to exhibit feelings of guilt and less likely to have 'traditional Bantu' delusions.<sup>84</sup>

### *Conclusion*

Studies on psychiatry in colonial Africa have revealed the difference between psychiatric practice in Europe and Africa. Vaughan's discussion, for example, shows how the concept of racial difference expanded into psychiatric notions of 'normality' and 'mental disorder'. Similarly, this chapter shows how the formalisation of racial segregationism after 1948 was legitimised by psychiatric discourse. Psychiatric discourse reflected the racist beliefs that the apartheid government promoted. At the same time, however, this chapter also supports Vaughan, Edgar and Sapire's emphasis that psychiatric discourse did not merely support apartheid ideology, but in some cases (such as with the focus on prevention in community psychiatry) contradicted them. Admittedly, many of the views that contradicted apartheid policies often did so unintentionally. These contradictory views also simultaneously supported apartheid notions. For example, the psychiatric focus on community justified the apartheid segregationist notions while contradicting the same policies that increased the incidence of 'mental disorder'. At the same time, however, community psychiatry offered a solution

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<sup>84</sup> Lamont, 'Predictability of Behaviour Disturbance in Patients', p. 87.

to the demands for a healthy labour force, while simultaneously substantiating racial difference in psychiatric services. These contradictions within psychiatric views reveal the larger contradictions that existed within the apartheid structure itself. Indeed, like psychiatric views, apartheid emphasised the need for adequate psychiatric services for the 'non-European' population, while it simultaneously neglected 'non-European' mental health services. These inherent contradictions meant that psychiatric practices in South Africa improved very little for 'non-Europeans' during this period, and in most cases, the gap between 'European' and 'non-European' psychiatric services increased.

## **CHAPTER TWO: 'MADNESS' IN THE HOUSE OF THE GOVERNMENT: DEMITRIO TSAFENDAS AND THE 'CRIMINALLY INSANE', 1966-1973**

Despite contradictions within apartheid policy, the South African economy had grown tremendously by 1966. 'White' (particularly 'White' Afrikaner) prosperity had increased significantly since 1948. In the 1966 general election, the nationalist government confirmed its leadership position in South Africa by successfully increasing its majority. However, on September 6, 1966, Demitrio Tsafendas, a 'mentally disturbed' messenger at Parliament of unknown racial status, stabbed the 'chief architect' and leader of the apartheid government, H. F. Verwoerd, four times at his bench in the House of Assembly. Verwoerd died shortly thereafter. The events surrounding Verwoerd's assassination are interesting in that they give insight into public, government and psychiatric perceptions of apartheid and community psychiatry. Furthermore, they offer a view (although somewhat limited) into the mind of an individual whose confusion emulated the experiences of many individuals who were racially categorised under the apartheid policies. Moreover, they offer insight into the paradoxical position that psychiatrists supporting community-oriented practices held within the judicial system and their ambiguous relationship with the apartheid government.

As Vaughan has suggested in her work on colonial Africa, the 'labelling' of the 'non-White' 'criminally insane' was often a difficult task. As the colonial government already had an 'Other' in the 'non-White', it did not need to create a 'mad Other' like in the nineteenth century Europe that Foucault describes. Therefore, often the task of



determining exactly what made an individual 'criminally insane' was done haphazardly.<sup>1</sup> In the 1960s in South Africa, this task was further complicated by the new 'open-door' policies of community psychiatry. In the previous chapter, I discussed how the formalisation of racial segregationism impelled the psychiatric field to move towards more community - oriented practices. In this chapter I intend to show how psychiatry's move away from custodial practices created a new dilemma for South African psychiatrists during a period when concern over social unrest was heightened by the President's assassination. As Robert Edgar and Hilary Sapire point out in their discussion on psychiatry during the 1920s and 1930s, authorities in South Africa:

invariably only confined deranged Africans in asylums when they disrupted the regimes and disciplines of work on white farms, in the kitchens, and mines or when they threatened social peace more generally, whether in the streets or 'native reserves'. The primary concern in confining mad Africans thus was less with 'curing' or alleviating their mental pain than with removing them as a source of disturbance to society at large.<sup>2</sup>

While it was certainly true that psychiatry mainly played a custodial role throughout most of the twentieth century, it is also important to note that psychiatrists were not merely the jailers of the state. Indeed, the introduction of 'open-door' policies through community psychiatry complexified psychiatry's role significantly. Psychiatry had an ambiguous relationship with the legal process in South Africa. Often judges, politicians and the public viewed psychiatric testimony as a means by which criminals eluded imprisonment. During the late 1960s, Verwoerd's assassination and the ensuing trial highlighted the

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<sup>1</sup> Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (California: Stanford University Press, 1991), p. 107.

<sup>2</sup> Robert R. Edgar and Hilary Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth-Century South African Prophet* (Johannesburg: Witwatersrand University Press, 1999), pp. 34-35

inability of community psychiatry to deal with the 'criminally insane'. Subsequently, psychiatric views were divided, with some psychiatrists calling for stricter regulations and control over the 'criminally insane' – particularly those classified as 'non-White' – while others continued to promote therapeutic and 'open-door' policies.

### *The Assassination and Depictions of the Assassin*

On September 6, 1966, at around 2:14 p.m., the parliamentary bells began summoning the Members of Parliament into the chamber. As the state President, H. F. Verwoerd sat down at his bench, Demitrio Tsafendas, dressed in his messenger's uniform, hurried up to him, pulled a large knife out of his uniform and stabbed Verwoerd four times in the chest and neck. As Verwoerd slumped over, several members of parliament rushed to his aid, while others restrained Tsafendas and wrestled the knife out of his hand. Verwoerd was taken to Groote Schuur hospital where doctors declared him dead on arrival. The police took Tsafendas to the Caledon Square police station. That evening, the police took Tsafendas to Groote Schuur Hospital for x-rays. He had a fractured nose and jaw, which had occurred in the scuffle to restrain him. Dr. Isaac Sakinofsky, acting head of the Department of Psychiatry at the hospital, examined him for about an hour and a half. When he asked Tsafendas why he had killed Dr. Verwoerd, Tsafendas had vaguely stated that Dr. Verwoerd was against the 'English way of life,' was against a 'Cape-to-Cairo movement' and supported what he saw as an unjust Immorality Act. After this examination at the hospital, the police then returned him to his police cell to await his trial.

Directly after Verwoerd's death, politicians and journalists alike grappled with explanations for this seemingly 'mindless killing' – words they used that explicitly suggested the 'insane' nature of the act.<sup>3</sup> 'A heinous crime,' the *Rand Daily Mail* concurred in its coverage of Dr. Verwoerd's death the day after the assassination. With little knowledge of the reasons for Tsafendas' actions, the editor of the *Rand Daily Mail* argued that it was obvious that the act was 'the impulse of a crank'.<sup>4</sup> Significantly, the editor's use of the word 'crank' does not associate the action with criminal activity as indicated in the preceding headline, but rather dismisses it as eccentric and delusional. Indeed, the depiction of Tsafendas as a peculiar 'madman' became increasingly prevalent as newspapers sought out more information on Tsafendas in the days following Verwoerd's death.

Public demands for information fuelled the zeal with which newspapers sought information. Indeed, the demand for newspapers reporting the death of Verwoerd was so high that the *Rand Daily Mail* had to reprint a special edition, which they made available the following day. Tsafendas' face donned the front pages of newspapers throughout South Africa. 'Face of the Assassin' blared the *Rand Daily Mail* with Tsafendas' huge eyes staring out from the page. However, few knew what type of man Tsafendas was and virtually no one knew anything about his past.

Demitrio Tsafendas was born in Lourenço Marques in Mozambique sometime between 1918 and 1921. He was the son of a Greek father, Miguel Tsafandakis, who

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<sup>3</sup> Editor-in-Chief, 'How Dr. Verwoerd Died', *Rand Daily Mail* (7 September 1966), p. 1.

<sup>4</sup> *Ibid.*

came from Egypt, and a Mozambican mother by the name of Amelia. At the age of one his father sent him to live with his grandmother in Egypt, but after five years he returned to Mozambique to live with his father and his new stepmother, a Greek woman who took an instant dislike to him. His father worked either as an engineer or as a mechanic and moved to the Transvaal when Demitrio was ten. Demitrio attended the Middleburg Primary School in the Transvaal for two years beginning in January 1928. A fellow schoolmate remembered Tsafendas as 'a popular boy who was not at all introverted.'<sup>5</sup> However, he also described him as 'not very bright' and 'very dark even for a Greek.'<sup>6</sup> Because of his 'dark' skin and 'fuzzy' hair, Tsafendas was nicknamed, 'Blackie,' which apparently gave him an inferiority complex.<sup>7</sup> When Tsafendas was 14, he returned to Mozambique and enrolled in a church school for two more years. At the age of 16, he dropped out of school and took up work as a shop assistant. In 1936, he returned to South Africa and worked temporarily at a munitions factory. During World War II, Tsafendas joined a United States naval convoy, which was the beginning of his extensive travels. Throughout Tsafendas' travels between the 1940s and 1960s, he picked up odd jobs. However, he did not keep these for very long, for he often ended up in psychiatric institutions. For example, after he journeyed from Canada to the United States, he was institutionalised as a schizophrenic for six months on Ellis Island in New York. According to his psychiatric records, he heard voices and had bouts of smearing his own faeces on the walls. His racial classification seemed to cause him anxiety, for the records

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<sup>5</sup> Staff Reporter, 'Boyhood Days of Tsafendas', *Rand Daily Mail* (September 8 1966), p. 3.

<sup>6</sup> *Ibid.*

<sup>7</sup> *Ibid.*

also reported him being in love with a girl in South Africa but afraid to marry her in case they spawned a 'Black' child.<sup>8</sup> Tsafendas also spent time in mental hospitals in Germany, Portugal and England. By the end of his travels, Tsafendas knew eight languages, which enabled him to get a job as a translator at the immorality trials of Portuguese and Greek seamen in Durban when he returned to South Africa in 1965. Having been estranged from his mother at an early age, Tsafendas then returned to Lourenço Marques that same year, in search for his mother. It is unknown whether he ever found her, but in 1966 after Verwoerd's assassination, she was reported to be still alive.<sup>9</sup>

Significantly, newspapers began questioning Tsafendas' racial background. Although Tsafendas was legally 'White', many newspapers began arguing that Tsafendas was of 'mixed' origin. The *Rand Daily Mail* for example, argued that Tsafendas' mother was a 'Coloured' Mozambican and stressed any connections that Tsafendas had with the 'non-White' community. It described Tsafendas having lunch at facilities frequented by 'non-Whites', his connections with 'Coloured' individuals and his dark complexion. Indeed, Tsafendas had spent most of his life not fully accepted by the 'White' community and he often insisted that he preferred spending time with the 'Coloured' community. His confusion over his racial classification became central to his own inner conflict and his contradictory statements to friends and associates. Just weeks before Verwoerd's assassination, newspaper reported that he had mentioned to an acquaintance that he

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<sup>8</sup> 'A wild boy nicknamed "Blackie"' Electronic Mail & Guardian (November 4 1997), p. 3 [electronic journal], accessed 13 June 2000: available from <http://www.mg.co.za/mg/news/97nov1/4nov-assassin2.html>

<sup>9</sup> Desmond Blow, 'Tsafendas' mother still alive', *Rand Daily Mail* (September 9 1966), p. 1.

considered changing his racial status to 'Coloured'.<sup>10</sup> At the same time, however, they reported that he had also mentioned to co-workers at the Parliamentary buildings that he was angry at the low status of the 'poor whites' in South Africa, and was upset that the Government 'was doing too much for, and spending too much money on the Coloured people.'<sup>11</sup> Implicit in these reports, was the idea that Tsafendas' actions were attached in some way to the rejection of apartheid, while also being the actions of a 'madman' who thought he was the martyr of the South African republic.

The difficulty in understanding Tsafendas' behaviour was due mainly to the idea that Tsafendas seemingly had little political motivation for stabbing Verwoerd. Indeed, this was increasingly emphasised by the nationalist government. The Justice Minister, John Vorster (who would become Prime Minister shortly thereafter) assured the public that Verwoerd's death was the work of a sole killer and was definitely not part of a larger political conspiracy. South African embassies worldwide assured the international community that Verwoerd's assassination was 'perpetrated by an unbalanced individual' and was, therefore, 'devoid of political significance.'<sup>12</sup> Moreover, many 'non-White' opposition leaders were quick to disassociate themselves from Tsafendas. Rev. Benjamin Rajuill, Chief Whip of the Opposition Transkeian Democratic Party stated: 'If his [Verwoerd's] murderer believed this would help the African people, he must be a misguided madman. I think I speak for all Africans in condemning this terrible act.'<sup>13</sup>

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<sup>10</sup> Staff Reporter, 'Court hears evidence of faulty reason, delusions', *Rand Daily Mail* (October 19 1966), p. 5.

<sup>11</sup> George Oliver, 'I have something to do, said assassin', *Rand Daily Mail* (September 7 1966), p. 2.

<sup>12</sup> 'Devoid of Political Meaning', *Rand Daily Mail* (7 September 1966), p. 2.

<sup>13</sup> Staff Reporter, 'Act Condemned by non-White leaders', *Rand Daily Mail* (7 September 1966), p. 2.

This quick projection of Tsafendas as a 'madman' and 'crank' reflected the need to maintain a sense of order and control in a chaotic and insecure political climate.

Verwoerd had stood as the symbol of the 'architect of apartheid', and he had endured numerous crises without retracting apartheid policies. Just six years earlier, David Pratt, a 'mentally disordered' 'White' farmer, had attempted to assassinate Verwoerd by shooting him in the head at the Rand Show, an annual amusement and exhibition event. Verwoerd had remarkably survived the gunshot wound; he seemed invincible. With his death, however, many domestic and international politicians believed that there was a chance that South Africa's political power had died with him. Stock markets plunged when the government released the news about Verwoerd's death, and as South Africa had recently separated from the Commonwealth and become a republic, South Africa was left increasingly vulnerable. Thus, for both the government and the public, the image of Tsafendas as a 'lone killer' whose actions were mainly due to his mental imbalance was important.

### *The Trial*

By the time psychiatrists had the opportunity to examine Tsafendas, the media and politicians had already deemed him a 'madman'. Therefore, on October 17, 1966, defence lawyer, Wilfred Cooper, told the court that he intended to show that Tsafendas was not mentally fit to be charged with murder and he subsequently petitioned to have Tsafendas placed under psychiatric observation. Dr. Harold Cooper, who had spent a total of six hours with Tsafendas and testified on behalf of the defence, argued that Tsafendas was a 'chronic schizophrenic' who was unable to fully understand the nature of

his crime. He brought up Tsafendas' obsession with a supposed tapeworm in his stomach – a tapeworm that Tsafendas claimed had enabled him to kill Verwoerd. In cross-examination, the Attorney General of the Cape, W. M. van den Berg, asked Dr. Cooper whether Tsafendas had deliberately planned to kill Verwoerd. Dr. Cooper admitted that Tsafendas had intentionally killed Dr. Verwoerd. However, he also pointed out that Tsafendas did not have an escape plan, therefore his act was not one of a rational clear-thinking individual. The presiding Judge, Justice Beyers, assisted by two assessors, an advocate and a medical superintendent of a mental hospital, was somewhat sceptical of the validity of the plea for mental observation.<sup>14</sup> Because of the Judge's scepticism, the role of psychiatrists became increasingly important in the court case. The defence attorneys obtained records from all the mental hospitals in which Tsafendas had spent time and called numerous psychiatrists to support Dr. Cooper's testimony. On the second day of the hearing, the defence called Dr. Ralph Kossew as another psychiatric witness. Kossew testified that three months before Verwoerd's assassination he had examined Tsafendas' mental state because Tsafendas had applied for a disability grant from the Department of Social Welfare. At that time, he too had classified Tsafendas as schizophrenic with a persecutive complex and hypochondria. In addition, Dr. Isaac Sakinofsky, who had examined Tsafendas the day of the assassination at Groote Schuur Hospital and two times thereafter, verified both Dr. Kossew and Dr. Cooper's findings. He argued that he had found Tsafendas 'mentally disordered' in terms of the Mental Disorders Act and had classified him as schizophrenic.

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<sup>14</sup> Staff Reporter, '...he planned to shoot Dr. Verwoerd not stab him', *Rand Daily Mail* (October 18 1966), p. 4.



On the third day of the evidentiary hearing, Dr. Abraham Zabow, another defence psychiatrist, also testified that Tsafendas was schizophrenic with paranoid tendencies. He maintained that Tsafendas suffered from delusions and thought-disorder and had lost contact with reality. Dr. James McGregor, a specialist psychiatrist and head of the Department of Neurology at the University of Cape Town, had testified earlier that he had also examined Tsafendas' and found him suffering from schizophrenia of the paranoid type. He too had noticed that Tsafendas obsessed excessively on an illusory tapeworm in his stomach and found that Tsafendas had no other aspiration in life but to get rid of it. In addition, he argued, like all the psychiatrists before him, that Tsafendas had no hope for recovery from his schizophrenia. Basing his view on Tsafendas' previous escapes from institutions in Germany and Portugal, McGregor argued that he did not think 'any ordinary asylum would hold this man for any length of time.'<sup>15</sup> McGregor's words would form the basis of the state President's final decision to imprison Tsafendas' rather than place him in a mental hospital.

Four days after the trial had begun, after hearing similar evidence of Tsafendas' schizophrenia from prosecution witnesses, Mr. Justice Beyers stated that he had no reason to prolong the proceedings of the case further and declared Tsafendas 'insane' and unfit to stand trial. He acknowledged that he had not immediately accepted the diagnosis of the first psychiatrist, Dr. Harold Cooper, since a court 'does not lightly sit back and allow a man who has committed a grievous crime to get away on a plea or an inquiry of

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<sup>15</sup> George Oliver, 'Doctor says no asylum could hold Tsafendas', (October 20 1966), p. 1.

this nature.<sup>16</sup> However, as the case proceeded, he realised that Tsafendas was 'obviously deranged.' He stated:

I have before me, on the evidence, clearly a man with a diseased mind, a mind subject to delusion, a mind which is so trammelled, if not guided, by irrational forces that obviously I cannot even begin to find whether he is guilty or not guilty of a crime at law. So really I have no option in the matter. There is really nothing more for me to decide and I and my two assessors find ourselves where we cannot do otherwise than say that the person presently before us is found by us to be mentally disordered.<sup>17</sup>

Subsequently, he committed Tsafendas to prison, pending the decision of the State President.<sup>18</sup>

### *Psychiatric Views of Crime and 'Insanity'*

The after effects of the Tsafendas trial reflected the ambiguous and contradictory beliefs held by psychiatrists about community psychiatry and apartheid. While many psychiatrists still promoted more 'open door' and community-orientated practices, others

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<sup>16</sup> Staff Reporter, 'Tsafendas is found insane: committed to prison', *Rand Daily Mail* (October 21 1966), p. 2.

<sup>17</sup> *Ibid.*

<sup>18</sup> Recently, Liza Key, a South African filmmaker, researched Tsafendas' history and conducted interviews with the assassin before his death. She suggests that Tsafendas was part of a wider conspiracy and argues that Tsafendas was not the 'madman' that he was so often portrayed as; rather, his actions seemed very thought out and with a sense of purpose. She argues that Tsafendas was a registered member of the Communist Party of South Africa before the war, and points out that although Tsafendas denied ever knowing Russian, there is some evidence in the recently released archive records that suggests otherwise. Indeed, Tsafendas himself had admitted to a cleric that he had attended training school in Russia. Key also uncovered the testimony of individuals who were astonished by the precision of the stab wounds, which they argued could have been the work of a 'trained assassin.' Key's research raises some interesting questions about the changing views of 'mental illness' in relation to political environments. The 'conspiracy theory' that Key advocates not only raises the question as to whether Tsafendas was as 'mentally insane' as many made him out to be, but also gives an interesting example of how a 'crazed madman' can transform into an 'unsung hero' over time. Interestingly, Tsafendas himself left a final request for a postmortem into whether his deed was a reasonable political act or merely a 'mindless killing' – his request was unfortunately not honoured. 'Hell in a cell alongside the gallows', *Electronic Mail & Guardian* (November 4 1997), p. 2 [electronic journal], accessed 13 June 2000: available from <http://www.mg.co.za/mg/news/97nov1/4nov-assassin3.html>; and Own Correspondent and AFP, 'Verwoerd's assassin dies', *ZA Now Daily Mail & Guardian* (October 10 1999), p. 7 [electronic journal], accessed 13 June 2000: available from <http://www.mg.co.za/mg/archive/99oct/10oct-news.html>

began calling for stricter regulations to control the 'mentally ill'. These contradictions seriously undermined psychiatry's position within the judicial system.

The same day that the judge passed down his decision on the Tsafendas case, the Minister of Justice, Mr. Pelsler, announced that a commission of inquiry headed by F. Rumpff would investigate the role of psychiatry and the existing legal statutes regulating the responsibility of 'mentally deranged' individuals. The final report stated the reason for the committee:

Through the tragic combination of circumstances leading to the death of Dr. Verwoerd, the problem of the violent mentally disordered person was brought pertinently to the attention of the authorities, and a shocked nation wants an answer to the question of how it could be possible for attacks to be made on two occasions on the life of the Prime Minister by mentally disordered persons and how such persons could be detected before they do serious harm.<sup>19</sup>

The Committee made note of the lack of confidence often placed in psychiatrists by the public and the legal profession. It noted that psychiatrists were often viewed as defending the acts of criminals and giving these criminals an opportunity to commit further crimes. Indeed, as previously indicated in the Tsafendas case, Justice Beyers himself had admitted his doubt about psychiatric evidence at first because he argued that the court could not simply allow a criminal to 'get away' with committing a crime. As R. W. S. Cheetham from the National Council of Mental Health stated in a memorandum to the Committee:

- (i) In the present method of conducting the criminal trial, with the onus on the defence to prove insanity 'as a defence', the psychiatrist, in giving evidence to indicate the presence of a mental disorder, is in reality making

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<sup>19</sup> Republic of South Africa, *Report of the Commission of Inquiry into the Responsibility of Mentally Deranged Persons and Related Matters* (Pretoria: Government Printer, 1967), p. 66

a diagnosis (as in any illness), and recommending therapy to the Court. This, however, is all too commonly regarded, by the public, as an attempt to defeat the ends of justice, and the purely medical attitude, required of him by his Hippocratic oath, is overlooked in the emotionality surrounding the trial and the identification of the public with the murdered or injured individual or family.

- (ii) Thus the public concept, all too frequently is that, in certain cases, psychiatrists 'get people off' criminal charges.<sup>20</sup>

Because of this negative view of psychiatric testimony, the Committee found that judges easily rejected psychiatric views that did not fit directly into the pre-existing legal perspective. For example, one of the many cases the committee cited was *Rex v. Kennedy* (1951) wherein the court refused to accept the psychiatric evaluation of Dr. Cooper, the same psychiatrist who testified at the Tsafendas case. Dr. Cooper found the accused in this case 'mentally disordered', but the judge dismissed Cooper's evaluation as based on improbable evidence. He argued that Cooper's definition did not fit the legal requirement and, in turn, the judge found the accused fit to stand trial.<sup>21</sup>

This negation of psychiatric testimony was partly due to the difficulty of determining the definition of 'criminally insane'. The court mainly relied on the substance of the M'Naghten Rules – five guidelines set up in the 1843 English court case of Daniel M'Naghten who had shot Sir Robert Peel's secretary and had suffered from paranoia. Generally speaking, the basis of the M'Naghten case is as follows:

...to establish a defence on the ground of insanity it must be clearly proved that, at the time of committing the act, the accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong... If the accused was conscious

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<sup>20</sup> *Ibid.*, pp. 60-61.

<sup>21</sup> *Ibid.*, p. 17.

that the act was one that he ought not to do, and if that act was at the same time contrary to the law of the land, he is punishable...<sup>22</sup>

This meant that if a psychiatrist deemed an accused 'mentally insane' and testified that he did not know the difference between right and wrong, then the accused would no longer be punished for criminal conduct. Instead, he would be placed in a mental hospital. Consequently, psychiatrists who acted as witnesses for the defence of many criminal cases were often viewed as defenders of the criminal and this placed them in direct opposition to the judge and/or jury. Furthermore, the qualities that made an individual unable to 'determine right from wrong' or having a 'defect of reason' were vaguely stated and open to interpretation. Indeed, the difficulty of defining exactly what made an individual 'criminally insane,' or, as some psychiatrists called it, 'psychopathic', had been a difficult issue for the South African government for many years. For example, the Class VI of the 1916 Mental Disorders Act had originally defined the 'psychopathic' patient, or as it was termed, the 'moral imbecile' as 'a person who from early age displays some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect.'<sup>23</sup> In 1944, the government revised this section to delete the term 'moral imbecile' and replace it with 'socially defective person'. Thereafter a 'socially defective person' was defined as 'a person who suffers from mental abnormality associated with anti-social conduct, and who by reason of such abnormality and conduct requires care, supervision and control for his own protection or

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<sup>22</sup> *Ibid.*, p. 8.

<sup>23</sup> Republic of South Africa, *Report of the Commission of Inquiry into the Mental Disorders Act* (Pretoria: The Government Printer, 1972), p. 38.

in the public interest.<sup>24</sup> The inclusion of Class VI in the Mental Disorders Act meant that 'moral imbeciles' or 'socially defective persons' could not be tried in criminal cases and had to be sent to institutions. However, in 1957, the government deleted Class VI and decided to insert nothing in its place. Many believed that 'psychopaths' could understand the proceedings and were perfectly capable of defending themselves. With no clear regulations concerning 'psychopaths', courts had further discretion concerning the treatment and punishment of these individuals.<sup>25</sup>

Some psychiatrists had a negative view of the competence of psychiatric testimony. They agreed with public and judicial perceptions that psychiatry allowed individuals to avoid responsibility for their actions. For example, in 1950, J. J. de Villiers argued that psychiatrists involved in court cases merely took part in a large 'poker-game' in the court where 'criminals' tried to convince the psychiatrists of their 'insanity', while the 'lunatics' attempted to deceive themselves rather than the psychiatrists. Psychiatrists, he argued, tried to outmanoeuvre both the criminals and the 'lunatics.' But, he argued, criminals were mostly successful at deceiving the psychiatrists, while psychiatrists were very seldom able to 'bluff' the criminals.<sup>26</sup> For de Villiers, psychiatric ideology lay at the heart of this 'poker game':

The psychiatrists get hold of a criminal, and point out to him that he has not really been responsible for his actions. The trouble lies not in himself, but in his stars – his environment, his upbringing, his father, his mother, his endocrine glands, his 'organ-inferiority', his 'psychic traumata before the age of five'. When, however, the psychiatrists get hold of a lunatic, they try to point out to him (or her) that he himself has been responsible

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<sup>24</sup> *Ibid.*, p. 38.

<sup>25</sup> *Ibid.*, pp. 38-39.

<sup>26</sup> J.J. de Villiers, 'Correspondence: Mental Disorder, Crime and Sin', *SAMJ* 24: 23 (1950), p. 455.

for his actions. The trouble lies not in others, but in himself – in his silly ideas about guilt, both in others and in himself.<sup>27</sup>

If a psychiatrist was in turn successful at convincing a 'lunatic' that he was responsible for his actions, de Villiers argued that surely the 'lunatic' should then be tried as a criminal. Unfortunately, he argued, this never happened, and psychiatrists continued to support criminals' lack of responsibility.

Similarly, a 1951 editorial argued that psychiatrists' concern did not lie primarily with the safety of society, but with the individual. Therefore, it argued that psychiatric practices made it 'extremely doubtful that a person may be held entirely responsible for his actions.'<sup>28</sup> Moreover, it contended that while psychiatric studies could offer further insight into the reasons behind the criminal behaviour, psychiatry could not take the place of the legal system.<sup>29</sup>

The issue of the 'criminally insane' became even more prevalent as psychiatry's role within the criminal system became more public. Some psychiatrists continued to suggest tougher regulations concerning the 'criminally insane' and drew on apartheid notions of racial difference to support their view. For example, P. H. Henning argued that criminal reactions to imprisonment depended on the race of individuals:

Dit is dus nie 'n ongewone verskynsel dat Blanke verhoorafwagtendes probeer om sielsiek verklaar te word nie. Dit verskaf gewoonlik nie moeite nie, want die pleidooi is: 'dit het skielik swart geword en toe ek weer sien het dít of dát gebeur'. Die gedraf van die mense is verder as 'n reël heeltemal normaal. Die Bantoe pasiënte, met wie ek in die Transvaal in aanraking gekom het, het geen nabootsingsprobleme opgelewer nie.<sup>30</sup>

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<sup>27</sup> *Ibid.*, p. 455.

<sup>28</sup> Editorial, 'The Criminal's Responsibility', *SAMJ* 25: 1 (1951), p. 6.

<sup>29</sup> *Ibid.*, pp. 6-7.

<sup>30</sup> P. H. Henning, 'Die Nabootsing van Geesteskrankheid onder Bantoe Verhoorafwagtende Mans van af Durban Gevangenis (Natal)', *SAMJ* 40: 38 (1966), p. 937.

[It is therefore not an uncommon occurrence that Whites try to be declared mentally ill. This usually proves not to be difficult because the defence is: "It suddenly became dark and when I came to, this or that had happened." The behaviour of the individual is subsequently as a rule completely normal. The Bantu patients, with whom I had come in contact with in the Transvaal, presented no faking problems.]

However, Henning argued that when he transferred to Fort Napier Hospital in Pietermaritzburg, he noticed that 'Bantu' patients attempted to use 'mental disorder' as a defence more often than in the Transvaal. He termed this use of 'mental disorder' as 'Ganser Syndrome'. Henderson and Gillespie define Ganser Syndrome as a hysterical pseudo-dementia, a mental reaction that occurs '[i]n situations in which a lack of mental responsibility, if recognised by authorities, would bring some advantage.'<sup>31</sup> They describe it in more detail as follows:

The *Ganser syndrome*, or 'syndrome of approximate answers', was described first in prisoners. The patient gives bizarre replies to questions; for example, asked how many tails a sheep has, he will reply 'two', or if asked how many legs a horse has, he may say 'five'... In some instances a much more elaborate attempt is made at dramatization, and in these the voluntary (simulated) element is much more clear.<sup>32</sup>

Ganser syndrome is therefore a term used to describe an individual's use of voluntary and purposeful imitation of 'mental illness' in order to avoid imprisonment. Henning surveyed mental hospitals throughout the country to see if Ganser syndrome was a common occurrence and found that psychiatrists rarely diagnosed it and knew very little about it. However, he found that Ganser syndrome was extremely prevalent in Pietermaritzburg. In order to find out why, he examined the records of patients admitted

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<sup>31</sup> Sir David Henderson and Ivor R. C. Batchelor, *Henderson and Gillespie's Textbook of Psychiatry for Students and Practitioners* 9<sup>th</sup> Ed. (London: Oxford University Press, 1962), p. 153.

<sup>32</sup> *Ibid.*, pp. 153-154.



for observation between 1 January, 1944 and 31 December, 1963 to see if Ganser syndrome always existed and whether or not it was on the rise. He examined only those patients who were admitted for observation and were not certified as 'mentally ill', and those patients who were certified, but later released. He found that the numbers of admissions had remained surprisingly constant from 1944 to 1958. However, from 1959 to 1963 these numbers increased almost 300 percent.<sup>33</sup> He attributed this dramatic increase of admissions to the rising numbers of 'Zulu' prisoners who used 'mental illness' as a defence.

Henning did not attempt to understand why 'Zulu' prisoners in Natal had a higher incidence of Ganser syndrome than the 'Bantu' in the Transvaal, and the reasons for this discrepancy remains unclear. The high number of 'Zulu' prisoners invoking Ganser syndrome could have been due to an increased awareness among 'Zulu' in the Natal of the benefits of feigning 'mental disorder', or it could have been due to the fact that higher rates of apartheid resistance among the 'Black' population occurred in Natal during this period than anywhere else. For whatever reason, Henning's various solutions to solving the excess of Ganser syndrome patients in Pietermaritzburg reflected an increased scepticism. Firstly, he suggested that psychiatrists become more aware of falsification. Any patient that psychiatrists admit for observation, he argued, must be treated as a potential fraud. Secondly, he proposed that psychiatrists obtain as much information pertaining to the accused and the crime as possible. He argued that usually individuals who were faking their mental symptoms had much to gain or had definite motives for their crime. Thirdly, he argued that psychiatrists must examine the general behaviour of

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<sup>33</sup> Henning, 'Die Nabootsing van Geesteskrankheid', p. 940.

the patient. He suggested that '[d]ie oomblik dat die pasiënt se gedraf so is dat jy die gevoel kry dat hy tonnelspeel, moet mens versigtig wees.' [the moment that the patient's behaviour is such that you get the feeling that he is play acting, you must be very cautious.]<sup>34</sup> Fourthly, Henning also proposed that patients be placed under intensive observation, especially those who withdrew or refused to speak. Fortunately, he argued, patients could not keep up constant silence for long periods and they eventually 'revealed themselves.' Therefore, he argued that there must be someone present at all times in order to witness the patient's conversation. Fifthly, Henning argued that psychiatrists should pay attention to the emotional conditioning of their patients. He argued that psychiatrists had to take into account the different reactions of 'Bantu' to their circumstances. For example, he argued that 'Bantu' individuals who found themselves in some form of trouble inherently did not show their emotions and often the disinterest and apathetic responses associated with 'mental illness' were part of their social conditioning. Finally, Henning argued that psychiatrists must be aware that many patients asked for translators despite the fact that they can speak English or Afrikaans. He contended that many 'Zulu' patients chose to use translators so that they could understand discussions between medical personnel without them being conscious of it. Furthermore, he argued that translators allowed patients more time to make up 'fantastical' answers to the questions posed to them.<sup>35</sup>

Henning based his entire argument on the idea that 'Bantu' accused in Durban were merely faking their 'mental illnesses'. He encouraged psychiatrists to be more

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<sup>34</sup> *Ibid.*, p. 941.

<sup>35</sup> *Ibid.*

cautious and less easily swayed into diagnosing 'Bantu' patients with 'mental illnesses'. He also argued that courts should have the right to re-try individuals whom the court had deemed 'mentally disordered' and who had recovered shortly thereafter. Henning's study relied on a racist notion of 'mental disorder' and criminality.

Indeed, race lay at the centre of the discourse on psychopathy. The editors of the *South African Medical Journal* argued that a 'psychopathic' person was someone who did not live within the social norms of his respective group:

'n Psigopatiese persoon is iemand wat van kleins af 'n volslae geraak toon aan die algemene gangbare waardes van die groep waaraan hy behoort. Hy is onberekenbaar en onbetroubaar, en kan glad nie onderskei tussen wat reg en verkeerd is in terme van die norme en wette van die gemmenskaap waarin hy leef nie.<sup>36</sup>

[A psychopathic person is someone who from an early age shows an utter desensitisation to the general prevailing values of the group to which he belongs. He is unpredictable and unreliable, and can not at all distinguish between what is right and what is wrong in terms of the norm and laws of the community in which he lives.]

Therefore, depending on which racial group an individual belonged to, the determination of him/her as a 'psychopath' differed. Many psychiatrists believed that 'non-Whites' differed both mentally and culturally, therefore the measurement for 'psychopathic' behaviour between cultures differed – many believed that most 'non-Whites' had fewer values and less sense of guilt than 'Whites'. As was stated in the previous chapter, psychiatrists saw criminals as having no guilty conscience and guilt was in turn directly related to specific types of 'mental illnesses'. Psychiatrists then applied these 'mental illnesses' along racial lines, believing that 'non-Europeans' experienced considerably less

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<sup>36</sup> Editorial, 'Die Hantering van Persone met Psigopatiese Neigings', *SAMJ* 40: 45 (1966): p. 1079.

guilt than 'Europeans'. Thus, criminals had different levels of 'mental illnesses' depending on their racial group. For example, paying particular attention to accused committed to mental hospitals who could thereafter be released, Alastair Lamont, the Commissioner of Mental Health, argued a few months before Verwoerd's assassination that one could predict the recurrence of criminal activity depending on the diagnosis (and therefore race) of the patient. Between 1964 and 1965, Lamont studied the records of 2,019 state certified patients and criminal patients; i.e. patients certified not mentally responsible by a court of law and patients that the courts had convicted of an offence and then later transferred to a mental hospital because of 'mental illness'. Out of the 2,019 patients, 69 percent had committed serious crimes. Lamont found that psychiatrists diagnosed 54 percent of the 69 percent of serious criminals with schizophrenia – the diagnosis most often given to 'non-White' patients. In comparison, psychiatrists diagnosed only 27 percent of those patients who had committed serious crimes with Defective Mental Development (DMD) – a 'disorder' commonly associated with 'White' patients.<sup>37</sup> Therefore, Lamont argued that the incidence of behaviour disturbance in 'Bantu' and 'Coloured' populations was significantly higher than for 'Whites'.<sup>38</sup> He argued that 'once a patient has been declared not-responsible... then it would be very difficult to say that he is responsible in the event of further anti-social behaviour. The patient population are aware of this and spoke of it as 'a free ticket to crime' or 'a licence for

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<sup>37</sup> Alastair Lamont, 'Predictability of Behaviour Disturbance in Patients Presenting with Psychiatric Symptoms', *SAMJ* 40: 5 (1966), p. 89. See Chapter One for further information on the racial differences in diagnosis of schizophrenia.

<sup>38</sup> *Ibid.*, p. 87.

crime."<sup>39</sup> Therefore, he argued that patients whom mental hospitals released would be more likely to conduct further criminal offences. Ironically, his study found that those patients that had been diagnosed with DMD were more likely to commit a second crime, probably because they would more likely to be released from mental hospitals than 'non-White' schizophrenic patients.<sup>40</sup> Lamont called for psychiatrists to be more aware of the significance of the diagnostic labels that they gave to their patients because diagnoses often influenced psychiatrists' recommendations of whether to return a patients to society or not.

Contrary to demands by psychiatrists to strengthen policies regarding the 'criminally insane', the majority of psychiatrists continued to promote community-oriented psychiatric and 'open door' policies. Indeed, many psychiatrists suggested that the government change existing regulations concerning the 'criminally insane' to reflect more modern ideas of psychiatry. In 1967, the Rumpff Commission heard testimony from numerous psychiatrists from different parts of South Africa and distributed a questionnaire to the departments of sociology, psychiatry/psychology and law at the various universities and numerous psychiatric and legal organisations throughout South Africa. The questionnaire concerned the existing regulations pertaining to 'insanity' defences and requested suggestions for revisions. Psychiatrists and psychologists were virtually unanimous in their denunciation of the M'Naghten Rules.<sup>41</sup> Psychiatrists argued

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<sup>39</sup> *Ibid.*, p. 88.

<sup>40</sup> *Ibid.*

<sup>41</sup> Republic of South Africa, *Report of the Commission of Inquiry into the Responsibility of Mentally Deranged Persons*, p. 51.

that the strict and universal rules laid out by the M'Naghten case did not recognise the various conditions surrounding a crime and the degrees of responsibility that existed among the 'mentally disordered'. R. A. Forster, Physical Superintendent of the Alexander Hospital argued:

It would seem that the question of criminal responsibility, especially as governed by the McNaughten Rules, or even by the broader view taken of those rules in South Africa, is quite impossible to the majority of psychiatrists. The rules endeavour to apply to the herd what can only be applied to a few individuals.<sup>42</sup>

The Medical Association of South Africa and the South African Council for Mental Health argued that the M'Naghten Rules were outdated and did not reflect the modern community-orientated state of psychiatry. Psychiatry, they argued, had changed since the M'Naghten case in England. The M'Naghten Rules only took into account the accused's recognition of right and wrong or the cognitive mental functions, and failed to recognise the implicit desires and affective disturbances of the individual.<sup>43</sup> Underlying this view was the recognition of the effect that socio-economic conditions had on the 'mental health' of individuals as suggested by community psychiatry. These psychiatrists argued that because the South African law 'assumes that there are still two alternative mental conditions, distinct from each other, each of which has to be assessed separately: first, a condition which can deprive a person of his capacity to discriminate between right and wrong, and secondly, a condition in which...an irresistible impulse has arisen,' it led to conflict with psychiatric evaluations of patients whose lines between right and wrong

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<sup>42</sup> *Ibid.*, p. 23.

<sup>43</sup> *Ibid.*, p. 27.

may not be clearly defined.<sup>44</sup> As a solution, many psychiatrists recommended that the government modify the Criminal Procedure Act to reflect that 'an accused who in respect of an alleged crime was not capable on account of mental disease or mental defect of appreciating the wrongfulness of his act, or of acting in accordance with such appreciation, shall be held not to be responsible.'<sup>45</sup> This suggestion directly opposed psychiatrists who suggested that a criminal mind can easily be determined by the degree of guilt an individual feels – i.e. individuals who did not experience guilt in any manner (which they considered to be mostly 'non-Whites') were criminals rather than 'mentally insane'.

It is important to note however, that the 'opening up' of legislation concerning the 'criminally insane' also supported apartheid racist policies by giving judges more authority in determining who was 'mentally insane' and who was not. Furthermore, it indirectly invoked an increase in calls for stricter policies regulating the 'mentally insane'. Indeed, psychiatric recommendations for stricter control over diagnoses and treatment of patients were a direct result of the promotion of community-orientated practices. As patients gained more freedom within the mental hospitals, concerns over 'dangerous' individuals grew and demands for stricter policies increased. Many psychiatrists argued that psychiatry was no longer adequately equipped to deal with criminal cases because psychiatric hospitals could not satisfactorily house 'psychopaths'. M. Ginsburg, Physician Superintendent at Fort Napier Hospital, argued that sending 'psychopaths' to mental

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<sup>44</sup> *Ibid.*, p. 51.

<sup>45</sup> *Ibid.*

hospitals was 'not only inadvisable but wrong for several aspects.'<sup>46</sup> He argued that 'psychopaths' disrupted other patients and caused considerable more work for already overworked psychiatric staff. In addition, he pointed out that mental hospitals had fewer security measures, allowing patients to escape more easily.<sup>47</sup> P. H. Henning, Medical Superintendent at Fort Napier and Lecturer at the University of Natal, agreed with Ginsburg that mental institutions with their new 'open door' policy were no longer appropriate for suspected criminals. He argued the new 'therapeutic' approach gave patients extended freedom and made mental hospitals more attractive places for criminals. Indeed, in a study published just two days after Tsafendas' verdict, Henning found that almost 40 percent of state patients in Fort Napier Hospital had escaped between 1944 and 1963.<sup>48</sup> Therefore, he argued that criminals would inevitably choose a mental hospital stay over prison and would be more inclined to attempt to fool psychiatrists into thinking they were 'mentally disordered'.<sup>49</sup> These views were in turn compounded by Verwoerd's assassination, which highlighted the inadequacy of the psychiatric field to deal with psychotic and 'mentally deranged' individuals.

### *Van Wyk Commission*

In March 1967, under the recommendation of the Rumpff Commission, the apartheid government proposed appointing another commission of inquiry into 'mental health' services and legislation in South Africa. The Commission reflected the

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<sup>46</sup> M. Ginsburg, 'The Psychopath and the Mental Hospital' *SAMJ* 32: 12 (1958), p. 318.

<sup>47</sup> *Ibid.*, p. 321.

<sup>48</sup> Henning, 'Die Nabootsing van Geesteskrankheid', p. 940.

<sup>49</sup> *Ibid.*, p. 937.



paradoxical position of the psychiatric field. It acknowledged the increased concern about controlling the criminally minded while also recognised the psychiatric field's new 'therapeutic' approach. The Commission was headed by a supreme court judge, J. T. van Wyk, and had representatives from the Department of Prisons and the Department of Labour along with two psychiatrists, two sociologists, a psychologist, a hospital administrator and a clinical psychologist. The Commission's objective was to examine the existing legal regulations concerning psychiatric services such as the Mental Disorders Act and make recommendations for updating these regulations.

Significantly, the Commission began under the pretext that the terms 'mentally ill' and 'mental health' should take the place of terms such as 'mentally defective' and 'mental disorder'. Psychiatrists had slowly been adopting these terms throughout the 1950s and 1960s as community psychiatry became more popular and drugs became more readily available. Indeed, the Commission adopted many of the recommendations that psychiatrists had consistently made since the 1940s. They highlighted the increasing problem of lack of accommodation, facilities and psychiatric staff. They argued that 'mental health's' isolation from general medicine merely compounded the negative stigma attached to 'mental health' and discouraged individuals from becoming involved in the psychiatric field. They suggested that the government should place public psychiatric hospitals under the administration of the provinces. This, they argued, would allow more flexibility and more localised training. The Commission also suggested that adequate outpatient facilities, night hospitals, follow-up programs and general hospital services should be set up. This adoption of more therapeutic and biologically centred terms, as

well as the Commission's concern over the isolation of 'mental illness', reflected the psychiatric field's effort to promote a more integrative and holistic approach to psychiatry.

At the same time, the Commission concentrated on individuals who were a danger to society, such as state patients and the 'criminally insane'. They dedicated specific sections to 'psychopathic' patients and forensic psychiatry. Confusion around the definition and treatment of a 'psychopathic' individual continued, but the Commission adopted a rather specific and negative definition as stated in the Encyclopedia of Mental Health that far exceeded the previous descriptions of 'psychopaths':

...an individual so defective in judgement and so lacking in control that he persists in aberrant, amoral, and often criminal behaviour with little evidence of conscience or ethics and without ability to profit from experience, example, or precept. He is commonly a supreme egotist, sadistic, heartless, craven and eely, with infinite capacity for victimising others and with seeming indifference to the pain and loss he habitually inflicts, except for the cruel satisfaction he sometimes derives from his malignant ill-doing. He is a classic hypocrite, maintaining a mask of fraternal concern so long as his imposture succeeds but projecting the blame on others and on circumstances his acts bring on the collapse of his fraudulent façade...<sup>50</sup>

In keeping along the same negative view of the 'psychopath', the Commission suggested that the definition of a 'psychopath' should not include a provision that would ensure a 'psychopath' receive medical treatment. Rather, they argued that it would be highly unlikely that 'psychopaths' would benefit from such treatment. Furthermore, the Commission argued that 'psychopaths' not only caused disruption in mental hospitals, but were disruptive in prisons as well. They maintained that 'psychopaths' caused fights,

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<sup>50</sup> Republic of South Africa, *Report of the Commission of Inquiry into the Mental Disorders Act*, pp. 39-40.

formed gangs, and failed to benefit from the prison experience at all. They argued, much like the Rumpff Committee, that 'psychopaths' should be kept neither in prisons nor in mental hospitals, but should be kept in hospital prisons or psychopathic hospitals.<sup>51</sup> In addition to the separate accommodation for 'psychopaths', the Committee suggested that a new provision be placed within the new Mental Health Act that would ensure that all medical practitioners, including psychiatrists, clinical psychologists, general practitioners etc. would report a 'mentally ill' individual whom they perceived as dangerous to others to the magistrate or to a policeman. Under the 1916 Mental Disorders Act, policemen were already able to detain 'mentally disordered' individuals who were dangerous to themselves or others. The Committee suggested that the government add a further provision to the Act that when a medical practitioner reported the existence of a dangerous individual, the police shall shortly thereafter apprehend that individual.<sup>52</sup> With respect to those individuals who were charged with criminal offences and subsequently detained, the Committee recommended that they not be released without the authority of the state President.<sup>53</sup> The Committee also argued that courts should allow the execution of 'psychopaths' because:

It should be borne in mind that psychopathic disorders do not arise over night, and that if a psychopath has been sentenced to death the fact that he is a psychopath would in all probability have been taken into account by the judge when deciding that the death sentence should be imposed.<sup>54</sup>

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<sup>51</sup> *Ibid.*, pp. 40-41.

<sup>52</sup> *Ibid.*, pp. 48-49.

<sup>53</sup> *Ibid.*, p. 54.

<sup>54</sup> *Ibid.*, p. 55.

'Psychopaths', they implied, had no hope of ever rehabilitating; therefore, the application of the death penalty was justified.

In relation to psychiatric involvement in the diagnosis of a 'psychopath' or 'criminally insane' individual, the Commission suggested that psychiatry be further removed from its involvement in criminal cases. It suggested that medical schools incorporate forensic psychiatry within their curriculum. Training in forensic psychiatry would emphasise that psychiatrists merely 'assist[ed] the authorities in determining the aetiology of criminal behaviour, offences and crimes which require[d] psychiatric investigation... and not act as 'amateur advocates.'<sup>55</sup> Furthermore, the Commission distanced itself from the issues concerning criminal regulations for the 'mentally insane' and argued that the sections in the previous Mental Disorder Act dealing with such cases should be removed and dealt with purely in the Criminal Procedure Act.

This distancing of the 'mental health' field from the 'criminally insane' would enable the psychiatric field to continue to promote community psychiatry, while also allowing the apartheid government to detain 'mentally ill' individuals in prisons rather than mental institutions if it so desired.

### ***Conclusion***

In 1973, the apartheid government changed the Mental Disorders Act to a new Mental Health Act that embodied many of the recommendations made by the Rumpff and van Wyk Committees. It opened more positively with a section on voluntary patients and outpatients and embodied many of the 'therapeutic' views that psychiatrists had promoted.

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<sup>55</sup> *Ibid.*, p. 30.

On the other hand, the new legislation also reflected the increased concern over the 'criminally insane' that existed after Verwoerd's assassination and it contained stricter rules for their confinement. As Vaughan has shown for colonial Africa, the process of determining what made an individual 'criminally insane' was a difficult one. Indeed, in South Africa, psychiatrists were divided on the matter. On the one hand, some psychiatrists called for stricter policies, while on the other, many wanted to distance themselves completely from the 'criminally insane' completely. The solution to many psychiatrists' problems was the 'psychopathic hospital'. However, as will be seen in chapter three of this thesis, the government never built the 'psychopathic prison' that would enable psychiatrists to distance themselves from 'psychopathic' patients. Instead, it contracted its long-term and 'psychopathic' psychiatric care (mostly made up of 'non-White' patients) to a private company that merely continued the custodial practices implemented earlier in state hospitals. What this chapter has shown is that, as Vaughan has argued for colonial Africa, psychiatrists in apartheid South Africa continued to perpetuate (although mostly indirectly or unintentionally) the racial segregationist notions of the apartheid government despite their stated opposition to them.

### **CHAPTER THREE – INCREASED SEGREGATION, ANTI-PSYCHIATRY AND THE ORIGINS OF CROSS-CULTURAL PSYCHIATRY (1970-1979)**

During the 1970s, two major transformations occurred within the South African psychiatric field; the privatisation of long-term health care and the introduction of 'cross-cultural' psychiatry. These two seemingly unrelated events were each the products of the expansion of racial segregation policies by the apartheid government and of the inability of community psychiatry to address the problems of long-term patients. In the previous chapter, I suggested that Verwoerd's assassination had highlighted the problems inherent within community psychiatry with respect to 'criminally insane' and long-term patients. Because of psychiatry's inability to deal with the 'criminally insane', during the 1970s, the apartheid government contracted out the treatment of long-term patients (the majority of whom were 'non-Whites') to a private company by the name of Smith Mitchell. This removed responsibility for long-term patients from the DOH, while addressing psychiatrists' concerns about overcrowding and staff shortages in state mental hospitals. It also allowed South African psychiatrists to continue implementing community psychiatric practices without having to deal with their 'therapeutic failures'. However, private institutions acted merely as custodians of long-term patients and conditions were far from 'therapeutic'. The sub-standard conditions in these private institutions came to the attention of international anti-psychiatric groups. These groups publicised the atrocious conditions within private institutions and criticised South African psychiatrists for supporting the apartheid system. Hence, the contracting out of long-term patient psychiatric care both assisted the continuation of community psychiatry and highlighted its failure.

Internationally criticised and disgraced, South African psychiatrists began to re-examine their focus on community psychiatry and move towards a more culturally relative approach. 'Cross-cultural' psychiatry became the new trend within the psychiatric field. It examined 'non-Western' forms of psychiatry and acknowledged socio-cultural influences on an individual's mental health. Although Megan Vaughan's study on psychiatry in British Colonial Africa does not specifically examine psychiatric trends past 1950, she does point out that culturally relative psychiatry had become increasingly popular throughout Africa during the 1960s and 1970s. She attributes this to an increase in African professionals who promoted more culturally relative psychiatric practices.<sup>1</sup> In South Africa, however, no African psychiatrists were trained in 'Western' psychiatry. Therefore, cross-cultural psychiatry was adopted because of a combination of 'Western' psychiatric trends which began to be more culturally sensitive, along with apartheid notions of difference. Therefore, cross-cultural psychiatry, like community psychiatry before it, was filled with contradictions. On the one hand, it promoted a less Eurocentric approach to the treatment of 'non-White' patients; on the other hand, it supported apartheid ideas of segregation through its focus on cultural difference. As Vaughan points out, these notions of cultural psychiatry were merely 'late-twentieth century and post-colonial version[s] of the arguments about "difference" which so preoccupied colonial psychologists and psychiatrists.'<sup>2</sup>

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<sup>1</sup> Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (California: Stanford University Press, 1991), p. 125.

<sup>2</sup> *Ibid.*, 125.

***Increased Segregation and the Relocation of Long-Term 'non-White' Patients to Private Facilities***

One cannot fully understand the changes that occurred within the South African psychiatric field during the 1970s without placing them within the context of apartheid policies of the 1960s and 1970s. During the 1960s, the Nationalist government changed its apartheid policies to include the creation of 'self-governing homelands'. The underlying principle of these homelands was, as Robert Ross suggests, a 'denial of any share in a common South African nationality for those who were not white. Rather, they were thought to belong to one of the following groups: Xhosa, Zulu, Swazi, Tsongo, Ndebele, Venda, North Sotho, South Sotho, Tswana, Indian and Coloured.'<sup>3</sup> The change of direction by the apartheid government has mostly been attributed to the after-effects of the Sharpeville shooting of 1960 – an anti-pass protest within Sharpeville township where police opened fire and killed sixty-nine people and injured one hundred and eighty. In the wake of this atrocity, large protests broke out throughout South Africa and overseas newspapers began to take an interest in the events within South Africa. In an attempt to control social unrest and placate international criticism (and the subsequent decline of international investment), the apartheid government, as Deborah Posel points out, redefined its notion of 'separate development' to one that included 'a new ideological discourse of "multi-nationalism" and "ethnic self-determination."<sup>4</sup> Under the guise of protecting 'ethnicity', the Department of Bantu Administration and Development began

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<sup>3</sup> Robert Ross, *A Concise History of South Africa* (Cambridge: Cambridge University Press), p. 135.

<sup>4</sup> Deborah Posel, *The Making of Apartheid 1948-1961: Conflict and Compromise* (Oxford: Clarendon Press, 1991), p. 231.



huge relocation projects of 'non-White' individuals into their respective homelands. The homeland system was anything but independent. Rather, the majority of the homelands remained financially dependent on and administratively restrained by the apartheid government.<sup>5</sup> For this reason, little development occurred within them, and the terrible conditions and atrocities that had brought attention to the inequalities within South Africa continued.

The movement of large numbers of people into ill-equipped and economically undeveloped areas contradicted the needs of the industrial and commercial sectors. Many companies seriously criticised the apartheid government's policy for interfering with the accessibility of its workforce. Not only was a cheap labour force less accessible, but its health was jeopardised. Indeed, the movement of large groups into the homelands caused an increase in illness and poverty. It also inflated the number of 'non-White' 'mentally ill' individuals. Diseases that affected the mind, such as pellagra, that were caused by inadequate diet reached critical levels during the 1960s [see Table 2]. As a temporary measure, the apartheid government contracted out the care of long-term mental patients to Smith Mitchell. Smith Mitchell, rumoured to have been an accounting firm, had provided the apartheid government with facilities for 'non-White' tuberculosis (TB) patients during the early twentieth century. However, as drugs became more readily available and fewer cases of TB were reported, Smith Mitchell branched out into the 'mental health' field. It transformed abandoned mining barracks and TB facilities into

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<sup>5</sup> Hermann Giliomee and Lawrence Schlemmer, *From Apartheid to Nation-Building* (Cape Town: Oxford University Press, 1989), p. 102.

institutions for the 'mentally ill'. This contracting out of long-term mental patient care enabled the DOH and psychiatrists to remove their 'non-responsives' (patients who did not respond to therapy) and open up beds for 'responsives' (short-term patients who responded to therapy), who could then be quickly returned to the labour force. As the recovery rate remained considerably lower for 'non-Whites' than for 'Whites', the majority of patients that the DOH moved to private institutions were 'non-White'.

Meanwhile, in keeping with its 'separate development' plan, the apartheid government also took over mission hospitals that had previously provided health care to all those in the rural areas. It divided each homeland into wards in which general hospitals were set up. These general hospitals were meant to offer general health services as well as psychiatric follow-up services. The government also set up a state mental hospital at Umzimkulu in the Transkei.<sup>6</sup> These services, however, were not enough to deal with the large number of mental patients needing care. Therefore, by the 1970s, the temporary measure of contracting long-term care to a private company had turned permanent. By 1976, Smith Mitchell had approximately 12,260 beds available for mental patients – 750 for 'White' patients and 11,500 for 'non-White' patients.<sup>7</sup>

Although the movement of long-term patients to private mental health facilities outwardly reflected a distancing of the DOH and the psychiatric field from the care of 'non-White' patients, internally the DOH and psychiatrists still controlled the admissions

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<sup>6</sup> *Ibid.*

<sup>7</sup> 'Commissioner for Mental Health says: These are Human Warehouses', *Peace and Freedom Supplement*, 3 (1976), p. 1, and Kevin Solomons, 'The Development of Mental Health Facilities in South Africa 1916-1976', in Francis Wilson and Gil Westcott (eds.), *Economics of Health in South Africa, Volume II: Hunger, Work and Health* (Johannesburg, Ravan Press, 1980), p. 273.

of patients to private hospitals through referrals and certification. In addition, the DOH appointed state psychiatrists as overseers of patients' care. Therefore, the line between state mental hospitals and private mental institutions was not entirely clear. Indeed, private mental institutions acted much like a microcosm of the homelands, reflecting a notion of separateness, while remaining economically reliant on and administratively restricted by the apartheid government.

### *Material Conditions Within Private Mental Institutions*

Although private hospitals created more beds for mental patients and eased overcrowding within state mental hospitals somewhat, the problems that had plagued 'non-White' patients within state mental hospitals were merely transferred to private institutions. Conditions within private institutions were considerably sub-standard. Overcrowding continued to be a problem, and most patients slept on mats on the concrete floor. Reports of high, prison-like windows and barbed wire fences reflected the custodial practices that took place within the walls. Patients were often excessively tranquillised and received little therapy or medical treatment. Psychiatrists were rarely present and patients were grossly neglected. The majority of patients became completely institutionalised, unable to be returned to society. Indeed, in 1975, the rate of patient release for private mental institutions was only 1 percent.<sup>8</sup>

One of the main reasons for patient neglect was the fact that the number of registered psychiatrists willing to treat 'non-White' patients was still very limited. Earlier

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<sup>8</sup> Solomons, 'The Development of Mental Health Facilities', p. 293.

ideas of training 'non-White' psychiatrists for 'non-White' patients had not been effective. In 1979, only one 'Coloured' psychiatrist was registered and six 'Asian' psychiatrists were in training. No 'Black' psychiatrists existed.<sup>9</sup> Opportunities for 'non-White' students became even less accessible during the 1970s when the government augmented its segregation policies concerning post-secondary institutions. In 1976, despite strong opposition from many psychiatrists, the apartheid government legislated that previously multi-racial universities, such as the University of Natal, could no longer admit 'Black' students to their medical program.<sup>10</sup> This 'phasing out' process was also to later include 'Coloured' and 'Indian' students. 'Non-White' medical students who would have attended the University of Natal were now expected to enrol in the new Medical University of South Africa (MEDUNSA) near Pretoria. The segregation of tertiary institutions such as universities and colleges was part of the government's new focus on 'multi-nationalism'. The government encouraged 'non-White' students attending these universities to use their skills in the homelands.<sup>11</sup> At the same time, however, the apartheid government did not want 'non-White' education to surpass 'White' education in any way. Indeed, the government seriously underfunded most 'non-White' education. Per capita expenditure on 'Black' students in 1977/78 was R54.05 compared to R551 for 'Whites'. This includes

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<sup>9</sup> Editorial, 'Medical Journals and International Hate' *SAMJ* 55: 15 (1979), p. 572.

<sup>10</sup> The response to this phasing out of 'non-White' students resulted in a large reaction from the medical community. In numerous letters to the government and the *South African Medical Journal*, professors, doctors, psychiatrists and administrators strongly rejected the government's directive. Many argued that the government was seriously jeopardising their position on an international level; no longer would the apartheid government be able to hold up the University of Natal as an example of national enlightenment.

<sup>11</sup> Pam Christie and Colin Collins, 'Bantu Education: Apartheid Ideology and Labour Reproduction', in Peter Kallaway (ed.), *Apartheid and Education: The Education of Black South Africans* (Johannesburg: Ravan Press, 1991), p. 174.

all levels of education, including tertiary education.<sup>12</sup> In addition, the majority of all leadership positions and faculty in the university were 'White', and only 'Western' forms of psychiatry were taught. Therefore, the numbers of 'non-White' psychiatrists remained low and the treatment of 'non-White' patients continued to be neglected.

An insufficiency of funds also constricted the effective treatment of long-term patients in private mental hospitals – particularly that of 'non-White' patients. Because conflicting reports exist, it is not clear as to the exact amount of funding given to Smith Mitchell.<sup>13</sup> However, the DOH claimed that it allotted Smith Mitchell the same funding per patient that it gave state mental hospitals. In 1970, the average daily rate for all patients was R3.50 a day. However, 'non-White' patients received only one third of the quota of 'White' patients.<sup>14</sup> Therefore, the average for 'non-White' patients was considerably less. *Peace and Freedom* journal reported that Smith Mitchell only received half of what state mental institutions received – R2.50 per 'White' patient per day, and only R1 per day for 'non-White' patients.<sup>15</sup> As Smith Mitchell operated on a for-profit basis, services and supplies had to be kept to a minimum. Many patients made their own beds, wore low-cost uniforms and were fed inadequate diets. In addition, many of the private institutions contracted out patients to local businesses for extra income.

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<sup>12</sup> S. Nombuso Dlamini, 'Critical Teaching Under the Bantu Education System', M.A. thesis (Halifax: Saint Mary's University, 1990), p. 53.

<sup>13</sup> Information regarding profits and expenditures within Smith Mitchell institutions has not been made available to the public.

<sup>14</sup> Solomons, 'The Development of Mental Health Facilities', p. 280.

<sup>15</sup> 'Commissioner for Mental Health says', p. 1 and 'Thousands Work and Will Die Here', *Peace and Freedom* 3, supplement (Jan 1976), p. 1.

Patients did not keep their earnings and Smith Mitchell added the money to the institutions' operating budgets.

Another reason for the continued neglect of patients within private hospitals was that the community psychiatric trends that had developed during the 1950s and 1960s, as seen in the previous chapters of this thesis, failed to recognise the needs of unresponsive patients. Indeed, community psychiatry focused only on those patients who could easily be assimilated back into the community. There was no place for non-responsive patients within the new psychiatric structure and very few successful therapies existed for them. Effective psychiatric drugs that enabled community psychiatrists to obtain high release rates were expensive. As the government only allotted one-third of the daily 'White' patient quota to 'non-White' patients, mental institutions for 'non-White' patients administered cheaper medications. Consequently, psychiatrists usually used first-generation drugs (i.e. drugs that had not been extensively tested and often had serious side effects) in 'non-White' institutions. This meant that 'non-White' patients were often used as test subjects in order to ascertain the effectiveness of new drugs. The DOH, along with state psychiatrists, justified the differences between drugs administered to 'non-White' patients and 'White' patients by arguing that they could not realistically distribute expensive drugs to 'non-White' patients without incurring extensive debt. Dr. Henning, chief of psychiatric services, reportedly stated that although the administering of anaesthesia and therapeutic drugs was a common occurrence in 'White' institutions, they were not a common procedure among 'non-Whites'. He argued that:

It's simply too expensive, too slow and too risky. Africans appear to be more susceptible to the effects of anaesthetics, and because we treat more Africans than Whites, we would have to double our staff if we used anaesthetics.<sup>16</sup>

### ***Anti-Psychiatry and Anti-Apartheid Movements***

In 1970, the terrible conditions within private institutions caught the eye of an anti-psychiatric organisation by the name of the Citizens Commission on Human Rights (CCHR), a subsidiary of the Church of Scientology. The Church of Scientology had been active in South Africa from the 1950s. By the 1970s, it had a mailing list of 25,000 individuals.<sup>17</sup> Originally founded by an American by the name of Ronald Hubbard, whose books, *Fundamentals of Scientology* and *Dianetics: The Evolution of a Science*, became the foundation for its followers' beliefs, the Church of Scientology condemned psychiatric practices within private institutions and accused the psychiatric field of human rights abuses against its patients. Scientology was (and still is) part of a larger, diverse anti-psychiatric movement that had developed in the 1960s – particularly in the United States. In the 1960s, works such as Erving Goffman's *Asylum* and Michel Foucault's *Madness and Civilization* formed the basis of anti-psychiatric sentiments. Goffman highlighted the substandard conditions within American mental institutions and psychiatrists' manipulation of patients as a means to maintain social order. Foucault suggested that political motivations lay behind the institutionalisation of psychiatric

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<sup>16</sup> 'Man Discovers the Gruesome Truth', *Peace and Freedom* 3, supplement (Jan 1976), p. 2.

<sup>17</sup> It is not clear exactly how many of these were active members of the organisation. Republic of South Africa, *Report of the Commission of Enquiry into Scientology for 1972* (Pretoria: Government Printer), pp. 16-17.

patients. Psychiatrists such as Thomas Szasz in the United States (who was a founding member of the CCHR) and R. D. Laing in Britain accused the psychiatric field of diagnosing individuals as mentally ill simply because they acted outside accepted norms.<sup>18</sup> Although the Church of Scientology was the more radical member of the anti-psychiatric movement, it shared a common conception with other anti-psychiatric groups. It argued that psychiatrists based an individual's mental health on a uniform idea of 'normal' that correlated with political and social motivations. They, like other anti-psychiatrists, believed, as Joan Busfield explains, that psychiatrists based their definition of 'mental illness' on 'a form of socially unacceptable, rule-breaking behaviour.' They were also 'critical of the medical focus on organic processes in the conceptualisation and treatment of mental illness, and consider[ed] psychiatry to be an institution of social control.'<sup>19</sup>

Because of their strong anti-psychiatric beliefs, the CCHR embarked on a four-year long investigation into abuses within the private mental institutions in South Africa. In 1974, the CCHR published a report in its *Peace and Freedom* journal, wherein it argued that private mental hospitals that mostly housed long-term 'African' patients were merely 'human warehouses' and 'labour camps'.<sup>20</sup> Comparing these mental institutions to concentration camps, one article depicted the conditions within the Randwest Sanatorium:

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<sup>18</sup> See Joan Busfield, *Managing Madness: Changing Ideas and Practice* (London: Hutchinson, 1986), pp. 80-114 for further discussion regarding the anti-psychiatric movement.

<sup>19</sup> *Ibid.*, p. 80.

<sup>20</sup> 'Commissioner for Mental Health', p. 1 and 'Thousands Work and Will Die Here', pp. 1-3.



It is completely walled-in on five sides. The outside walls are the backs of sleeping quarters. There are small windows fixed slightly open. Some are broken. All are dirty... There is a huge open courtyard in the centre of the laarger [*sic*] compounds. Sleeping quarters are big open halls with lavatories in the centre. The rooms are hosed down each morning. The various sections are wired off with a few hundred patients in each section...<sup>21</sup>

Another article described the conditions within the Poloko Sanatorium, established in 1972 in the Tswana homeland:

Mentally defective children, and even epileptics, are being shipped in along with geriatric patients. The institution is short staffed and overcrowded. The sewage system is in urgent need of repair. Wards need painting and there are only mats on the floor in the sleeping quarters. Industrial therapy [occupational therapy] takes place in a corrugated iron building shed.<sup>22</sup>

Despite intense investigations conducted into the Church of Scientology's administration and threats from the apartheid government to restrict the organisation's activities, the CCHR continued to investigate and publish articles about abuses within private mental hospitals. However, its means of investigation were often unconventional and sometimes illegal. In 1976, there were reports of Church of Scientology members who broke into the offices of the DOH, church offices and the office of Mr. Tabatznik, the director of Smith Mitchell institutions, in order to obtain information regarding mental health practices. In addition, the apartheid government accused the organisation of forging the Secretary of Health's signature in a letter to the World Health Organization admitting to the various ill treatments that went on in private mental hospitals. Indeed,

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<sup>21</sup> 'Thousands Work and will Die Here,' p. 3.

<sup>22</sup> 'Commission for Mental Health,' p. 3.

the continuous persistence of the CCHR annoyed government officials. Many government officials complained about receiving copies of the 'detestful little publication' of the *Freedom* journal that contained information about the conditions in mental hospitals in their mailboxes whether they wanted them or not.<sup>23</sup> Furthermore, there were also reports of harassment by members of the Church of Scientology against individuals who were against the practices of the Church. For example, Dr. Fisher, MP for Rosettenville, Transvaal and the Chairman of the Medical Council of the United Party, brought charges against individuals from the Church of Scientology who had defamed and harassed him repeatedly after he asked for an inquiry into Scientology.<sup>24</sup>

Nevertheless, the continued perseverance of the CCHR and its damning publications about conditions within the mental institutions sparked both domestic and international outrage at the abusive treatment of psychiatric patients. In South Africa, Fleur de Villiers in a column entitled 'Millions out of Madness' in the *Sunday Times*, argued that Smith Mitchell was making a profit off the 'mental illness' of 'Black' individuals. She suggested that expenditures on patients were minimal and argued that the company had a vested interest in keeping patients within their institutional walls:

The number of these human warehouses where care is reduced to a minimum and cure a forgotten word is growing year by year – as are the profits of the company which now has such a monopoly on madness that as one authority told me, "it can virtually dictate mental health care in South Africa."<sup>25</sup>

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<sup>23</sup> Dr. G. De V. Morrison in *HAD*, (19 February 1976), col. 1593.

<sup>24</sup> Republic of South Africa, pp. 119-121.

<sup>25</sup> Fleur de Villiers, 'Millions out of Madness', *Sunday Times* (27 April, 1975)

Similarly, South Africa's *Scope* magazine published a series of articles about an ex-psychiatric patient's experiences within mental institutions in South Africa. Horace Morgan, who had reportedly lost his memory in 1937 and was held in South African mental institutions for 37 years, spoke of his detainment and his attempts to escape from the abusive environment in which he had been placed. Based on interviews with Morgan and sections of his diary which he had kept during his stay in the mental hospitals, *Scope* reported physical and mental abuse that Morgan underwent during his long stay within a mental institution and argued that he had spent most of his 'wasted, tragic life in a cage'.<sup>26</sup>

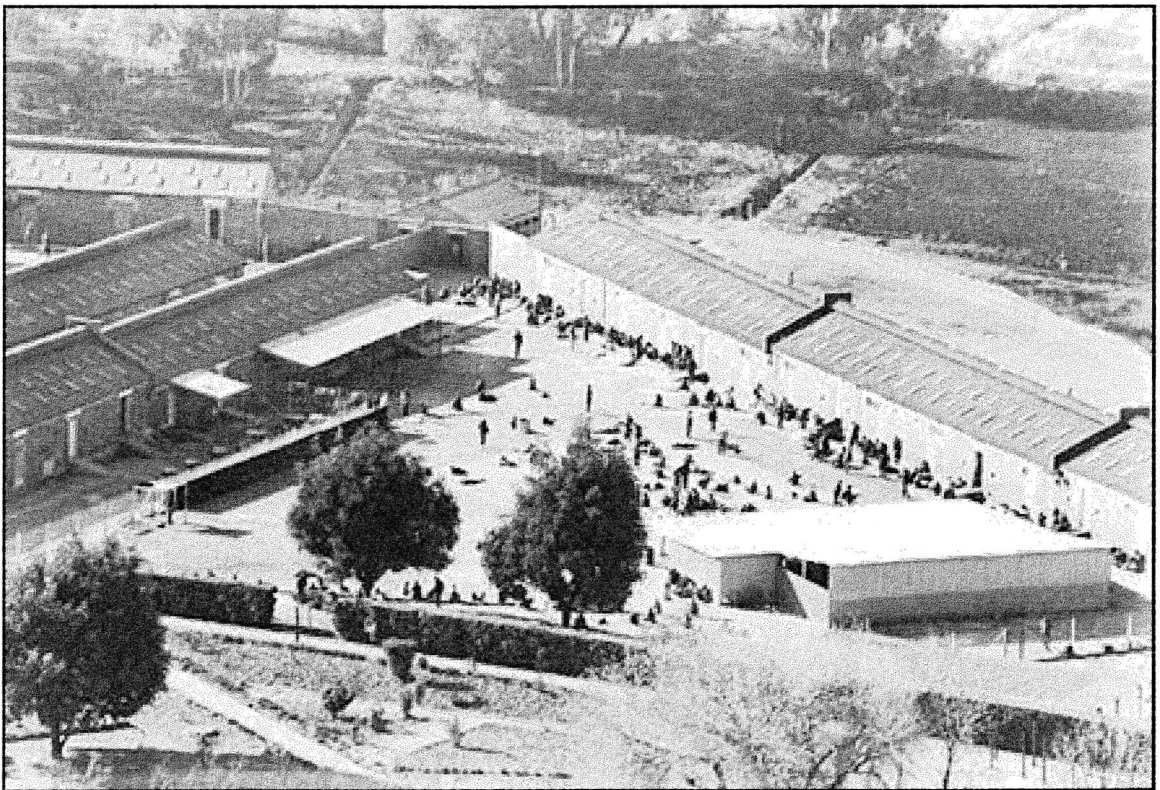
Internationally, the Swedish newspaper *Dagens Nyheter* published a series of articles in 1976 depicting the terrible conditions in which patients lived and the abusive practices of psychiatrists in South African private mental institutions. That same year, the New York *Voice* published an article entitled, "New Kind of Concentration Camp Inside South Africa" that also depicted terrible conditions in the private mental hospitals in South Africa. It attributed the exposure of these conditions to the Church of Scientology and included photographs taken by the *Freedom News Service* in South Africa.

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<sup>26</sup> Quoted in *HAD* 18 February 1976, col. 1522.



**Figure 1: Patient Looking through Bars at Randwest Sanatorium. Originally published in *Peace and Freedom* (Jan 1976): 1.**



**Figure 2: Randwest Sanatorium. Originally published in *Peace and Freedom* (Jan 1976): 3.**

The effect of these articles was far-reaching. Firstly, they sparked international political criticism and investigations into the practices within both state and private mental institutions. For example, in 1977, in response to articles published in *Dagens Nyheter*, Jeanne-Martin Ciase, chairman of the United Nations Special Committee Against Apartheid, in conjunction with the World Health Organization (WHO) condemned the apartheid government for permitting inhumane treatment within psychiatric hospitals. He also called for an international investigation into psychiatric practices within South Africa. In 1977, the WHO conducted a preliminary study based on published reports and consultations with experts on psychiatric institutions in South Africa. It produced a report that noted the gross differential treatment between 'White' and 'African' psychiatric patients and noted that the majority of 'African' patients were involuntarily detained. It also likened the treatment of psychiatric patients to 'business deals' where individuals were exploited for the economic benefit of Smith Mitchell.<sup>27</sup>

Secondly, the articles and subsequent investigations raised the 'Western' psychiatric field's awareness of the inequalities within South Africa. European and North American psychiatrists wrote condemning articles about South African psychiatric practices and sanctioned the South African psychiatric field. They ceased to invite South African psychiatrists to conferences, pressured their governments into not recognising

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<sup>27</sup> HAD, (1 June 1977), cols. 8948-9 and 'Apartheid and Mental-Health Care', *The Lancet*, II: 8036 (1977), p. 491.

South African medical degrees, denied South African psychiatrists visitation rights to various mental institutions and revoked South African psychiatrists' membership from their organisations.

This sanctioning by the international psychiatric field resulted in a strong defensive response by South African psychiatrists – particularly those within MASA. MASA published a scathing rebuttal to the international community entitled, 'Medical Journals and International Hate'. MASA denied all accusations against it and argued that 'Western' psychiatrists were ill-informed and simply wanted to 'stir up international strife.'<sup>28</sup> Other psychiatrists also responded quite strongly to the allegations against them. For example, L. A. Hurst of the Witwatersrand Department of Psychiatry, in a letter to the *South African Medical Journal*, strongly supported Smith Mitchell. He argued that Smith Mitchell institutions had an 'encouraging therapeutic atmosphere' that should be encouraged and supported.<sup>29</sup> In addition, L. S. Gillis, on behalf of the Society of Psychiatrists of South Africa (a subsidiary of MASA) wrote a letter in rebuttal of the WHO's report to the British journal, *The Lancet*. He argued that it was 'unwarranted to tie the apartheid tin to the tail of the psychiatric cat, no matter how much of a pleasing din it makes'.<sup>30</sup> Gillis contended that the WHO report was full of inaccurate information. Rather, he argued that the WHO did not take into account the fact that 'a much higher proportion of Blacks, particular those from country areas, become behaviourally

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<sup>28</sup> Editorial, 'Medical Journals and International Hate', *SAMJ* 55: 15 (1979), p. 572.

<sup>29</sup> L.A. Hurst, 'Correspondence: Advances in Contemporary Psychiatry', *SAMJ* 50: 27 (1976), p. 1036.

<sup>30</sup> L. S. Gillis, 'Letters to the Editor: Mental-Health Care in South Africa', *The Lancet* II: 8044 (1977), p. 920.

disturbed (often uncontrollably) as a result of toxic, infective, or exhaustion syndromes.<sup>31</sup>

Lastly, the publicity of conditions within private mental institutions provoked extensive parliamentary debates about the publication of articles about mental institutions. In response to the numerous CCHR's articles and the WHO investigation, the apartheid government denied all of the allegations and argued that the Church of Scientology was simply 'waging a vendetta' against the Secretary of Health.<sup>32</sup> It contended that many of the allegations of abuse were simply unwarranted and argued that many of the patients in private institutions chose the sub-standard conditions themselves. For example, Dr. G. De V. Morrison argued 'Bantu' individuals preferred to sleep on the ground, as he believed that 'it was what they were used to'. In addition, the government argued that the so-called 'labour' that patients performed on a daily basis was simply a form of 'occupational therapy' which was for their own good.<sup>33</sup> In order to prevent further publications regarding conditions within mental institutions, the apartheid government inserted a clause into the Mental Health Act that read:

No person may, without the permission of the Secretary for Health –  
 ...publish or cause to be published in any manner whatsoever any false information concerning the detention, treatment, behaviour or experience in an institution of any patient or any person who was a patient, or concerning the administration of any institution, knowing the same to be false...<sup>34</sup>

The government also placed a ban on any photographs, sketches or pictures depicting

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<sup>31</sup> *Ibid.*

<sup>32</sup> *HAD*, (19 February 1976), col. 1576.

<sup>33</sup> *HAD*, (9 May 1975), cols. 5738-9.

<sup>34</sup> *HAD*, (2 March 1976), col. 2312.

mental institutions or patients of any kind. Even though many opposition MPs during the House of Assembly debate on the amendment expressed concern over the loss of freedom of the press, the Nationalist government justified its actions by couching its arguments in terms of 'protection of the vulnerable'. Mr. H. Miller of the NP argued that:

the person whom it is endeavoured to protect, the person who requires [the] most protection; the person who, of all people, is the most vulnerable, viz. the mental patient, who very often has not the funds to look after himself and cannot take the step which any organization or institution could take of instituting an action of defamation against the newspaper or any other steps that may be necessary. Therefore, the objective here is to protect this most vulnerable section of the community.<sup>35</sup>

The banning of what the NP considered 'offensive material' was not a new concept for the apartheid government. Indeed, the control over the media was central to the apartheid government's notion of 'moral purity'.<sup>36</sup> The government had set up a Publications Control Board in 1963 to ensure that opposition to the apartheid government was controlled and liberal ideas from the international community were not imported. Therefore, the banning of any material concerning mental institutions was merely another element of the larger process of social control devised by the apartheid government.

### *Cross-Cultural Psychiatric Studies*

Although the movement of long-term patients to private institutions enabled South African psychiatrists to continue community-orientated therapies without having to concern themselves with their 'therapeutic failures', it also highlighted the shortcomings

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<sup>35</sup> *HAD*, (19 February 1976), col. 1595.

<sup>36</sup> Ross, *A Concise History*, p. 134.



of community psychiatry. Not only was the removal of long-term patients an admission that community psychiatry had failed to solve the problem of long-term patients, but subsequent criticism from anti-psychiatric groups greatly publicised these failures. Therefore, many South African psychiatrists were impelled to search for more humane solutions to their long-term patient problems. As the majority of long-term patients were 'non-Whites', psychiatrists began to ask themselves whether 'Western' forms of psychiatry were indeed relevant to 'African mental illness'. They also began to examine 'African' perceptions of psychiatry and 'mental illness' and suggested that South African psychiatrists become more knowledgeable of their patients' cultures. They called this new culturally relative approach, 'cross-cultural' psychiatry. Early 'cross-cultural' psychiatry incorporated a phenomenological approach to psychiatry; i.e., it became concerned with the contents and organisation of conscious experience.<sup>37</sup> It contradicted apartheid ideas of psychiatry by recognising that conscious experience influenced both psychiatrists' and patients' ideas of 'mental illness', and promoted a less Eurocentric approach to psychiatry. At the same time, however, cross-cultural psychiatry adopted the apartheid government's 'multi-ethnic' notion of 'separate development' and held on to the racist notion of cultural difference. Cross-cultural research was, therefore, filled with contradictions.

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<sup>37</sup> Defined by Lucy Yardley ed., *Material Discourses on Health and Illness* (London and New York: Routledge 1997), p. 29.

Cultural or cross-cultural psychiatry<sup>38</sup> was not a new concept in the psychiatric field. Indeed, from the very introduction of Freudian psychoanalysis in the early twentieth century, cultural understandings of the mind became increasingly popular. Freud explicitly used anthropological sources to support his argument that humankind shared universal psychological complexes that originated from their ancestors.<sup>39</sup> Community psychiatrists also used aspects of cultural psychiatry to support their ideas that individuals who remained in their respective 'culture' were likely to have a less incidence of 'mental disorder.' However, while community psychiatry was intricately linked to organic definitions of psychiatry through its use of psychological drugs, cross-cultural psychiatry rejected biological definitions of 'mental illness'.

Indeed, the rejection of psychological drugs was central to the South Africa psychiatrists' notion of cross-cultural psychiatry. Once the initial excitement of psychological drugs wore off, many psychiatrists exhibited significant apprehension regarding the focus on biological causes of psychiatric illness. Their objection towards drugs was partly due to the fact that drugs had not been the dramatic solution that pharmacological companies had made them out to be. For example, A. B. Daneel conducted a study on intrathecal trifluoperazine in the Valkenburg Hospital in the Cape. His results showed that although one-third of the schizophrenic patients responded

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<sup>38</sup> The term 'cultural psychiatry' has largely remained undefined by those working within the field. For the purposes of this thesis, 'cultural psychiatry' is a form of psychiatry that attempts to understand the symbols and cognitive organisation of understandings of 'mental illness' and rejects the notion that 'mental illness' is organically based.

<sup>39</sup> For further information on the origins of cultural psychiatry, see Edward F. Foulks, 'Anthropology and Psychiatry: A New Blending of an Old Relationship', in *Current Perspectives in Cultural Psychiatry* (New York: Spectrum, 1977), pp. 5-18.

positively to the drug, relapses were high and the numbers were not significantly different from individuals who were administered ECT.<sup>40</sup> Many South African psychiatrists also drew on international studies to argue that drugs were not the miracle cure that the psychiatric field had hoped they would be. In France, for example, it was found that 40 percent of depressive patients did not respond to appropriate psychiatric drugs; psychiatrists in Japan noted that many patients developed resistance to anti-depressive drugs.<sup>41</sup> In 1975, S. B. Sachs, a psychiatrist from East London, argued against the effectiveness of drugs. He argued that the large influx of drugs into the psychiatric field made psychiatrists play what he termed 'therapeutic roulette' when prescribing drug therapy for their patients. He argued that the scientific methodology adopted by psychiatrists when prescribing drugs was deceptive. Rather, he suggested that psychiatrists should not attempt to determine the severity of a 'mental illness' on a set scale as was commonly done, but should take into account the relative human nature of the patient itself. Psychiatrists, he argued, should not become so wrapped up in the organic symptoms of their patients that they forget every other therapy available for patients.<sup>42</sup>

While some cultural psychiatrists welcomed drug studies, they contended that in South Africa, cultural psychiatry was equally important. They suggested that no single biological solution existed for South African psychiatric patients because of the country's

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<sup>40</sup> A. B. Daneel, 'Intrathecal Trifluoperazine in Schizophrenia', *SAMJ* 40: 3 (1966), p. 47-50.

<sup>41</sup> S. B. Sachs, 'The Uncertain Psychiatrist', *SAMJ* 49: 53 (1975), p. 2181.

<sup>42</sup> *Ibid.*, pp. 2181-2182.

variety of cultural and racial backgrounds. Therefore, they urged psychiatrists to obtain further knowledge of their patients' backgrounds and cultures for better diagnoses.

In 1973, A.G. Le Roux conducted a cross-cultural psychiatric study of four ethnic groups living in the northern Transvaal homeland areas. This study, he argued, was meant to draw 'attention to the importance of an historical-cultural approach to the study of mental abnormalities among the Bantu of South Africa.'<sup>43</sup> Le Roux highlighted cultural influences on patients' perceptions of 'mental illness' and drew on anthropological studies to support his data. The incorporation of other disciplinary studies into psychiatry not only indicated a further movement away from the biological definition of psychiatry, but also reflected an attempt to understand the 'Bantu' mind that continued to thwart the psychiatric realm. Le Roux's study acknowledged the inadequate way that psychiatrists had previously dealt with 'Bantu' psychiatry. He argued that knowledge of 'Bantu' cultural background was important in order to gain an intrinsic understanding of the psychiatric syndromes in 'Bantu' communities. As the education of 'Bantu' psychiatrists had not been especially successful, he suggested that psychiatrists become more cognisant of the way that anthropological studies of the 'Bantu' could enable them to gain further insight into the 'mental disturbances' of their patients. He suggested that the strict diagnostic categories imposed on 'Bantu' patients and psychiatrists' inadequate understanding of cultural difference caused the prevalence of schizophrenic diagnosis among 'Bantu' patients:

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<sup>43</sup> A.G. Le Roux, 'Psychopathology in Bantu Culture', *SAMJ* 47: 43 (1973), p. 2077.

The emphasis... on stupor, pre-occupation, and poor contact with reality, reflects either the general invariant nature of personality disorders or a stagnant terminological dearth. The latter also seems to be the case with psychiatric diagnosis among Bantu patients where the diagnoses rigidly stress one major disorder, viz. schizophrenia. It is possible that this rigidity stems from an insufficient anthropological background of those concerned with the diagnosis.<sup>44</sup>

In an attempt to shrug off the all encompassing 'Western' diagnostic labels, Le Roux surveyed two hundred and twenty-seven psychology students in order to produce a list of commonly used 'Bantu' terms for various forms of mental 'disorders'. This list included words from many different ethnic groups within South Africa that depicted 'madness', witchcraft, breaking of tradition and foolishness. By understanding these terms, he argued, psychiatrists would gain insight into the representative symbols and relative depictions of 'mental illness' which were often misunderstood by psychiatrists. Through understanding the patient's perceptions of 'mental illness', Le Roux contended that psychiatrists would be more able to diagnose their patients accurately.<sup>45</sup>

Le Roux was not alone in his argument that the psychiatric field did not have adequate knowledge of 'non-White' culture to accurately ascertain their patients' mental condition. M. Vera Bührmann also argued that South African psychiatrists had to adopt and understand 'African' notions of psychiatry in order to effectively deal with their patients. In a 1977 *SAMJ* article, she highlighted the difficulties that 'Western'-trained psychiatrists experienced when dealing with Xhosa patients. Psychiatrists, she argued,

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<sup>44</sup> *Ibid.*, p. 2081.

<sup>45</sup> *Ibid.*, p. 2082.

faced language, culture and psychiatric assessment barriers, mainly because Xhosa individuals had different interpretations of 'mental illness' and medical assistance:

The appearance and behaviour of Xhosa patients can be misleading, because the examining situation is strange, and their rules of good conduct and appropriate behaviour may be different from ours. Our appearance also brings in so many racial factors and expectations which could be both good and bad and that proper assessment can be rendered more difficult. Their 'way of relating', which is an important psychiatric observation, cannot be assessed in the same way as is done with a White patient. The apparent deviousness, evasiveness and caution... can easily be interpreted as being of 'psychiatric significance'.<sup>46</sup>

Bührmann advocated the use of anthropological and other research on 'African' communities in order to understand patients better. A greater understanding of the Xhosa patient's language, society and culture, Bührmann argued, would enable psychiatrists to be more effective in their work with Xhosa psychiatric patients.

Similarly, G. Daynes and N. P. Msengi emphasised the need for psychiatrists to understand 'African' beliefs when dealing with 'African' patients. In a 1979 article, Daynes and Msengi questioned the relevance of 'Western' psychiatry in the Transkei area. They argued that patients in the Transkei who consulted 'Western' practitioners expected answers to questions to 'why am I ill?' and 'who made me ill?' rather than the biomedical answers to the question 'what is the illness?' They suggested that psychiatrists with their scientifically-fixed notions of biomedical causes tended to forget the impact that culture had on patients' (and psychiatrists') perspectives on 'mental illness':

... a full understanding of the aetiology of certain disorders such as schizophrenia still eludes us... Let those in the medical research centres unite with those in the field to help practitioners answer the unasked

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<sup>46</sup> M. Vera Bührmann, 'Western Psychiatry and the Xhosa Patient', *SAMJ* (1977), p. 465.

questions "Why am I ill?" and "Who made me ill?", and so increase the relevance of Western psychiatry for their patients.<sup>47</sup>

At the First National Congress of Psychiatry in 1975, this trend of moving away from the biological towards the cultural was noticeable. Many South African psychiatrists expressed an increased concern about gaining an understanding of the cultural differences among different racial groups. Yvonne Blake presented a paper entitled, 'Dynamic Approaches' which stressed the fact that 'man cannot be studied or understood in isolation.'<sup>48</sup> W. D. Hammond-Tooke presented a paper that stressed 'African' worldviews in order to explain illnesses. L. M. Mohapeloa stressed the role of traditional healers in Lesotho and Frances Reinhold presented a paper that argued that a 'thorough knowledge of cultural beliefs of the people with whom one is working is essential.'<sup>49</sup>

Implicit in the above studies is the acknowledgement by South African psychiatrists that psychiatry was socially constructed by its participants. Ironically, this view supported the anti-psychiatric movements' rejection of the 'scientific' and 'organic' explanations for the origins of 'mental illness'. Indeed, South African psychiatrists questioned their own role within psychiatry and even began to emphasise their limitations and lack of knowledge. Emphasis was no longer placed on the biological condition of the patient, rather, South African psychiatrists began to examine expressions of 'mental illness' through symbols and social process. This focus on culture and subsequent

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<sup>47</sup> G. Daynes and N. P. Msengi, "Why Am I Ill? Who Made Me Ill?" The Relevance of Western Psychiatry in Transkei', *SAMJ* 56: 8 (1979), p. 308.

<sup>48</sup> 'First National Congress of Psychiatry: Abstracts of Papers', *SAMJ* 49: 24 (1975), p. 983.

<sup>49</sup> *Ibid.*, p. 985.

rejection of the biological notions of 'mental illness' contradicted earlier community psychiatrists' ideas of biological differences among races and directly challenged the notion of racial differences in diagnoses. It also directly contradicted apartheid ideas of Social Darwinism, race and biological difference.

However, the movement towards understanding the 'culture' of different 'ethnic' groups within South Africa also supported the apartheid government's racist notions of disproportionate 'multi-ethnicism'. Indeed, most cross-cultural studies were based on very stereotypical notions of 'White' and 'non-White' culture, often reminiscent of the 1960s racist degeneration theory discussed in the first chapter of this thesis. For example, Daynes and Msengi's based their argument on an idea of a homogeneous, static interpretation of a 'Black' culture. They argued that 'Black' culture was simply more 'broad' and 'less-advanced' than 'Western' culture, yet still malleable enough to incorporate 'Western' ideas:

It must be remembered that as there is no such concept as 'chance' in African philosophy, a newly discovered cause for a previously unexplained happening will not be rejected but will be received and tested against experience. Although the Western philosophy of life and approach to illness differ very considerably from those of Blacks, their frame of reference is so broad that certain Western ideas can be incorporated into it without upset, and these new concepts can become relevant for them.<sup>50</sup>

Similarly, Le Roux based his argument on the idea that four homogeneous, static 'ethnic' groups existed within the Northern Transvaal homelands. He argued that progressive differences existed between 'Western' and 'African' cultures. 'Western' man,

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<sup>50</sup> Daynes and Msengi, 'Why am I Ill?', p. 307.



he contended, had rejected his ceremonies and rituals after the Middle Ages and 'was able to rid himself of the paralysing fear of demons and other supernatural forces' without experiencing any feelings of loss or strain.<sup>51</sup> In 'Bantu' culture, however, he argued that a 'gradual conversion from a primitive to an enlightened approach to mental conditions, did not take place.'<sup>52</sup> Like South African psychiatrists in the 1950s and 1960s, Le Roux argued that increased industrialisation and urbanisation caused the mental degeneration of 'non-White' individuals:

Transitions, which for the Western man took centuries, are for present-day Bantu telescoped into decades. The rejection of beliefs in the spirits and forefathers, of rites, rituals and ceremonies held dear by specific communities and Bantu society in general, is being forced upon individuals, particularly the educated Bantu, by a new scientific orientation. The impact of such subtle parallel forces generated by a primitive thought system and by a scientific thought system, not only has a disorganizing effect on the beliefs of the people concerned but it undoubtedly also has a disruptive influence on the minds of individuals.<sup>53</sup>

This view of the 'primitive' and 'disordered' 'Bantu' supported the prevailing Social Darwinistic beliefs that still underscored the apartheid notions of segregation. Indeed, many psychiatrists argued that the differences that existed between the groups within South African society merely testified to the need for separation. For example, South African psychiatrists' rejection of traditional healers as professional colleagues was a reflection of their segregationist and racist stance. In 1976, the *South African Medical Journal* published an editorial entitled 'Herbalists, Diviners and even Witchdoctors'. It strongly discouraged any form of partnership with 'traditional' healers. The editorial

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<sup>51</sup> Le Roux, 'Psychopathology in Bantu Culture', p. 2077.

<sup>52</sup> *Ibid.*

<sup>53</sup> *Ibid.*, pp. 2077-2078.

suggested that the 'traditional' healer's practices were different from those of the psychiatric field and argued that healers studied a completely different field:

The strictest member of Medical Council would not have the slightest objection to a doctor's asking the advice of an architect in connection with the design and use of facilities; in fact, such intelligent gathering of knowledge is a *sine qua non* for good medical practice and is to be encouraged. But that does not mean that the doctor may set up rooms with an architect or refer patients to him. Let those in rural practice, or wherever the problem applies, sit down with witchdoctors or diviners or herbalists, whichever term is apt, and talk and learn and try to understand more about mores and taboos, but partnership is something else.<sup>54</sup>

Accordingly, although psychiatrists stressed an increased understanding of 'non-White' culture, in actuality they promoted difference and segregation.

### ***Conclusion***

Cross-cultural psychiatry was a means by which psychiatrists could shrug off the notion that they were simply tools of the apartheid state. Influenced by anti-psychiatric studies, cross-cultural psychiatrists during the 1970s moved away from the limitations of community psychiatry and rejected the biological definitions of 'mental illness'. Cross-cultural psychiatry opened up a new culturally relative perspective on the practice of psychiatry and for the first time took into account the patient's views on 'mental illness'. However, as Vaughan has so rightly pointed out, cross-cultural psychiatrists failed to shrug off the racist and discriminatory notions promoted by the apartheid government. Rather than addressing the abuses within the private mental hospitals, cross-cultural psychiatry substantiated the NP's new 'multi-ethnic' discourse. Therefore, cross-cultural

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<sup>54</sup> Editorial, 'Herbalists, Diviners and even Witchdoctors', *SAMJ* 50: 19 (1976), p. 721.

psychiatry became a means to promote difference between 'White' and 'non-White' individuals and differed little from previous community psychiatric ideas. For those 'non-White' patients within mental institutions, this meant that their needs remained unaddressed, and that the appalling conditions within the mental institutions would continue throughout the rest of the twentieth century.

## CONCLUSION

In 1979, the American Psychiatric Association investigated an accusation that South African psychiatric institutions detained political dissidents for the apartheid state. It found that although there were significant differences in services for 'Whites' and 'non-Whites', there was no evidence that the South African government confined its opponents in mental institutions.<sup>1</sup> The fear that the South African government used mental institutions as houses of political control stemmed from anti-psychiatric organisations, such as the Church of Scientology, that had been influenced by works that were written in the 1960s, such as Michel Foucault's *Madness and Civilisation*. As I have outlined earlier in this thesis, Foucault's work described the use of mental institutions by European political regimes during the nineteenth century as a means to control their opposers. Psychiatrists, he contended, subjectified the state dissidents and created the 'mad Other'.<sup>2</sup> In apartheid South Africa, one would assume that the dominant nature of the state would also take advantage of the opportunity that mental institutions afforded them to control their opponents. However, as I have shown, between 1948 and 1979, this was not the case. There are many reasons that the South African government did not use mental institutions as a form of social control. Megan Vaughan has rightly argued that because the 'Other' had already existed in colonial Africa in the form of the 'African', the colonial government had no need to create a 'mad Other' in order to subjectify their opponents.<sup>3</sup>

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<sup>1</sup> 'Report of the Committee to Visit South Africa' *American Journal of Psychiatry* 136: 11 (1979), pp. 1498-1506.

<sup>2</sup> Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Random House, 1965)

<sup>3</sup> Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (California: Stanford University Press, 1991), p. 118 and 202.

Similarly, in apartheid South Africa, the very racist nature of apartheid ideology also meant that the 'mad Other' did not need to be applied. There were some exceptions, as Robert Edgar and Hilary Sapire have pointed out in their description of Nontetha Nkwenkwe's confinement, but, as Edgar and Sapire themselves suggest, situations such as Nontetha's were not common.<sup>4</sup>

Another reason that the apartheid government did not use South African psychiatric institutions to confine political dissidents was that psychiatrists were not simply the political pawns of the apartheid government. Vaughan, Edgar and Sapire have also acknowledged that psychiatrists often opposed the government under which they worked, but they have not effectively examined these oppositions. This thesis has expanded on their limited studies of psychiatric contradictions. It has argued that although the line between psychiatrists and the state was not clear, many South African psychiatrists often opposed, both directly and indirectly, the policies of the apartheid government. The adoption of community psychiatry in the 1950s and 1960s, for example, contradicted apartheid notions of racial segregation through its focus on prevention. Similarly, psychiatrists used cross-cultural psychiatry in the 1970s to project a more culturally aware approach to psychiatry that directly opposed the racist nature of apartheid.

However, as I have also argued, the line between supporting the apartheid government and opposing apartheid ideologies was continuously blurred. The adoption

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<sup>4</sup> Robert Edgar and Hilary Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth-Century South African Prophet* (Johannesburg, Witwatersrand University Press, 1999), p. 123.

of community and cultural psychiatric trends also supported apartheid notions of segregation, sometimes intentionally. Because of their focus on difference, community psychiatry and cultural psychiatry often increased the gap between 'Whites' and 'non-Whites'. Therefore, most psychiatrists who opposed apartheid ideology merely ended up perpetuating ideas of racial difference.

As this thesis is merely a rudimentary study, there are some questions that remain unanswered where further research is needed. Important questions such as, 'how do patients shape psychiatric knowledge?' and 'what were the role of intermediaries, such as nurses, within the psychiatric field and the apartheid structure?' Further research also needs to be completed on those who frequented or took their family members to 'Western' psychiatrists and those who did not. If they chose not to visit 'Western' psychiatrists, what were their other options? These questions highlight further issues of resistance, resilience and choice. Research into patient trends also leads to a larger question of 'what is psychiatry?' Does it merely encompass those registered, officially-sanctioned individuals, or does it include a large range of individuals, including 'traditional healers', who deal with people's 'mental health'? Although I have attempted to place psychiatrists within the larger context of the international community, further study into all types of psychiatrists' positions within the larger psychiatric field, both within Africa and the rest of the world, is definitely needed. My research has supported Vaughan's notion of psychiatry within colonial Africa, however, it is also important to recognise that apartheid South Africa, as a settler state, was considerably different from colonial states. Indeed, this recognition potentially challenges Vaughan's generalisation of psychiatry in Africa.

Psychiatrists played a complex role, which I have highlighted here, but more research into the differentiation of the psychiatric field and those who have contributed to psychiatry should be conducted.

The complexity of the role that psychiatrists played within apartheid is largely due to the complexity of apartheid itself. Indeed, this thesis has indirectly been about the changing and contradictory nature of apartheid. It has examined, through the window of psychiatry, the complexity of and the contradictions existing within the apartheid state. Many historians have studied the complexity of the apartheid state. Debra Posel, for example, has pointed out that apartheid was often a confusing and haphazard ideology that had no 'grand plan' and was teeming with contradictions.<sup>5</sup> Yet it was these very contradictions that had allowed apartheid to remain as effective as it did for so long. As Saul Dubow, has argued, the apartheid government's ability to simultaneously believe in two contradictory ideas was one of the main reasons for its success.<sup>6</sup> Similarly, the ability of the South African psychiatric field to both support and oppose apartheid ideologies enabled psychiatry to continue treating patients in atrocious conditions under the guise of compassion. This ability to believe opposing notions is aptly represented in P. H. Henning's statement in a reply to the American Psychiatric Associations report on South African psychiatry in 1979:

I dispute the implication that the differences in our service standards result from malicious disregard for other human beings. The Department of Health provides physical facilities to each population group that are

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<sup>5</sup> Deborah Posel, *The Making of Apartheid 1948-1961: Conflict and Compromise* (Oxford: Clarendon Press, 1991), p. 5.

<sup>6</sup> Saul Dubow, *Scientific Racism in Modern South Africa* (Cambridge: Cambridge University Press, 1995), p. 248.

usually an improvement on the standard of living of the social environment from which most patients come. The services in these facilities are related to the cultural practices of the group accommodated.<sup>7</sup>

By examining apartheid through psychiatry, this thesis has also argued that psychiatry was historically influenced. Indeed, from the beginning of the nationalist regime through to the height of its power and the beginning of its decline, specific social, economic and political changes shaped psychiatric views and practices. South African psychiatry at the beginning of apartheid rule was quite different from that in 1979. The move away from custodial to community-orientated practices, and then to cross-cultural approaches were indicative of South Africa's move towards increased segregational practices during a period in which other African countries were moving towards independence. South African psychiatry was not, as Edward Shorter argues for 'Western' psychiatry, a 'scientific reality'.<sup>8</sup> Indeed, today, psychiatrists are still grappling with the definition of 'mental illness', and are attempting to create a universal psychiatry that does not impose the psychiatrist's own notions of 'normal' onto the patient.

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<sup>7</sup> P. H. Henning, 'Letters to the Editor' *American Journal of Psychiatry* 137: 7 (1980), p. 864.

<sup>8</sup> Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), p. viii.



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