AN ENGLISH ASYLUM IN AFRICA:
Space and Order in Valkenberg Asylum

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The authors explore the use of space within and outside the buildings of Valkenberg, a Cape Colonial asylum. Valkenberg's design was conditioned by a complex interplay of factors: the way insanity itself was viewed by the colonial government, developments in medical knowledge, social-economic relations in the colonial setting, and practical forms of treatment. The internal structuring of space within the building, and the way the building was situated in the landscape, are graphic representations of 4 influences, in tension with each other: determination to reform the colony's psychiatric practices, a desire to reproduce British institutions in colonial settings, a stigmatizing fear of insanity and lunatics, and a desire to maintain strict segregation between White and Black staff and patients.

Toon mij uw huis, en ik zal zeggen wie u bent. (Show me your house and I will tell you who you are.) —Old Dutch proverb

In recent times the history of institutions has taken a central position in the history of the human and social sciences. It is now widely recognized that modern institutions, such as schools, mental hospitals, factories, and prisons, played a crucial role in the way in which the subjects of the social and human sciences emerged (e.g., Foucault, 1975, 1979; Rose, 1985). Given the extensiveness of this literature, it is a little surprising that interest in the design of these buildings was slower in developing. The literature on the architecture of mental asylums, the institution of central concern in this article, showed something of an upsurge in the early 1980s, when the work of Brown (1980), Donnelly (1983), Markus (1982), and Scull (1980) appeared. At present a lot more is known about asylum architecture in the 19th century in Britain and the United States, through the more recent work of people such as Edginton (1994), Markus (1993), Philo (1989), Stevenson (1993), and Taylor (1991).

The study of asylum architecture forms part of a larger literature on the shift in certain societies to reliance on institutions for the care of the mad. This literature is characterized by lively disagreement (see Scull, 1999). Some authors explain the extraordinary growth in the number and size of lunatic asylums in

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America, Britain, and Europe during the 19th century in terms of social control being extended over deviancy: Scull (1980, 1993), for example, focused on the larger external forces contained in the growth of middle-class capitalist societies, Rothman (1971) focused on the effects of these changes on the professionalization of psychiatric knowledge, and Foucault (1965) focused on the extension of "governmentality" to the mad.

Four issues raised by the debate are pertinent to this article. First, the insane increasingly came to be differentiated from other categories of dependent people, such as the chronically sick, the aged, and orphans, and this resulted in a perceived need for specialized institutions for their care and confinement. Second, humanitarian concern over conditions in madhouses played a role in establishing state regulation of the processes of identifying and institutionalizing the insane. Third, the medical profession had a vested interest in being identified as appropriate caretakers for the growing lunatic population, and over the course of the 19th century an increase in medical knowledge about the origins and treatment of insanity consolidated their hegemonic control of insanity as a field of intervention. Finally, specialized care in asylums was a key ingredient in the medical response to the needs of the insane. Also, there were broader sociological influences, such as industrialization and the establishment of a market economy (Scull, 1993), and the growth of state-regulated institutional responses to all aspects of civil life, including commerce, industry, education, and illness (Foucault, 1965). It is also clear that there were many local variations to this broad history, in America, Europe, and England, as well as in the colonies.

Reasons for the massive growth of the asylum population during the 19th century are therefore complex. The consequences are less so. Large numbers of people were segregated into mammoth buildings. Their entry and exit were strictly regulated by law. For much of the day they were under surveillance by increasingly specialized staff. The sheer weight of numbers necessitated strict control over routines of eating and sleeping, work and recreation. To deal with the numbers involved, a bureaucracy was spawned: Patients were numbered, systematically observed, and written about. Discipline and control were essential, not only as a response to the often-frightening symptoms of madness but also to the regulation and physical well-being of large numbers of aimless, frequently able-bodied, adult men and women, some of whom were confined against their will. At the same time, there was a general concern to present asylums to the general public as receptacles for the humane treatment of the insane—as havens rather than as prisons. The architecture of custom-built asylums reflected these contradictory needs.

In the present article we do not directly address this debate about the origin of mental asylums and the growth of their number of residents; rather, we address it by means of an examination of how the spatial order of the Valkenberg Asylum represents attempts to deal with wider concerns of social order. The building itself had to contribute to establishing order: It had to acknowledge patient classification; segregation of patients along a number of categories; surveillance of their behavior; and how inmates, staff, and visitors interfaced in space. Much more central to our concerns here are the discourses and practices about space and how these were used in the construction and running of the Valkenberg asylum.

The asylum architects of the 19th century were faced with a challenge to
design a transformative space, because the asylum itself was to be an agent for change. "The designers of the asylum insisted that it was the virtue of the asylum-as-physical thing to assist in the cure of deranged thought. The building itself was seen to be a critical tool for rehabilitating the lunatic," wrote Saris (1996, p. 543) about an Irish asylum. In the United States as well, "the asylum was designed in such a way as to facilitate moral and medical treatment" (Grob, 1994, p. 71). To accomplish this, the architects had to create order in the spatial arrangements of the asylum and its surroundings. As indicated above, this created the dilemma of constructing a facility that would reflect the lack of restraint required of humane treatment while simultaneously exercising discipline and control over inmates by means of the organization of space.

We examine the architecture of a colonial asylum, Valkenberg Asylum, which was built toward the end of the 19th century in one of the British colonies, the Cape Colony in South Africa. As a result of the colonial link to Britain, we were able to identify a number of familiar themes identified in the literature on 19th-century asylum architecture and to examine how these played themselves out locally. Apart from the original architectural drawings, the primary data sources for the present study have been patient case records, annual reports and correspondence of asylum superintendents, and annual reports of the Inspector of Asylums.

Undifferentiated Institutions: Robben Island and Somerset Hospital

Donnelly (1983) indicated that the design of asylums, as purpose-built institutions to house the insane, was not much of a concern in Britain until the 1780s. For the United States, Rothman (1971) put this development in the first half of the 19th century. Examples from other countries also indicate that this development occurred in the 19th century: Edginton (1988), for example, said that in the Canadian province of Manitoba no institutional form of treatment existed before 1871—except the gaol. Throughout Africa, purpose-built asylums were largely a 20th-century development (McCulloch, 1995; Vaughan, 1991).

Valkenberg Asylum, the institution at the center of this study, was completed in 1896 and was the first institution in South Africa specially designed and built to house the insane. Its early history was a response to the difficulties and shortcomings the local government experienced with accommodating the insane in gaols and hospitals. Valkenberg's reputation as a colonial showpiece of modern institutional care for the insane owed much to the stigma and scandal associated with those places.

Until 1846, the only accommodation for the insane in the western Cape, apart from gaols, was at Old Somerset Hospital in Cape Town, which was built in 1818 as a civilian resource by Dr. Samuel Bailey. After his bankruptcy, it was taken over by the Burgher Senate and became a public institution in 1821. It also accommodated the chronically sick, paupers, and lepers. It was never regarded as satisfactory for any of these purposes, and just before the removal of some lunatics to Robben Island in 1846 the dean of Cape Town commented that "anything more wretched and inappropriate for its unfortunate inmates cannot be imagined than the lunatic wards" (Burrows, 1958, p. 122). Old Somerset Hospital nonetheless continued to be used to accommodate lunatics, with numbers between
1880 and 1891 fluctuating between 100 and 170 (Moyle, 1987, p. 12). There were repeated calls for Old Somerset to cease to function as a lunatic asylum. In 1890 Dr. Cox, Surgeon in Charge, wrote at the end of his annual report: "It is necessary again to call attention to the absolute unsuitability of the Institution for the treatment of lunatics and the urgency for their removal."¹ Despite the opening of Valkenberg in 1891, and the transfer of many patients there, by 1909 there were still 10 insane patients in Old Somerset Hospital. In June 1905 Dr. Jane Waterston, official visitor to Valkenberg, remarked in her report on the contrast between the "open sunny courts with their grass and trees" at Valkenberg and "the terrible lunatic court in the Old Somerset with its very high walls, crowded dark cells, Mixture of races and colours, without a blade of grass or the smallest tree." She added that "‘under observation’ in such a den is a screaming farce."²

Robben Island lunatic asylum, and accommodation for the chronically sick and lepers, opened in 1846 (Deacon, 1994). For many years a convict station, it had also been a whaling station and a convalescent hospital for soldiers. Like Old Somerset Hospital, it drew together three deviant groups within a single institution and became a "dumping ground" for men and women who, unlike able-bodied convicts, were unable to work (Deacon, 1991).³ Inadequate accommodation, which had to take account of the widely divergent needs of each group, was a problem from the outset. In addition, poor sanitation, chaotic medical management, pregnancies among female lunatics, and corruption and drunkenness among the staff led to repeated eruptions of scandal (Deacon, 1994). Despite reforms undertaken by London-trained Dr. Edmunds between 1862 and 1872, Robben Island remained a source of disquiet. Scandals continued well into the superintendence of British-trained Dr. Ernest Moon, who had experience at Derby Borough Asylum and was placed at Robben Island between 1904 and 1920.⁴

Periodic public unease about conditions on Robben Island and in Old Somerset Hospital in the decades before the establishment of Valkenberg Asylum was fueled by pressure in the colony as a whole to provide increasingly differentiated public facilities. These would serve a number of aims. They would divide lunatics from other deviant groups; enforce segregation by race and gender; and allow for classification within groups, separating those with a more hopeful prognosis from the chronically ill, dependent, or insane. It was in this context that the long-debated need to rehouse lunatics on the mainland, in accommodation built for the purpose, took place.⁵

¹ House of Assembly, G.37–1891:25. See also Dodds’s report on his inspection of Old Somerset Hospital, 1890, G.37–1891:19.
² Colonial Office papers, CO 7977, June 1905.
³ Dr. Jane Waterston, Visitor’s Report on Valkenberg Asylum, Colonial Office Papers, CO 7322, December 29, 1899.
⁴ Colonial Office Papers, CO 8053, February 15, 1908.
⁵ A summary of the debate about the location of new asylum accommodation for the insane in the Western region of the Cape can be found in Dodds’s Inspector of Asylums report for 1892, G.17–1893:137–140. See also the brief history of Robben Island Asylum included in the Report of the Commissioner in Mental Disorders for the years 1916–1918 (House of Assembly, U.G. 31–1920:17–19.
Bounded Space

The appointment of Dr. William Dodds as the colony’s first Inspector of Asylums in 1889 played an important part in actualizing the decision to create a custom-built asylum on the mainland. A Scottish-trained doctor who had experience working in British lunatic asylums, Dodds was given the responsibility of guiding lunacy legislation and modernizing the colony’s asylums. Valkenberg, of which he was superintendent, was to be his showpiece, the measure of his professional success. Quoting at length from suggestions made by the English Lunacy Commission with respect to the siting of asylums, Dodds stressed the necessity for modern asylums to have easy access to water, gas, and food supplies as well as recreational facilities from which both staff and patients might benefit. He represented Robben Island as “of little help to a mind struggling with disease,” not only because of its isolation but also because of its association with convicts and lepers.⁶

The site eventually settled on was at one time a farm belonging to Cornelius Valk, and it was from him that the asylum took its name. The land had been purchased by the government of the Cape Colony in 1881 and was used as a reformatory (the Porter Reformatory) for boys until the site was approved by the Colonial Secretary as suitable for the accommodation of the insane. It was situated on the outskirts of Cape Town, in line with 19th-century lunacy reforms to site asylums “in the countryside, or in ‘retiring’ places near towns” (Donnelly, 1983, p. 31). As an additional advantage, the asylum was separated from the residential area by the Liesbeeck River on one side and the Zwart (Black) River on the other, both of which became impassable during heavy rains (see Figure 1). Thus there was little need for perimeter fences, or walls, to act as a buffer between the asylum and its surrounding area. It was an ideal site for an asylum: It provided a bounded space for confinement without drawing attention to that fact by artificially constructed markers of separation.

The spatial performance of segregation had little impact on public anxieties about the new asylum site. In 1889 there was a petition from the “landed proprietors” in the area protesting against the establishment of the asylum on the reformatory land. The astronomer at the Royal Observatory, which bordered on Valkenberg’s grounds, asked “what steps are to be taken to render our houses and grounds safe from unwelcome and possibly dangerous visits from the patients.”⁷ Compared to the complete banishment effected by committal to Robben Island, Valkenberg was indeed relatively accessible. Moreover, Dodds constantly drew attention to the site’s relative accessibility, because he had strong views about the therapeutic effect of regular outings, contact with the community, and frequent visits from family and friends.⁸ Both of these factors contributed to public alarm about the new asylum.

Anxiety about the presence of lunatics on the mainland was rekindled when Dodds proposed, shortly after the main buildings of the White asylum were completed, that Black patients be accommodated at Valkenberg instead of on

⁷ Colonial Office Papers, CO 1470, June 17, 1889.
⁸ Colonial Office Papers, CO 7175, August 1894.
Figure 1. Buildings and grounds circa 1900, showing the two rivers that formed Valkenberg Asylum's boundaries, the agricultural arrangements, and symmetrical arrangement of the main buildings. 1 = pigs; 2 = laundry; 3 = workshop; 4 = female ward; 5 = male ward; 6 = croquet; 7 = tennis court.

Robben Island. It was not until 1916 that the Old Plague Camp, Uitvlugt, sited across the Black River from Valkenberg, was opened to accommodate Black insane patients. Its separation from the White asylum, both geographically and in name, as well as its historical association with the plague, were powerful reminders of its segregated and stigmatized position in relation to Valkenberg. This was not to change until Valkenberg became racially integrated in the early 1990s.

Thus, Valkenberg Asylum was both accessible and isolated, and was separated from society, but not in absolute terms. For outsiders, its imposing buildings were visible from across the river. It was also discursively visible, a site of curiosity and debate. Its residents were close to an urban environment, with relatively easy road and train access.

Designed Space

The new asylum was designed by Sydney Mitchell, of Sydney Mitchell and Wilson, Edinburgh, Scotland. He was recommended by the Board of Lunacy for

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9 Colonial Office Papers, CO 7608, October 2, 1901.
Scotland and had done work for them, including the asylums of Gartloch and Govan, near Glasgow. Asylums, so it was thought, were his specialized work. The drawings by Mitchell are dated 1892, but they do not appear to have been received until August 1893, too late for a parliamentary vote of funds for that year (Radford, 1979, p. 278). A start was made in 1894 on one ward block for men and was practically finished that year. Another, for women, was also put in hand in November. Patients moved in in early 1896.

Although adaptations to the climate of South Africa were discussed by Mitchell and Dodds, the buildings were in the style of European asylums. The buildings themselves were arranged on what was a dispersed pavilion plan, with the separate blocks surrounded by open spaces but joined by covered walkways (see Donnelly, 1983; Edginton, 1994). This plan had become current in Britain from the early 1880s on.

The buildings were symmetrically arranged about the administration block, which acted as the focal point of the design. The formal approach to the asylum was toward the administration block, providing the best elevation of the complex. It was symmetrical in design and screened the visitor from the service elements behind it. Thus the visitor first and foremost saw a “clean,” orderly façade to the institution, with the “messy” and more informal aspects hidden from first view. The main block, behind the administration block, contains a number of diverse elements, all separately expressed and roofed. Thus the front elevation of the building was preserved by pushing all the elements concerned with the services to the rear. Radford (1979) saw this pattern in Cape domestic houses as well, where a fine façade was accompanied by a service “tail,” containing kitchen and dining room, for example.

The symmetrical arrangement of buildings, and of the design of buildings themselves (see Figure 2), are noticeable from these designs. To Brink (1992), symmetry was the concrete manifestation of abstract concepts such as a regard for order and the ability to exercise control. Because we know that the arrangement of space within the asylum was designed to be part of treatment, it is not too fanciful to suggest that symmetry itself could be the material expression of the ideas of regularity, order, and organization.

In 1910 The Cape Town Guide wrote of Valkenberg’s “picturesque position on the summit of a gentle eminence overlooking a landscape that, except for the mighty mass of Table Mountain overshadowing it, might well be an English one.”11 Showalter (1987) quoted Dr. Isaac Ray’s 1846 description of the “English landscape”:

Many of them are placed on eminences which command an extensive view of the adjacent country, the field of vision embracing hill and valley, wood and water, in their most agreeable combinations; while fields of grass and tillage, divided by hedges and trees, grazing herds, cottages, and country seats, form the nearer features of a landscape reposing in the softened light of an English sun. (p. 35)

10 Colonial Office Papers, CO 1488, February 1892.
Figure 2. Symmetry in the façade of the central administrative building.
The buildings, setting, recreational activities—which included garden parties and cricket matches—and the exclusively White patient population established Valkenberg as a colonial showpiece. It was also an institutional summary of colonial relationship, an obdurate display of colonizers' refusal to adapt institutional culture to foreign conditions. Intrinsic to this was the assumption that in order for White colonials to feel socially at ease they needed protection from contagion by constant confrontation with difference, regardless of whether this took the form of racial or architectural diversity (Swartz, 1999).

Space and Patient Classification

Classification has been fundamental to scientific methodology since the esprits simplistes of the 17th century and the Enlightenment (see Lovejoy, 1960). It not only systematizes observation, but it also claims to reflect the natural order of things. In the case of human affairs, it sought to reproduce for social relations the sort of simple order thought to inhere in nature (Goldberg, 1993). Classification of patients was the cornerstone of the treatment of insanity, and in the Cape Province four categorizations had to be accommodated: race, gender, disorder, and social class. This provided a special challenge for the asylum architect and for asylum staff: how to utilize space to acknowledge these categories.

Segregation by gender was universal in asylums throughout the world and extended to segregating male from female nursing staff (Tucker, 1887). The asylum regulations for the Cape, which replicated those in Britain, stipulated that

no male nurse, servant, or patient (except in the discharge of a duty with adequate authority and under proper supervision) shall be allowed to enter the female wards, nor shall any female patient enter the male wards. In cases where the physician superintendent shall deem it advisable, he may appoint nurses or female servants to do duty in the male division. Under no circumstances shall a male nurse or male servant be placed in charge of female patients.

The regulations also stipulated that in the case of visitors, “no male . . . shall remain in a room with a female, except in the presence of a nurse or other third person not a patient” (see footnote 13). As the medical certificates and periodicals in the Valkenberg series demonstrate, both male and female insane patients were frequently identified as behaving in sexually inappropriate ways. This included masturbation, public displays of nudity or sexual desire, and liaisons across racial boundaries. Gender segregation in asylums was partly a protection for women, who were perceived as actively encouraging or defenseless against the advances of unscrupulous male staff, visitors, or patients. Experience on Robben Island, where a number of women became pregnant during their period of committal before strict gender segregation was enforced, proved to the authorities that such protection was necessary (Deacon, 1994).

Segregation by race, linked often to unequal facilities, was also a widespread

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12 It is interesting that there was never a policy in the Cape, as there was in India, of repatriating insane British colonials. In the absence of such a policy, Valkenberg was important as a place in which the British insane could feel “at home.” For a description of Indian practice, see Waltraud Ernst’s (1991) book.

13 House of Assembly (1914, p. 12).
practice. In 1855 an American asylum attendant, Charles H. Nichols, wrote that the “Coloured” insane “should be accommodated in special cottages or lodges situated near the main edifice for whites, but so entirely distinct from it that all desirable separation of the races may be maintained” (quoted in Grob, 1973, p. 247). In India, it was thought to be “altogether impossible” to mix patients of different race, class, or gender (quoted in Ernst, 1991, p. 75). Although both American and Indian colonies purported to see humane treatment for all sufferers as important, in practice the poorer and racially stigmatized patients were forced into overcrowded and badly resourced facilities (Ernst, 1991; Grob, 1994).

Classification of patients, with racial classification being a first priority, was a constant theme of Dodds’s Inspector of Asylums reports. In 1891, commenting on the necessity for Black patients in Old Somerset Hospital to make use of White patients’ lavatories, as no others were available, Dodds said, “These Lunatic wards . . . are altogether unfit for the care and treatment of persons of unsound mind.”14 In 1892 he complained of the failure of Robben Island
to introduce racial classification on the female side. There are three wards or sections, and in all white and coloured are mixed. I feel sure that this is very undesirable, and that it could be very much lessened, if not entirely obviated; and I hope an earnest attempt to do so will be made.15

Concern about racial contact within Cape asylums eased as fully segregated institutions were opened. However, continual policing of the racial boundary performed essential discursive work by rehearsing the need for fine discriminations between “White” (no color) and “color.” Apart from separating White from “Native,” this process sought to insulate Whites from people whose ethnic background was identified in terms of “mixed” blood, despite the impossibility of detecting such difference by physical means. In this way, shadings of color became a complex summary of judgments that only Whites could make, on the basis of class, social standing, language community, and parentage. Thus segregation was increasingly inscribed as the insulation and hence purification of Whites, with those closest to white in color being the target of intense scrutiny.

The consolidation of segregationist policy on the basis of race was justified solely in terms of White patients’ welfare. Being accommodated with Black patients was considered to be offensive to the sensibilities of White patients and their relatives.16 Given a general shortage of accommodation, and the necessity to segregate by race and gender, other forms of classification, such as the separation of noisy patients from those who were quiet or recovering, were seldom achieved.

Foregrounding race and gender as being of primary importance in the spatial organization of patient groups meant deleting class as an appropriate means of patient classification.17 A meeting between the superintendents of all Cape asylums in 1907 arrived at the decision that “it would neither conduce to economy or

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14 Colonial Office Papers, CO 1485, 1891.
15 Colonial Office Papers, CO 1524, June 7, 1892.
16 Colonial Office Papers, HFB 3, April 26, 1907.
17 However, in the colonial context the Black population was underresourced in terms of educational and employment opportunities. This linked race and class, so that segregation on the basis of race often, but not always, mirrored class divisions.
efficiency to associate the better class of Coloured Patients with Europeans; rather it would lead to great dissatisfaction on the part of many of the European patients themselves, and their friends.\textsuperscript{18} The inclusion of “friends” in this comment makes clear the asylum superintendents’ sensitivity to the public image of their establishments. Provision was made for both White male and female private patients, who for a fee were accommodated in small, prettily decorated wards; were given private bedrooms; and were fed a more liberal and varied diet than the majority of patients.

Concern about classification was not confined to the insane: There was also anxiety about staff. Male and female staff were strictly separated in both work and off-duty spaces, including recreational space, such as drawing rooms. Black staff, who in the early years were all servants, were also separated from White staff. Although Valkenberg was created for White patients only, a section was opened for Black patients in 1916. It was situated on the site of an old plague camp called Uitvlugt and was geographically separated from “White” Valkenberg by a small river. Segregation of the two sections was rigidly enforced.

It is not surprising that the segregated structures appearing at the end of the 19th century showed a clear pattern of discriminatory treatment of both patients and staff. At Fort Beaufort Mental Hospital, which was for Blacks only, the annual cost per head was £32.1.1, whereas at Valkenberg, which was for Whites only, the annual cost per head was £42.6.0 (Swartz, 1995). By 1919, 3.7 pennies were being spent daily on Valkenberg patient maintenance, compared to the 2.5 pennies spent at Fort Beaufort. Similar discrepancies emerged for diet scales as well. Male staff earned more than female staff, and Whites earned more than Blacks. What was interesting was that no justification of this was deemed necessary—presumably because it was thought to be transparently obvious.

Part of the dangers of contact between Blacks and Whites related to the perceived danger that Black men posed to White women. This sprang from the stereotype of Black men as sexually overactive and powerful. The Attorney General of South Africa, addressing Parliament in 1902, commented:

\begin{quote}
This is a matter of the gravest importance, for once the barriers were broken down between the European and native races in this country, there was no limit to the terrible dangers to which women could be submitted, particularly in isolated places. (Hallett, 1979)
\end{quote}

Although a perceived necessity to segregate patients by race and gender was primary in the design of Valkenberg’s buildings, Dodds had wished diagnostic categorization, based on the tables of the Medico-Psychological Association of Britain, to be taken into account. A variety of classification systems, all of which segregated patients by gender, were developed in British asylums in the second half of the 19th century (Grob, 1973, p. 225). These included classification of patients into groups according to the “hopefulness” of the case, measured by the length of time the person had been insane and the number of attacks he or she had suffered. The degree to which they were quiet or noisy, violent or tractable, also affected classification. Social class, frequently determined by ability to pay for

\textsuperscript{18} Colonial Office Papers, HFB 3, April 26, 1907.
treatment, was part of the classificatory system. The grouping of patients similar in social class and degree of disturbance was thought to remove "causes of irritation" that might exacerbate the insanity (Noble, quoted in Skultans, 1975, p. 145). Grob (1994, p. 86) argued that this separation in terms of class reflected "the widespread belief that patients should not be forced to associate with those who made them uncomfortable."

Dodds used the need for patient classification in his appeal for funds. In 1892 he stated that the condition of the buildings made such classifications impossible:

> It is quite impossible for me to classify the patients. Instead of having separate wards for the sick, feeble, and dying, for recent cases, for convalescent and quiet cases, for epileptics, for dementias and cases of degraded habits, and so on, each of them specially designed for the class of cases that occupy it, we have but two wards on each side, and these are not separated from each other as they should be, so that all the different classes are more or less associated with one another.\(^\text{19}\)

Despite the stated intention to house different types of patients in separate accommodation, this was undermined by the lack of accommodation. In the first 20 years of Valkenberg's existence lack of funding and overcrowding put paid to that. In 1896, for example, the ward built for female convalescent cases could not be reserved for these patients alone. Note, however, that it was this category that broke down—not race or gender.

**Space, Labor, and Confinement**

Valkenberg had extensive grounds, and the uses to which outdoor spaces were put became integral to the identities of both staff and patients. The asylum was set up as a model of effective treatment for early and curable cases of insanity. Treatment consisted primarily of regular remedial occupation in pleasant surroundings. The management rules for staff stated that "endeavours should constantly be made to occupy the minds of the patients, to induce them to take exercise in the open air, and to promote cheerfulness and happiness among them."\(^\text{20}\) The asylum had a thriving farm, with a dairy herd, pigs, and an extensive vegetable garden. This, and the workshops, provided many opportunities to employ male patients in labor intended to distract them from their mental affliction. The extensive space enjoyed by many male patients, as they attended to farming or gardening tasks, differed strikingly from the smaller, more confined spaces within which the female patients sought remedial activity. Women worked indoors, doing needlework, or helping in the steam laundry or kitchen. This gendered structuring of available space mirrored conditions for colonists outside the asylum. White women in towns and cities were discouraged from roaming far from "safe" domestic spaces (Swaisland, 1993).

Recreational activities included dances, concerts, amateur theatrical productions, magic lantern entertainment, conjuring, football, cricket, tennis, croquet, avenue teas, drives, and visits to town. All of these activities required sizeable spaces, whether indoors or out, and these were provided for in the generous

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\(^{19}\) House of Assembly, G.17-1893:5–6.

\(^{20}\) House of Assembly (1913, p. 2).
proportions of the halls of the administrative building and in the grounds surrounding the buildings (see Figure 1).

Gender was only one determinant of access to the available space in the asylum. Violent, disruptive, or suicidal patients were under strict surveillance and were less likely to be given the freedom of venturing beyond the airing courts. Paying patients were also given more space: Their sitting rooms were less crowded, and they had the possibility of sleeping alone, in private bedrooms. Moreover, White patients had larger spaces, both indoors and out. There were no recreational facilities for Black patients and no private bedrooms for them other than the single cells used for dangerous or destructive patients. Such cells, which were part of every ward, in the Black and White sections of the asylum, were not private: They had observation windows built into the doors, and the occupants were regularly under the gaze of attendants.

Racial classification also affected the use of workspace. Whereas White patients readily engaged in “remedial occupation,” discursively constructed as healthy and congenial work in harmonious surroundings, Black patients were used as an unpaid source of labor. Black men were used to clear ground and to build roads, to muck out barns and sites, and to undertake the heavier physical tasks in the workshops. Skilled work and less demanding, cleaner farming chores were reserved for White male patients. Black women worked daily in the laundry and supplied domestic labor for the wards and kitchens. Although White patients were strongly encouraged to engage in some sort of occupation, they were not forced to do so; Black patients were given no option but to work. Thus, although Black and White patients frequently shared physical spaces, the work they undertook was differently constructed. What was a form of freedom for White patients, through access to large spaces, was for Black patients simply another form of confinement.

No attempt was made to disguise this racialized use of space in the colony’s asylum system. In 1908 Grahamstown Asylum was on its way to becoming a Whites-only facility. The medical superintendent, Dr. Cowper, while stating that “this is a very desirable thing,” remarked that

one is bound to confess that the labour forthcoming from the Native patients will be sadly missed on the farm, in the kitchen and in the laundry. With a view to compensating for this loss an attempt has been made to induce more European patients to work, but so far with but moderate success.\(^{21}\)

Cowper wrote in 1918 that “the withdrawal of the native labour supply was rather severely felt” (see footnote 21). In Valkenberg, the admission criteria for Black patients reinforced this pattern: Numerous case records suggest that Black patients were admitted only if they were quiet and relatively self-contained—and therefore likely to work well. By regarding Blacks primarily as an unpaid menial labor force, attention was drawn away from their insanity and need for care. Thus the Black inmates of Uitvlugt were like servants, and in this disguise their occasional contact with European patients reproduced the pattern of contact between Blacks and Whites in society at large.

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Intimate Space

Concern with cleanliness, both of the buildings themselves and of patients’ bodies, is a constant feature of the annual reports, reports of official visitors, and case records. Cleanliness is a physical embodiment of order, and Dodds made clear that he regarded men and women “clean in habit” as suitable for admission to Valkenberg. This criterion applied to the first admissions to the asylum in 1891 and again with the admission of the first Black patients in 1916. In the asylum context, “dirty” or “faulty” habits referred to incontinence of urine or feces, poor table manners, slovenly dressing, and masturbation, an activity that was thought to exacerbate symptoms of insanity. For White patients, clean habits were an indication of relatively good prognosis, or progress toward recovery. For Black patients cleanliness was a sign that they would be a trouble-free source of labor. “Clean” Whites maintained their position at the head of the racial hierarchy, free from impurities of blood and the mark of degeneration. It is ironic that it was clean Black bodies that constantly serviced this racialized status quo.

Like prisons, asylums were designed with the possibility of constant surveillance in mind. As Foucault (1979) pointed out, the panopticon model was designed to instill in prison inmates the sense that they may come under the critical and corrective gaze of warders at any time. Such a gaze was not only beyond their control but at times also outside of their awareness. The result was the birth of inner surveillance, a subjective vigilance against being “caught unawares.” Nineteenth-century asylums, of which Valkenberg is an excellent example, were no different. Patients were watched by attendants, often through observation hatches that allowed them to see everything while remaining largely unobserved themselves. Lack of intimate space in asylums had a number of implications.

Just as being criminal robbed prison inmates of the freedoms of privacy, so madness robbed lunatics of their right to intimate space. It was, however, discursively constructed as care rather than punishment. Lunatics did not have doors on toilet stalls or pails because they might use the privacy to harm themselves or others. Moreover, the “faulty” habits of some lunatics meant that they required constant supervision (see Figure 3). They bathed in the presence of ward attendants because they might attempt to drown themselves, wet their clothes, or play with the water. They slept in the presence of other patients under the watchful eye of attendants. Even those locked into single cells, because of their disruptive behavior, were regularly checked. During the day, they were never out of the company of patients and staff. It was only as patients began to recover their mental equilibrium that possibility of access to intimate space improved. In the block for convalescent and paying patients, for example, toilets had doors.

Staff expectations of patients’ behavior were extremely pessimistic, as the following demonstrates:

An attendant may have to submit to receiving the foulest abuse, to be spat upon, and have urine thrown in his face. He has to attend to patients of insanely dirty
Figure 3. First-floor plan of a typical patient ward, illustrating the lack of privacy in open dormitories and the provision for the surveillance of patients.
habits, who may smear themselves and their rooms with filth, and who, for months, may need to be washed and attended to like napkinned infants.\textsuperscript{22}

Lack of intimate space in prisons was primarily about undisciplined, violent behavior and punishment, both physical and moral. In asylums, patients were treated as children whose access to intimate spaces was barred because they could not be trusted to maintain adult standards of cleanliness and muted sexuality. Paradoxically, however, it was the lack of private space in the asylum’s wards that worked against the possibility of patients behaving with adult discretion with respect to intimate habits. In this way, the asylum’s architecture reflected the expectation that patients would in some respects behave like “napkinned infants” because of their “insanely dirty habits.” It also made it difficult for them to keep their “dirtiness” hidden from the ever-vigilant staff.

This had implications for staff as well as patients. The General Asylum Regulations of 1892 state the following:

Patients often entail on the attendants most unpleasant duties, but by regular and persevering attention, very great improvement can be effected in their habits, just as in the case of children; so much so that it is in the interest of the attendants, as well as their duty, to bestow the utmost pains on such cases.\textsuperscript{23}

Dodds makes it clear in his inspector’s reports that wet and dirty patients reflect badly on the habits of attendants. He gave instructions that patients were to be toileted frequently, if they tended to soil themselves, and also to be raised at night. He commented with approval on wards that showed improvement in the numbers of patients who stayed dry at night.\textsuperscript{24}

Professional Space

It was not only mental patients who lacked privacy in asylum settings. There was some variation according to rank and gender but, on the whole, nurses and attendants also had access to very little private space. When off duty, they slept on the grounds, in accommodation built close to the wards in case they should be needed urgently. Only the matron and the head attendant had suites of rooms, which were to be found in the same buildings that accommodated administrative offices on the ground floor; subordinate staff were in single bedrooms. Dining rooms for staff were segregated by race and gender. Apart from this, all staff were expected to eat together in a series of dining rooms, segregated by race and occupation. The nursing staff was thus separated from servants. Access to outside space was also strictly monitored. Off-duty staff were forbidden to “walk or stroll about the institution grounds.”\textsuperscript{25} No staff were allowed to marry without permission, and women were obliged to resign when they got married. Only married male staff were eligible to apply for cottage accommodation on the grounds.

\textsuperscript{22} Dodds’s letter is dated January 1903, and the petition is dated December 20, 1904; Colonial Office Papers, CO 7918.
\textsuperscript{23} House of Assembly (1892, p. 4).
\textsuperscript{24} An example is the comments made on Old Somerset Hospital’s management of incontinent lunatics in May 1890 (Colonial Office Papers, CO 1524).
\textsuperscript{25} House of Assembly (1913, p. 45).
Leave could be summarily canceled by the superintendent in order to meet the needs of the institution.

On duty, only the superintendent, matron, head attendant, and charge nurses had relatively private office space. The superintendent was assigned an examination room, a surgery, and an administrative office. Nurses or attendants shared the office space attached to wards, rooms in which all administrative tasks were undertaken. These rooms also provided interview space during visits to the wards by the doctor on duty. When sleeping on the ward, nurses and attendants were in rooms that allowed for observation of sleeping patients. During the course of the day, staff not only cleaned, bathed, dressed, and fed patients but they also were expected to play games with them, take them for walks, and to be dance partners when balls were held.

Lack of private professional space in which “treatment” could take place was a striking feature of Valkenberg. There are a number of reasons for its absence. Apart from providing homey custodial surroundings, very little could be done for the insane. There was no perceived need for private space within which patients and doctors could talk. A limited initial enquiry into the history of the insane episode provided sufficient information to arrive at a diagnosis and formulate a hypothesis about the etiology of the disorder. Further reports on the patients were derived from nurses’ accounts of ward behavior and, on occasion, brief interviews, conducted in the office space attached to the wards. Moreover, the course of “treatment” offered by the asylum was underpinned by an ideology of moral re-education and diligent occupation, neither of which demanded private professional space. On the contrary, the model guiding Valkenberg’s use of space was the family home, in which parents and children lived and worked together.

Conclusion

This article is about the arrangement of space and what it may mean. For a start, our sources indicated an acceptance of a specialized space for the care and confinement of the mad, separate from other categories of dependent people, as we indicated in the beginning of the article. As a British colony, developments in this regard in South Africa were extensions of changes in Britain during the 19th century. This was to be expected, and British doctors and psychiatrists, as well as British architects, were the major actors in the construction of Valkenberg Asylum as a colonial showpiece.

The design of Valkenberg Asylum indeed reflected the best features of the designs then available to architects. It was located just outside a populated urban area, with relatively easy access for visitors to the institution and residents to the outside world. Overall, the buildings were placed according to a dispersed pavilion plan, accepted at the time as an efficient design for asylums. It had an aesthetically pleasing setting in the countryside. It contained ample recreational and work facilities, the latter contributing to its near self-sufficiency in agricultural products. In addition, the buildings themselves were generously proportioned, designed for specific functions.

Humane concerns certainly played a part in the decision to build this facility; the conditions in the “undifferentiated spaces” of Robben Island and Old Somerset Hospital were unacceptable to the colonial government and medical frater-
nity alike. However, there clearly were larger forces at work, which we did not specifically address. For one, the construction of Valkenberg formed part of the modernization of South African asylums and legislation dealing with the mad. This speaks directly to the expansion of state regulation of these matters (Foucault, 1965; Scull, 1993). Furthermore, it was a vehicle to demonstrate professional success for a number of medical doctors, thereby increasing their acceptance as the appropriate professionals to deal with the mad (Rothman, 1971). It is useful in this debate to attempt a separation of causes from effects. In the developments described in this article administrators, doctors, and architects, when they built asylums, clearly had in mind not only containment of the insane but also “treatment” (of a kind) that was represented popularly as “humane.” But the effects of being in large institutions organized around routines were absolutely controlling, as any large institution is. There was no other way of managing large numbers of extremely unruly people.

We have argued, following authors such as Grob (1994), Donnelly (1983), and Saris (1996), that asylum buildings and their surroundings had to create a sense of order. Spatial order clearly reflected significant aspects of the social order in the Cape Colony: race relationships, gender relationships, and the interaction of large numbers of the stigmatized insane people with each other and with their keepers. Unregulated conduct across these social categories posed a threat to the social order, and the asylum itself, its design and its surroundings, had to establish a pattern of contact that reduced the perceived threats. Furthermore, the building and its surroundings had to assist in the treatment of the mad. Indeed, what treatment there was consisted of little more than remedial occupation in pleasant surroundings, as we indicated. Space had to be ordered in a certain way to manage that treatment delivery.

The institution also had to be well ordered in terms of its day-to-day functioning and management, as an indispensable part of a more humane treatment of the insane. Thus, patients had to be classified and housed accordingly; segregation in terms of sex, race, and class had to be effected and monitored; surveillance of all residents had to be maintained efficiently; recreation and work activities had to carry on; and so on. These activities required their expression in a spatial arrangement.

All of this presented architects of asylums in the late 19th century, and the staff who ran them, with a number of paradoxical tasks. They had to tread a fine line between freedom and confinement, domesticity and institutionalism, recreation and labor, and treatment and simple incarceration. They were required to accommodate large numbers of people and yet invoke a sense of hominess and family. They had to encourage adult responsibility in the face of childish dependence and manage able-bodied men and women as if they were ill and in need of nursing care. Often, the experience of space as one, rather than the other, of these opposing elements lay less in the structures of the buildings than in the way they were discursively constructed.

These paradoxical requirements were made even more difficult in the Cape colonial setting. For White patients and their relatives to feel “at home” with the asylum, Africa itself had to be shut away. Moreover, White patients and staff needed to be positioned as different from, and better than, their Black counterparts.
As the history of the county asylums in Britain has shown, the sheer weight of patient numbers turned them into storage space for chronically incapacitated men and women with little hope of ever returning to their homes and families. What started off as a need to express order in the building itself, in its landscape, and in its management, turned into little more than control, where “patients lived in an atmosphere in which personal liberty was constrained and behavior regulated” (Grob, 1994, p. 82). The increase in numbers of patients, and the corresponding increase in the size of the asylum buildings, played their part in creating a large, completely dependent, institutionalized population of insane people. Large wards and day rooms took the place of smaller, more homey spaces, and opportunities for meaningful occupation and exercise became increasingly hard to find. The social organization of the asylum had to become more rigid and coercive to maintain order and rationality. This negated the principle that the building and its environment act as essential tools in the recovery of the mad. Treatment was reduced to little more than custody, containment, and an orderly regime.

In importing a British model for the construction of asylums, the Colonial Office in the Cape imported some of its problems. As this article demonstrates, the buildings of Valkenberg obviated against patients experiencing themselves as adults who had an important role to play in their own recovery. However, the colonial context had a major impact on the human drama playing itself out within its confines. It is ironic that the importance of Black patients as a source of labor was a significant factor in maintaining their ability to be productive and in shoring them up against the devastating effects of long-term incarceration. Moreover, their exploitation as a source of labor made it possible for White patients to enjoy the benefits of living, as far as their insanity would allow, as a privileged class, surrounded by tamed countryside and replete with recreational opportunities.

References


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