

The historical development of psychiatry in South Africa since 1652

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The history of psychiatry in South Africa stretches back to the first settlement by Europeans in the Cape of Good Hope in 1652. Its development falls into 3 phases with some overlaps. The first was a period of expediency and restraint during the early stages of the occupation of the Cape by the Dutch East India Company; the second, which could be called the psychiatric hospital era, was under the control of the British from the earlier part of the 19th century towards the beginning of the 20th century; and the third, broadly speaking, is the modern period since then. This article traces major developments over these 5 centuries to the present time, when psychiatry has become a highly evolved modern medical discipline.

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The Dutch East India Company perforce had to make the first efforts to deal with mental illness among early settlers and passing soldiers and sailors at the Cape. Accommodation for the behaviourally disturbed was in a primitive structure adjacent to the first Van Riebeeck fort; this was enlarged in 1674 but proved inadequate, and when a new hospital was built in 1699 adjacent to the Company Gardens, mentally ill patients were moved 'into a small enclosed apartment for locking up the mad'. It is interesting to note that this pattern (hospital facilities for the mentally ill becoming inadequate for growing needs) has endured to this day in many of our modern psychiatric hospitals. A third hospital was built in 1772 near the Company Gardens, again with some space for mental patients, and again this became overcrowded and patients were transferred to the nearby Slave Lodge. The opening of Somerset Hospital in 1818 under the British colonial government was a new hope. Some beds were set aside for 'lunatics' who were cared for among the physically ill. This was the only such facility in the Cape Colony at the time, so patients were admitted from as far away as the Eastern Cape.¹

Psychiatric diagnosis as we know it did not exist, and the mentally ill, lacking an obvious physical cause, were simply called 'insane', 'mad' or 'lunatic', the latter because of the supposed effects of the moon. They were largely thought to be possessed by demons

– which could be dispersed by 'alienists', an appellation which endured well into the late 19th century. It is interesting to note that the concept of mental illness as a disease only came about towards the end of the 18th century, and the term 'psychiatry' was coined by a French physician in 1808. Causes were not known but, apart from the functional psychoses of mania and schizophrenia, malnutrition, malaria, epilepsy, alcoholism and syphilis must have been causal. Treatment did not exist as such; it was purely a matter of ensuring the safety of the person and controlling violent or disruptive behaviour. The next development, intended to relieve the overcrowding at Somerset Hospital, was the transfer in 1836 of mental patients to Robben Island. This had been a convict station but now became a refuge for lepers, lunatics and the chronically sick.² It continued to be the main resource for the mentally ill in the Cape until the building of Valkenberg Hospital in 1892, although patients were still admitted there until its psychiatric facilities were finally closed in 1920. It is reported that living conditions in the early years were dreadful; 'buildings were decrepit, overcrowded and verminous', patients lived in squalor and management was unfeeling. 'It was quite usual to find them kept in dark insanitary cells, filthy, covered in festering sores and chained to iron rings.'² Things improved with the appointment of Dr J C Minto in the mid-1860s, who decreed that mechanical restraint was not to be used unless seclusion had been tried; he considered that 'kindness and decision is found generally to restore order' and he improved living conditions and instituted occupations for patients, making mats and baskets for sale. Treatment was entirely symptomatic, consisting mostly of sedatives and hypnotics; bromides were a standby to settle agitation, and in excess might well have induced psychotic symptoms. Calomel (which contained mercury) was used to produce the evacuation of so-called toxins: we are not told of its ill effects but they must have been common and serious.³

The psychiatric hospital phase

The situation changed towards the end of the 19th century when it became clear that temporary lock-up and restraint arrangements and containment in police cells were not adequate or in keeping with current ideas. The spirit of humanism underlying the Enlightenment in Europe and the French Revolution was seeping through to South Africa, which was largely under British control at that time. New ideas led to the building of dedicated institutions

for the mentally ill, based on British and American models; these had extended wings for the wards and closed courtyards where necessary. It was considered that mental hospitals, then called asylums, should be placed in some sort of a garden or park setting as fresh air, pleasant surroundings and useful occupation would aid recovery. Treatment, though, was limited – there were no effective drugs and no cures other than the natural abatement of symptoms. Several such hospitals were built towards the end of the 19th century, some on the plans of overseas buildings and others in disused army encampments, Fort England Hospital in Grahamstown being the first in 1876, Fort Beaufort in the Eastern Cape in 1897, Kowie Hospital in Port Alfred, also in disused barracks (1889), Valkenberg Hospital in Cape Town (1891), Weskoppies Hospital in Pretoria (1892), Oranje Hospital in Bloemfontein (1883) and Townhill Hospital in Pietermaritzburg in 1882. Later additions were Komani Hospital in Queenstown in 1922 followed by Stikland Hospital in Bellville (1963) and Lentegeur Hospital on the Cape Flats in 1974. Witrand Institute catered for the mentally retarded in Potchefstroom, and the Alexandra Care and Rehabilitation Centre was established in Cape Town in 1922.

These institutions were governed by the so-called Lunacy Laws and specific regulations dealing with the mentally ill which varied in the Boer Republics; but, with Union in 1910, the responsibility for psychiatric hospitals was vested centrally in the state Department of Health which was also responsible for new legislation (the Mental Disorders Act of 1916).

Patients were now better housed and cared for but the custodial orientation remained, i.e. to lodge, secure and care for the physical and mental needs of people who were psychotic. As time passed, however, overcrowding built up again – a constant feature of South African institutions owing to the combination of the chronic nature of many mental illnesses, the lack of effective treatment and that there were no other resources available. Only with the advent of new effective treatments and the development of community services, has the pressure on psychiatric hospitals been reduced, although overcrowding is still a predominant problem.

Then followed an interregnum period that lasted to the end of the First World War, during which time no important therapeutic advances took place, except a realisation of the influence of the mind on bodily function; combat stress, collectively called 'shell shock', was recognised as an entity that could manifest with physical symptoms and hysterical syndromes. Freud, Jung and other psychodynamic psychiatrists breathed hope of help in the early years of the 20th century, but the usual run of psychotic and severely disturbed patients was unaffected by their insights. There had been, however, some movement regarding organic mental illness in Europe and America in the second half of the 19th century – newly discovered salvarsan was the hope for neurosyphilis, but it proved to be ineffective in chronic infections. New classifications of mental illness by Kraepelin, Bleuler and others constituted an important

step towards a better definition of types of illness, allowing for more specific treatments.⁴

Modern psychiatry

Since the period covering the transition of the 19th into the 20th century, each new nosology has opened up enquiry and experimentation. The DSM and ICD have split the atom, so to speak, and we can now examine the minutiae of each diagnostic entity in terms of pathogenesis, course, outcome, and the therapeutic effects of a particular psychotropic drug or therapeutic agent.

Major therapeutic advances, however, had to wait until the 1930s: among the most significant was convulsive therapy which followed from the observation that epileptic seizures had an effect on schizophrenic symptoms, and this led in 1935 to the induction of seizures by the injection of camphor and cardiozol, and, most significantly, by electroconvulsive therapy. The production of hyperthermia by infection with malarial parasites was used for neurosyphilis and, in the 1950s, insulin, to produce hypoglycaemic coma which was thought to be effective in schizophrenia. Once again, results were not encouraging and, by the early 1960s, this dangerous treatment had been discontinued. Some therapies, however, including newly developed drugs, continued to be used without effect for several years. It appears that the evaluation of new therapeutic measures requires a lead time of at least a decade until a sufficient number of reliable investigations demonstrate their lack of efficacy – and sometimes, too, their danger.

There has been much change in the modern era, i.e. from about the mid-20th century. Although beset with the residual problem of large chronic populations, psychiatric hospitals offered the components of modern psychiatry including outpatient clinics, a therapeutic team approach, social and community services, occupational therapy, rehabilitation, etc. The transfer of responsibility for psychiatric services to provincial health authorities in 1987 gave a major impetus because of the emphasis on curative services and more diverse venues and forms of therapy. In the process, psychiatry came closer to general medicine and lost some of the stigma that had bedevilled it.

Under the apartheid regime, strict legislation concerning separate facilities and accommodation for black patients was enforced but, beginning in 1991, transformation and consolidation began in some hospitals and led to the total abolishment of racial distinctions when a new government came to power in 1994.

The next phase was arguably the most significant in the long history of psychiatry: the development and use of effective psychotropic drugs, more particularly, for psychotic and depressive conditions. These arose out of a better understanding of biochemical and physiological processes in the brain and, as experiments multiplied and knowledge grew, many psychotropic medications were developed. Chlorpromazine was the first in 1955; this quieted

patients so that violent and disruptive behaviour could be controlled, and made it possible for hospital stay to be reduced and patients to be treated in the community. Of the many other medications developed since, some were quite specific, some more efficient, and some more dangerous. Many have fallen by the wayside. Lithium was discovered in 1949 as an effective treatment for some forms of bipolar illness, and imipramine was introduced in 1958. They did not cure, but controlled or abated symptoms and in many cases violent behaviour; they made it possible to look beyond mere custodianship to active therapeutic measures, notably psychological treatments, group and outpatient therapy, therapeutic communities, etc.

As a result of the new medications and ideas coming out of World War 2 experience, psychiatry was rapidly evolving in Britain. Old-style custodial mental hospitals were closed with the move of psychiatry to general hospitals and the community. The term 'psychiatric' rather than 'mental' was preferred, and a variety of ancillary therapies and treatment venues were set up, including day hospitals, outpatient clinics, therapeutic communities, multidisciplinary teams, social clubs and rehabilitation centres. Special units for particular conditions were created, e.g. eating disorders, personality disorders, child and adolescent psychiatry and geriatric psychiatry. This move into mainstream medicine had major results in South Africa, the most notable being the establishment of academic departments of psychiatry in general hospitals, notably in the Johannesburg, Groote Schuur, Pretoria, Tygerberg and other general hospitals. Active collaborative relationships developed with other branches of medicine, and psychiatry came to be increasingly accepted as a major medical discipline. The understanding of psychiatric illness as a treatable medical condition reduced its stigma and brought a greater willingness of patients to be treated. One example (and there are many in different parts of the country) was the establishment of an inpatient treatment unit for alcoholism in a medical context at Groote Schuur Hospital.

It did not, however, prove possible to phase out psychiatric hospitals because of the special situation in South Africa with its large peri-urban and rural populations, poor transport, overcrowding in informal settlements, and poor community and social support services. But, as indicated, psychiatric hospitals have moved with the times: they began to offer a variety of purpose-orientated treatments and therapeutic facilities, e.g. a psychogeriatric unit at Stikland Hospital and a province-wide system of community care at Oranje Hospital in Bloemfontein. Outpatient clinics were established at most hospitals, and legislation in 1976 made provision for a community service in country areas associated with particular psychiatric hospitals. Peripheral outpatient clinics were established in many parts of the country which catered mostly for patients who had been discharged from hospital, but also for newly referred patients.

Tara Hospital in Johannesburg was the forerunner of the new ideas.⁵ It arose out of the closing of 134 Military Psychiatric Hospital in 1946

when a group of military patients and a few young doctors were transferred to Tara – then a branch of the Johannesburg General Hospital. Shortly thereafter, it became an independent psychiatric hospital, the first under the control of a provincial health authority, – until then all institutional psychiatry had been under the State Department of Health. By and large, Tara dealt with less severe and recoverable cases without legislative certification. Exponents of the new psychiatry were brought from England and Holland to advise, including some of the main architects of the changing British system – Maxwell Jones, Thomas Main and John Bowlby, among others. Mention must be made of Dr H Moross who was largely responsible for the development of Tara and the superb leadership of Miss Iris Marwick, the Chief Nursing Administrator. Both have been recognised nationally and internationally for their pioneering work.⁶

There were many firsts: a Children's Clinic was set up in 1947, a Day Hospital in 1953 and a Psychiatric Community Service in 1956. In subsequent years, as a result of the transfer of psychiatric services to provincial authorities, similar treatment venues were established in other provinces, some in association with general hospitals.

Tara also pioneered the training of specialist psychiatrists, of whom there was an acute shortage in South Africa. Apart from a few in private practice, most of whom had been trained overseas or practised jointly as neurologists, and a few senior psychiatrists in mental hospitals who registered when the specialist register of the South African Medical Council was instituted, most psychiatric hospitals were staffed by medical officers who gained their experience in the working situation.

The first South African academic training was initiated at the University of the Witwatersrand in 1949, leading to the Diploma of Psychological Medicine with specialist registration thereafter. This was based on the equivalent British qualification and was associated with registration for the MMed degree. Seven candidates had graduated in 1951, a second group in 1952, and similar training programmes were subsequently established at all South African medical schools. About 20 psychiatrists are now registered annually with the South African Medical Council. It was soon realised that a diploma was not appropriate for this important medical discipline, and the Fellowship of the Faculty of Psychiatry of the College of Medicine was created in 1961.

The first full-time post of Professor of Psychiatry (Professor L Hurst) in an academic department was created in 1954 in a joint appointment between the Transvaal Provincial Department of Health and the University of the Witwatersrand. Academic departments and the fulltime appointment of professorial and other staff followed at all medical schools.

The undergraduate teaching of psychiatry greatly expanded at all medical schools. This had previously consisted of some lectures by

a senior member of the local psychiatric hospital – often a part-time honorary professor – and a few visits to the local mental hospital; but as psychiatry grew into a major medical discipline, it gained increased teaching time, and is currently the fifth major clinical subject in the final MB BCh examination at most medical schools.

Psychiatric nursing has a long and proud history. Training began with the establishment of new hospitals at the end of the 19th century, and there were many fine and caring mental hospital nurses, both male and female. They were the backbone of the service although, in keeping with the psychiatry of the time, this was in a custodial institutional context. A constant feature over the years was a shortage of trained nurses resulting in heavy and sometimes non-nursing workloads. In the 1960s, the old-style mental nurse training was discontinued and additional training in general nursing was given to existing personnel. Because of the growing need to expand the psychiatric skills of general nurses, an integrated training course that included psychiatric nursing was introduced for all nurses by the South African Council of Nursing. Also offered was an advanced course in psychiatric nursing at Tara in the 1950s and at Groote Schuur Hospital in Cape Town in 1962. An outstanding group of psychiatric nurse practitioners were produced, but the qualification was later discontinued as it was considered that all nurses should have psychiatric training and experience, although less specialised and for a shorter period. Overall, the new direction in psychiatric nursing brought a better understanding of mental illness to nurses and underpinned the increasing importance of the new progressive psychiatry; it also helped to diminish the stigma of mental illness among the profession and the public. The training of other members of the multidisciplinary therapeutic team – psychiatric social workers, clinical psychologists and occupational therapists – was also initiated in co-operation with the relevant university departments in the Witwatersrand and Cape Town, and this was soon followed by similar academic departments elsewhere.

A significant development was the action of the Department of Health in 1974, beset with an overload of chronic patients and a shortage of beds in its psychiatric hospitals, to transfer large numbers of chronic patients to a private health server known as the Smith Mitchell Organisation. Objections were raised in some quarters, as a large proportion of the patients were black, but the Society of Psychiatrists and an investigative team from the American Psychiatric Association, were satisfied after full inspections that the facilities and services were acceptable. This freed up many hospital beds, allowing psychiatric hospitals to concentrate more on acute illnesses and intensive treatments. However, pressure on psychiatric hospitals soon built up again.

The role of the Society of Psychiatrists in the story of psychiatry in South Africa is significant.⁷ Its origin had been first a combined group of psychiatrists, neurologists and neurosurgeons of the Medical Association of South Africa, formed in Johannesburg in 1953, which soon thereafter split into separate specialities, each

retaining its own identity. The Society of Psychiatrists was formed in South Africa in 1962. The Society has established branches in all provinces and has made an important contribution to the needs of psychiatric patients and the profession, acting as a pressure group for the mentally ill and holding regular conferences and meetings on academic topics and important issues of the day. Under its revised name, the South African Society of Psychiatrists (SASOP), it now celebrates its 60th anniversary.

In common with other medical disciplines, psychiatry had to function within the legislative framework of a oppressive apartheid regime that enforced the segregation of black patients and subjected them to indignities and restraints. SASOP made many public representations to government and responsible controlling authorities regarding abhorrent practices and legislation that affected the mental health of their patients, e.g. the care of political detainees, and the effects of these enforcements on the mental health of individuals affected by the infamous Immorality Act, the Mixed Marriages Act etc.⁷ Numerous psychiatrists tried to mitigate some of these effects on individual patients. The Society has maintained high ethical standards and remains committed to the Declarations of Hawaii, Tokyo and Helsinki.

Mention must also be made of the role of the College of Psychiatry in the Colleges of Medicine of South Africa, which was previously called the Faculty of Psychiatry in the Colleges of Medicine of South Africa. Its first graduation with the FFPsych qualification (now the FCPsych (SA)) was in 1961. In addition to its examining role, the College has continued to play an important advisory and planning role in the training of psychiatrists. It was recently decided that the College's final examination will be the only national exit qualification that will be recognised by the Health Professions Council of South Africa for the purposes of future registration of specialists in psychiatry.

Private practice was for many years the only resource for psychiatric treatment, other than that provided by psychiatric hospitals. Some of the early practitioners established private hospitals, and many have done sterling work in outpatient departments and the community. Without their endeavours, the shortfall would have been even more marked.⁸ There has been a marked increase in the number of practicing psychiatrists in recent years, both in hospital and private practice, but unfortunately many have been lost to overseas inducements, and a shortage still exists, particularly in rural areas. Nevertheless, the situation is improving: in 1965 there were 70 psychiatrists registered with the South African Medical Council; this number rose to 302 by 1977 and is now close to 400 – still insufficient for a population of about 50 million.

The important role of non-governmental and other voluntary organisations must be emphasised. Funding from the Departments of Health and Social Welfare is a model of public-private joint endeavour and has worked well over many years. Included are

mental health societies and the work of the Depression and Anxiety Disorders Group. The Cape Mental Health Society has already celebrated its centenary, and there are many voluntary organisations that deal with the support and rehabilitation of mentally ill and mentally retarded persons all over South Africa, which work closely with public and private psychiatric hospitals and in some areas function as *de facto* community services. Many also offer rehabilitation and sheltered training. The role of these voluntary organisations has been largely under-appreciated, and credit and praise must be given for the selfless work of their members.

Mental health legislation

Various acts and regulations have been promulgated from earliest times, becoming more inclusive and detailed with passing years. Most were concerned with the property and the holding and restraint of disordered persons. By the end of the 19th century, the Cape Colony and the Boer republics had passed their own Lunacy Laws. At the time of Union in 1910, however, consideration was given to unified legislation and, in 1916, the first comprehensive legislation, known as the Mental Disorder and Defective Persons Act, was drawn up by Dr JT Dunston, the first Commissioner for the Mentally Disordered and Defective Persons. He was also responsible for much-needed improvements in the psychiatric hospitals of the day. Several revisions and amendments were made to this Act over the years to meet changing conditions and new practices, resulting in the most recent legislation – the progressive Mental Health Care Act of 2002.

Since the establishment of academic departments, there has been an increasing flow of research. Two medical research council (MRC) research units have been established as well as research relationships with world bodies such as the World Health Organization and other international agencies and investigators. Important achievements are the regular production of 2 important psychiatry journals: the official scientific journal of SASOP, being the *South African Journal of Psychiatry*, now in its 18th year; as well as the official journal of the African Association of Psychiatrists, being the *African Journal of Psychiatry*.

So much for the past; where has our history led us? Mental illness has always been with us and always will be, and much of it is chronic, with causes that are either not known or, at the present state of our knowledge, not remediable. What we have learned is that psychiatric illness has many roots, including the genetic, the medical, the social and the cultural, all of which contribute to

different forms of illness and require different management and treatment. It is clear that we need co-ordinated and comprehensive services with easy access for patients. The framework already exists, although facilities and resources vary – there are psychiatric institutions and services in every province, some with specialised services, others that are less organised and understaffed, some in need of new buildings and supplies. It will not be possible to reduce the number of our psychiatric hospital beds, as has been attempted in more developed societies with some success, because of the structure and situation of the South African population and the lack of adequate community and social services. Barring the effects of momentous new findings in the biochemical and neurophysiological fields, then, the direction of mental health services is already set, and what is now needed is more of the same. Certain priorities have become clear: firstly, provision of integrated mental health services at a primary care level; and secondly, a variety of specialised units is needed in urban centres where specially trained staff and appropriate facilities are available to deal with particular disorders, e.g. acute emergency centres – usually best placed in general hospitals – eating disorders, psychogeriatric units, child and adolescent units, addiction units, forensic units and long-term rehabilitation units.⁹ And in the communities and country areas, the need exists for expanded services, particularly continuing care and rehabilitation.

What is the way forward, then? It is clear that more extensive and encompassing facilities and services are needed, and it is hoped that the proposed National Health Insurance will provide psychiatry with the incentives and opportunities that are being planned for general medical care. Much depends on the will, the vision and the finances to develop such services. Nonetheless, improvements and better organisation must and hopefully will continue.

The author wishes to acknowledge information about early developments from the series of articles on 'the history of mental health services of South Africa' by Max Minde, published in the *South African Medical Journal* in volumes 48 and 49 of 1974/1975.

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