The influence of moral therapy on the landscape design of lunatic asylums built in the nineteenth century

Rory du Plessis*

* Rory du Plessis is a lecturer in Visual Culture Studies in the Department of Visual Arts at the University of Pretoria.

Abstract

There is a need to diminish the dominance of the panopticon as a model for investigating the design of nineteenth-century lunatic asylums. In particular, this need is justified by a number of theorists who argue that the 'panopticon principles' of observation and seclusion were not significant tenets of asylum design and visual culture. Instead, there was an emphasis on deliberately overcoming such aspects in favour of bringing patients together in large open spaces and using non-prison-like architecture. Such ideals and design features are hallmarks of moral therapy that postulate the curative potential of the asylum through the placement of patients in a carefully designed environment. Consequently, the landscaping of an asylum's external environment was paramount in ensuring therapeutic possibilities. This importance was expressed through a number of design features that nearly all asylum landscapes contained. The author aims primarily to identify such design features by discussing renowned international exemplars of moral therapy. Following from this identification, a secondary aim is to examine the influence of moral therapy in several South African asylums.

Introduction

In reviewing the historical records of South African lunatic asylums during the nineteenth century¹ it is striking how they include aspects pertaining to the picturesque, to pleasing landscapes, vistas and verandas. In these accounts, landscape and asylum design are not footnotes embedded in an asylum's annual reports, surmounted by a corpus of medical and surgical notes. Rather, the accounts are fundamental to the institution – its therapeutics, ethos and design. For example, at Weskoppies (an asylum in Pretoria) the official description in 1895 was 'a beautiful building very healthily situated, with large gardens and cultivated fields' (in Plug and Roos 1992:219). Weskoppies, in common with other asylums

reviewed, shared a belief in the curative potential of the asylum – a possibility forged in its architecture and landscape design. Such therapeutic aims, and the curative potential of the asylum, are expressions of moral therapy.

The above insights underscore the aim of this article, which is to examine the influence of moral therapy on the landscape design of a number of South African asylums built in the nineteenth century. In order to do so, the author proceeds to outline moral therapy as pivoting along the central tenet of the asylum as curative, and to show how this possibility is connected to the design and use of the landscape. Furthermore, a discussion follows of international asylums that are emblematic of the design of therapeutic landscapes. Lastly, after identifying the key characteristics of asylums that are representative of therapeutic landscapes, some South African asylums that share similar features are discussed. Such ensuing discussions offer an alternative to the panopticon as the dominant model for asylum design, which has been erroneously based on the work of Michel Foucault. In order to address this misreading of Foucault and to diminish the panopticon as a model for asylum design, the article commences by examining Foucault's asylum research.

Foucault and the asylum

The study of the asylum received a powerful stimulus from Foucault's *Madness and civilization* of 1967 (Melling 1999:1, 18; Scull 1993:5), so much so that a number of scholars date the commencement of the detailed investigation of asylums from the publication of Foucault's text (see Melling 1999).² Yet many of these subsequent investigations demonstrate an uncritical and generalised reading of Foucault, one hallmark of which is the panopticon being credited as the leading scholarly model for analysing asylum design (see Philo 1989). Consequently, studies in the visual culture of asylums are overplayed by notions that the asylum bears similarities to the design of the panopticon. Yet such a model is at odds with, first, Foucault's distinction between the panopticon and panopticism, and second, with recorded history. It is precisely these two aspects that are outlined further, in order to diminish the dominance of the

panopticon as a model for nineteenth-century asylum design.

Foucault's distinction between the panopticon and panopticism

The panopticon was originally conceived by Jeremy Bentham in 1791 as a type of building design which allows an individual to observe others, without the observed being able to tell whether they are being watched or not (Foucault 1991:201). Thus, it is a spatial arrangement that, from the point of view of the guardian or the observer, allows the multitudes to be numbered and supervised; from the point of view of the inmates or the observed, they are detained in solitude and are relentless scrutinised (Foucault 1991:201). Foucault's interest is not in the panopticon (the actual building design) but in how it provides a model for modern societies in their pervasive inclination for surveillance (Foucault 1991:217). In order to connote the latter meaning, Foucault uses the term 'panopticism' to define precisely this movement in modern society towards more generalised surveillance and, consequently, refers to how it contributes to aspects pertaining to discipline (Foucault 1991:209). Therefore, one needs to make a distinction between Jeremy Bentham's panopticon as a penal building and Foucault's panopticism, with its reference to surveillance and discipline. For Foucault (1991:215–216), discipline is identified neither with

an institution nor with an apparatus; it is a type of power, a modality for its exercise, comprising a whole set of instruments, techniques, procedures, levels of application, targets; it is a 'physics' or an 'anatomy' of power, a technology. And it may be taken over either by 'specialized' institutions (the penitentiaries or 'houses of correction' of the nineteenth century), or by institutions that use it as an essential instrument for a particular end (schools, hospitals), or by pre-existing authorities that find in it a means of reinforcing or reorganizing their internal mechanisms of power; ... or by apparatuses that have made discipline their principle of internal functioning, ... or finally by state apparatuses whose major, if not exclusive, function, is to assure that discipline reigns over society as a whole (the police).

From the above, it is discernible that in Foucault's references to institutions he does not elucidate the precise architecture or spatial arrangements that these institutions were to display (Philo 1989:283–284), but focuses on the 'disciplinary techniques' conducted in them, through which human subjects were observed and surveyed and converted into responsible 'docile bodies' (Philo 1989:264). Such disciplinary techniques include observation, which is not necessarily conducted via the design of a building, but through an accumulation of reports and registers that recorded 'behaviour, attitudes, possibilities, suspicions – a permanent account of individuals' behaviour' (Foucault 1991:214). In cognisance of the above discussion, research pertaining to the asylum needs to be cautious about identifying Foucault's panopticism as resembling or being conceptually reducible to Bentham's panopticon (Caluya 2010:623; Philo 1989:269).

Historical records of asylum design

Philo (1989) is critical of accounts that describe history as full of asylums that reveal 'panopticon' design. To elucidate further, although Philo (1989:266) acknowledges that Bentham's panopticon did exert an influence on the plans and architecture of asylum design, such influences were only expressed as slight similarities to the features of panopticon design; even more significant is the fact that no true panopticon asylums were ever built (Edginton 1997:93; Philo 1989:266). Furthermore, Philo (1989:261) argues that even the 'panopticon principles' of observation and seclusion were not significant tenets of asylum design, as the proposed plans and architecture of asylums did not proceed from isolation and surveillance. Rather, they depended on deliberately overcoming seclusion and observation in favour of bringing patients together in large open spaces and focused on non-prison-like architecture (Philo 1989:282). Such design features are hallmarks of moral therapy, which was so popular that it resulted in panopticon design not being taken up widely (Philo 1989:269).

The asylum's discursive themes

One consequence of scholarly studies mistaking Bentham's panopticon for Foucault's

panopticism is that the architecture, physical layout and environment of asylums become inscribed with the themes and focus of control and inspection. Such misconstruction is not only a misreading of Foucault but, as indicated earlier, is also at odds with the actual history of asylum design that strove, through the ideology of moral therapy, to overcome the very aspects of isolation and surveillance. Thus there is a need for asylum research to highlight moral therapy – in its therapeutic aims and curative potential – as conveyed in the design, architecture, surroundings and layout of the asylum itself. Yet this departure from panopticon design features is not to suggest that Foucauldian panopticism, as a model of a disciplinary programme acting on humans to produce 'docile bodies', was not present in the institutional running of nineteenth-century asylums. In other words, asylums might not be characteristic of the physical space of the panopticon, but the management and programmes at the asylum may reveal panopticism (Walsh, Stevenson, Cutcliffe and Zinck 2008:254). For example, observation through record-keeping and ward reviews can be regarded as part of an asylum's disciplinary programme.

To substantiate further, Foucault (2009:238) identifies a number of structures essential to the nineteenth-century asylum. One such structure is defined as observation and classification. In particular, observation was deployed in the asylum in order to 'spy out any incongruity, any disorder, any awkwardness where madness might betray itself' (Foucault 2009:236). In this regard, observation provided a means to constantly scrutinise the patient in order to reveal the presence and various incidences of mental illness – a continual pursuance of the individual for the signs in which madness becomes distinct from reason (Foucault 2009:236). A second structure named by Foucault is judgement. For Foucault (2009:237), the structure of judgement 'confined madness in a system of rewards and punishments, and included it in the movement of moral consciousness'. This is an important operation, as it encouraged patients to cooperate in becoming docile, to manage their own disagreeable behaviour in order to assure their lack of restrictions and guarantee their rewards. As such, this operation is at odds with modes of discipline that are enacted through physical and overt,

brutal and repressive means. Thus, physical restraint in the asylum is censored in favour of self-restraint (Foucault 2009:237). From the above theorisation, Foucault dismisses patient observation as an element of care and reconstitutes it as a technique of discipline: the structure of observation maintains in the patient an awareness of constantly being monitored, and through judgement instils in the patient the need to regulate his/her own conduct.

Through outlining such disciplinary structures as an essential component of the asylum, Foucault challenges proponents of Whig history who regard moral therapy as humanitarian progress.³ Rather, Foucault deems the therapeutics offered in moral therapy as principally linked to patient self-disciplining (Rutherford 2003:33–34). Although there is no doubt that Foucault provides a valid argument there, he is erroneous in stating that the asylum within moral therapy is primarily repressive. Instead, moral therapy needs to be regarded as 'fundamentally ambiguous' (Scull 1993:8): the humane and benevolent care offered by moral therapy did signify a marked departure from directly brutal means, yet it also came to be a mechanism for inducing conformity (Scull 1993:8). Thus, moral therapy should be placed in a tension between the desire to promote humane treatment versus the advancement of self-discipline in patients (Rutherford 2003:84); a tension between rehabilitation and repression (Scull 1993:379).

Although cognisant of the above tensions between humanitarian care and disciplined subordination in moral therapy, this article seeks to give preference to an exploration into the benevolent side of moral therapy. This preference is warranted by the fact that moral therapy's ethos of humanitarian care and its conviction of the curative powers of the asylum led to distinctive and substantial features in the design of the landscape.

Moral therapy

Generally speaking, in the seventeenth century, the mentally ill were incarcerated in huge state institutions that resembled prisons (Curtis 2004:197; Thompson and Goldin 1975:54). In these institutions, conditions were particularly poor and treatment included chaining the mentally ill to the walls, or keeping them in cages or holes in the ground

(Curtis 2004:197; Yanni 2003:25). However, by the end of the eighteenth century, moral therapy offered an alternative model for treating insanity and spurred the need for asylum reform.⁴

Moral therapy was first pioneered at the end of the eighteenth century at the Retreat in Yorkshire, England (subsequently referred to as the York Retreat). The therapy offered there can briefly be described as a mild regimen focused on placing patients in a carefully designed environment with the minimal use of physical restraint (Hickman 2005:48). Although moral therapy was pioneered at the York Retreat, the term itself, along with the first disciplined study of moral therapy, is attributed to the Frenchman Philippe Pinel (Sachs 1999:239; Sutton 1986:36–37). In particular, Pinel built on the contribution of the York Retreat to coherently communicate the central tenets of moral therapy as a concern with the abolition of all forms of physical punishment and restraint, and to offer patients a regular routine of activities conducted in a restful setting. These routines included farming and gardening, as well as daily outdoor walks. Furthermore, Pinel's book, *A treatise on insanity* (1800), propelled improvements in the treatment and physical environments of the mentally ill (Sachs 1999:239).

From the above discussion, it is important to underscore that moral therapy hinged on two factors: the removal of physical restraint and punishment, and the promotion of active therapy – an understanding that everyone and everything in the patient's environment influenced their mental condition and therefore possessed therapeutic potential (Sutton 1986:35). The emphasis on alleviating mental distress through the therapeutic possibilities of the environment was encapsulated in the term 'moral therapy'. The meaning of 'moral' in the mid-1800s encompassed the mind, emotions and soul that existed independently of the physical body but could be influenced by pleasing sensory and emotional stimuli. In other words, by moral therapy assuming a reciprocal connection between mind and body, it premised that residing in an asylum – which saw the patient being placed in a therapeutic environment – could exert a direct healing influence on the mind (Tomes 1994:xv–xvi).

In sum, moral therapy denoted the conviction that the asylum was curative; a potential that was, in large part, drawn from

the asylum's landscape (Parle 2007:11; Piddock 2007:37–38; Rothman 1971:132; 133; Rutherford 2003:13).⁵ Thus, it was believed that residing in the specifically designed setting of the asylum was responsible for restoring health – not the medicines that might be administered or the surgery that might be performed there (Rothman 1971:133). Although the curative potential of the asylum was attained through the design and use of the asylum's various architectural and landscape features as instruments of recovery (Hawkins 1991:5; Parle 2007:45; Piddock 2007:1), this article only focuses on the landscape and emphasises how it impacts on the design of the asylum building.⁶

Landscapes of the asylum

As already indicated, in moral therapy the asylum grounds and patient occupation therein were fundamental to the treatment of insanity (Hawkins 1991:40; Piddock 2007:39). Consequently, the landscaping of an asylum's external environment was both mandated and extolled. This mandate took shape through a number of design features that nearly all asylum landscapes contained: the asylum was to have a country location with ample grounds; it had to be located on a hillside for unobstructed views of the surrounding landscape; and the scenery ought to be tranquil natural, picturesque and rural (Rothman 1971:138; Yanni 2003:34). Such features ensured that there was abundant space for amusement, exercise and outdoor activities such as gardening and farming (Allderidge 1990:40; Hawkins 1991:42; Parle 2007:45). These very features held therapeutic value in that they aided the patients through exercise (by restoring bodily health), recreation or occupational therapy (intrinsic to working in the gardens), and were central to the reform of the nineteenth-century asylums (Hawkins 1991:38–39; 40; Prandoni and Kanhouwa 2005:8). As such, asylums of that era were laid out with landscaped vistas to provide a therapeutic experience, and the maintenance of the grounds, gardening, and farming became intrinsic components of the therapeutic regimen (Marcus and Barnes 1999:13).⁷ In order to further support the distinctive influence that moral therapy had on the landscape design of asylums, the following section describes several

early asylums in the history of nineteenth-century America and England.

The York Retreat

The York Retreat was founded at the instigation of William Tuke (Pidcock 2007:39), and was directed by Tuke and his son Samuel. In 1813, Samuel Tuke published *A description of The Retreat*, which detailed the operation of the therapeutic system of treatment and the management of the patients' lives and movement at the York Retreat. Amongst others, the treatment stressed the potential capability of patients to recover lost reason through useful labour and recreation in pleasant settings (Hawkins 1991:74). These aspects were captured in the design of the York Retreat's grounds, which allowed for outdoor activities such as gardening, there was an exercise area as well as walking-trails throughout the picturesque setting of wooded glades, gardens and orchards (Digby 1985:43; Edginton 1997:94; Hawkins 1991:74; Pidcock 2007:40; Sachs 1999:238).⁸ The retreat was located on an elevated site of 11 acres – later extended to 27 acres in 1839 – in the rural countryside (Digby 1985:37; 43; Hawkins 1991:74; Pidcock 2007:53; Thompson and Goldin 1975:72). Besides the grounds offering patients opportunities for both labour and recreation, their visual stimulus alone was believed to favourably impress patients' minds: the tranquil setting made it possible for patients to regain their serenity (Digby 1985:43).⁹ This belief, that the mere act of viewing the landscape could have a positive effect on a patient's mental state, was so influential that it even informed the architecture of the asylum – the design of the building allowed patients to see the outdoors from inside (Hawkins 1991:74; Hickman 2005:48; Hickman 2009:429; Sachs 1999:238).¹⁰

Not only is the York Retreat credited with sparking the ideas associated with moral therapy, but following the publication of Tuke's *A description of The Retreat* (1813), it became the most influential model for the design of reformed asylums in England, the United States of America and many other countries (Edginton 1997:92; Hawkins 1991:74; Rutherford 2003:82; 376; Sachs 1999:238; Thompson and Goldin 1975:71). This influence is evident in the reformed asylums built during the early and mid-1800s, which had grounds designed

in the English landscape style (rolling hills, groves of trees, and pathways) and emphasised the location (pleasant, rural surroundings), to afford patients a closer link to nature (Edginton 1997:94; Sachs 1999:242).¹¹ Thus, the York Retreat was the primary English pioneer of the therapeutic use of the landscape, and in the nineteenth century it also became the most renowned exemplar of this notion (Rutherford 2003:84). Its ground-breaking approach was not only in terms of the architecture and landscape, but also in understanding how these forms were conceptualised as therapeutic instruments: the patients' interaction with and use of the landscape as a therapeutic component in the treatment of mental illness (Edginton 1997:94; 98). The precise influence of the York Retreat, as evident in the design of asylum landscapes in both the United Kingdom and the United States, is outlined below.

United Kingdom

Following the appearance of Tuke's *A description of The Retreat* in 1813, a number of works followed that dealt with the role of the physical arrangement of the asylum as part of curing insanity (Pidcock 2007:52). In particular, these works, which appeared throughout the nineteenth century, described all facets of asylum design and how specific features supported such curing (Pidcock 2007:19–20). In England, John Conolly wrote *The construction and government of lunatic asylums and hospitals for the insane* (1847), in which he called for a change in prevailing asylum design and management practices. His recommendations included the fact that the landscape of the asylum should have some form of scenery (Pidcock 2007:57; 62–63) and that the property should be surrounded by gardens or a farm (Sachs 1999:239–240).

William Alexander Francis Browne was a Scottish lunacy reformer who was just as prominent as his English counterpart, John Conolly (Scull 1991:vii). In his book, *What asylums were, are, and ought to be* (1837), Browne (1991:183) affirmed that an asylum 'ought to be constructed with a direct reference to the comfort and the cure of the inmates'. The location of the asylum buildings was a key factor in contributing to the 'cure of insanity, and to the enjoyment of those under treatment' (Browne 1991:182). As such, Browne (1991:181) articulated a number of

requisites for an asylum's appropriate location, declaring that the site was to be 'healthy, [and] that it should possess the advantage of a dry cultivated soil and an ample supply of water, that it should be so far in the country as to have an unpolluted atmosphere, a retired and peaceful neighbourhood'. Furthermore, Browne (1991:182) believed that if the asylum's buildings were 'placed upon the summit or the slope of a rising ground, the advantages are incalculable'. One advantage was that patients could easily be induced to exercise, and benefits could be reaped through a varied landscape in which 'the necessity for exertion and the exhilaration which attends it are greater' (Browne 1991:182). In other words, undulating grounds hold the potential, by providing patients with interesting and delightful views, to influence them to take part in outdoor exercise and thus reap the associated benefits (Rutherford 2003:175). Browne also made provision for landscape features within the design of the asylum buildings through the use of airing courts – walled areas adjoining buildings. For Browne (1991:190–191), the airing grounds

should be planted, have a fountain; a portion of ground prepared as a bowling green; they should be stocked with sheep, hares, a monkey, or some other domestic or social animals. ... the centre should be raised as a mound or terrace, so high only as will give a wide and animated horizon but so low as will prevent any intercourse taking place with the inhabitants in the immediate neighbourhood. The patients are thus, in a certain sense, restored to the world while reaping all the benefits of seclusion. They have an immense number of new and pleasing and yet unexciting impressions conveyed to their minds, all calculated to suggest healthy trains of thought, all foreign to their morbid feelings ...

From the quote it is evident that by following Browne's design considerations, patients were offered activity, privacy, interaction with animals, and exercise.¹² Moreover, the landscape offers the therapeutic potential of proposing affirmative thoughts and restoration to the community – aspects aligned to the curative aim of moral therapy. Yet, Browne was not merely content with making modifications to asylum and landscape design, rather he actively sought to engage patients in outdoor

occupations and employment. He accomplished this vocational interaction through the addition of gardens and farms to the asylum, which were 'cultivated by or under the direction of the lunatics' (Browne 1991:193). In doing so, Browne (1991:192) hoped the patients would begin 'to associate the pleasures which the beauty of nature affords with the ordinary and obligatory occupations of life'.

From the contributions outlined here, along with others not referred to, many newly built asylums provided open spaces for exercise and recreation, as well as for gardening and agriculture. These elements (and their provision) were so crucial in the treatment of insanity that a pamphlet issued in 1870 by the British Commissioners in Lunacy stated that there should be at least one acre for every four patients to allow for agricultural employment, exercise and recreation (Sachs 1999:239–240).

United States of America

The preceding discussions endorse Yanni's (2003:34) contention that the landscape of the asylum has to be identified as an essential component in the treatment of insanity. This belief is clearly expressed in a number of nineteenth-century asylums in the United States. For example, the grounds of St. Elizabeth's Hospital were lush and landscaped – there was a wealth of gardens, expansive lawns, fountains, ponds and graded walks (Prandoni and Kanhouwa 2005:6). The Vermont Asylum boasted a cultivated meadow, with picturesque scenery (Hawkins 1991:44). The Bloomingdale Asylum in New York City was modelled on the York Retreat. This is most apparent in the asylum being located on elevated land which commanded an extensive view of the surrounding countryside (Hawkins 1991:83–84). Yet, to fully explore the importance of the landscape, some discussion must be dedicated to the physician and asylum superintendent, Thomas Story Kirkbride. The leading advocate of moral therapy in the United States, Kirkbride dictated much of asylum design in the early and mid-1800s in the United States; these very designs bore similarities to the York Retreat (Sachs 1999:240–241; Tomes 1994:6).

Kirkbride set out to make the Pennsylvania Hospital for the Insane a leading example of an asylum where moral therapy, architecture

and landscape formed an integral therapeutic whole (Hawkins 1991:104). In its location (elevated position and visual appropriation of the surrounding countryside) it embodied the influence of the York Retreat (Hawkins 1991:111). The hospital was watered by several springs and a stream, and the property consisted of gently undulating meadows, interspersed with groves of forest trees. Yet, in recognising the potential for the landscaping of the grounds, Kirkbride initiated a yearly programme of improvements. Commencing with the laying of paths, he continued with the placement of ornamental summer houses and rustic benches – all of which were located in particularly pleasant locations. The planting of flower beds and borders, improvements to the stream banks and fish pond, the addition of an enclosed deer park, and regular planting of trees and shrubs followed (Hawkins 1991:105).

Kirkbride led the design of asylums by defining and standardising the landscape design in all mental asylums in the United States (Hawkins 1991:138–139). One way in which he did this, was through a number of publications. In 1847, he published an article which was later issued as a pamphlet outlining his general guidelines for the location and construction of asylums. In terms of the guidelines pertaining to the landscape, Kirkbride specified that asylums should always be located in the country, in a healthy and fertile district; and that the surrounding scenery should be aesthetically pleasing and contain features to attract the interest of the patients (Hawkins 1991:138–139; Tomes 1994:141). In 1849, Kirkbride was asked to prepare a series of resolutions codifying the design tenets of asylums for the Association of Medical Superintendents of American Institutions for the Insane (AMSAI). Of interest are the propositions pertaining to the landscape, which included that asylums should always be located in the countryside; and that each asylum should have at least a hundred acres of land, or half an acre per patient. Of this amount, no fewer than fifty acres had to be given over to gardens and pleasure grounds for patients (Hawkins 1991:142–144; Sachs 1999:240–241). By the end of the nineteenth century, asylums had been built according to these propositions in some twenty-eight states, and the general consensus was that landscaping should be done to make the grounds as

beautiful and attractive as possible (Hawkins 1991:142–144). Apart from the scenic setting, asylums that followed Kirkbride's tenets were also characterised by their thriving agricultural operations (Ziff 2012:143). The importance Kirkbride allocated to agricultural operations is identified in his 1854 treatise, *On the construction, organization and general arrangements of hospitals for the insane*. In this treatise, Kirkbride (1854:7) notes that agricultural operations not only had to provide provisions for the asylum, but that they had to also offer an appropriate means of exercise, labour and occupation for patients. These very activities were an important means of treatment:

Regular moderate labor in the open fields or in the garden contributes most essentially to their comfort, and tends to promote their recovery. Labor, then, is one of our best remedies; it is as useful in improving the health of the insane, as in maintaining that of the sane. It is one of the best anodynes for the nervous, it composes the restless and excited, promotes a good appetite and a comfortable digestion, and gives sound and refreshing sleep to many who would without it pass wakeful nights. (Kirkbride 1854:62)

Through the publications outlined above, Kirkbride came to be acknowledged as the leading American authority on asylum construction and design (Tomes 1994:6). The asylums that followed Kirkbride's designs can be described as 'a visual and architectural record of nineteenth-century psychiatry's tenets' (Ziff 2012:8) in that they underscored that mental illness was curable through the physical setting and the occupations offered at the asylum.

South African asylums of the nineteenth century

The scope and influence of moral therapy became fully realised from the first decades of the nineteenth century, in which the Western world shared a belief in the curative potential of the asylum through its landscape design (Parle 2007:50). One means through which asylum administrators sought to achieve this aim was through the therapeutic benefits of various landscape features as instruments in

recovery. By following on from the discussion on the central characteristics of the landscape design of asylums internationally, this section examines asylum grounds in nineteenth-century South Africa as comparable to similar design elements and therapeutic potential found in the international context.

In the nineteenth century, the asylums in South Africa included Weskoppies (1892)¹³ in the Zuid Afrikaansche Republiek; *Staatshospitaal en Krankzinnigen Gesticht* (1884) in the Orange Free State; Town Hill Hospital (1880)¹⁴ in the Colony of Natal; and Fort England Asylum (1875),¹⁵ Port Alfred Asylum (1889), Fort Beaufort (1894), Robben Island Infirmary (1846) and Valkenburg Asylum (1891) in the Cape Colony. Many of the doctors working in these asylums were recruited from Europe and brought with them the management strategies and philosophies that guided their treatment of patients, namely moral therapy and non-restraint, which were in keeping with the most advanced reformed institutions in Europe and the United States (see Burrows 1958:291; Deacon 1996:291; Minde 1975b:368; Parle 2007:16; Plug and Roos 1992:218–219; Swanson 1994:8; Swartz 1996:7).

The bases and precedents of such an internationally disseminated moral therapy and its theory and practice in South Africa have been explored by a number of authors (see Deacon 1996:288; Deacon 1999:108–109; Deacon 2003:22; Minde 1974a:1629; Parle 2007:42–46; Plug and Roos 1992:221; Swanson 1994:71; Swartz 1996:27–28). Although a key focus of these authors is on the asylum and its curative technique of moral therapy,¹⁶ most references to the landscape design of the asylum are limited to either adjunct or mere descriptive accounts. Thus, the central aim of the following discussion is to offer an appraisal of such sources in order to forefront the landscape references as, firstly, a pervasive aspect of South African asylum design and, secondly, to indicate its relation to the therapeutic aims of an institution.¹⁷

Weskoppies had its origins in 1889 when it was decided to build an institution for the mentally ill in the former Botanical Gardens in the west of Pretoria (Meiring 1980:16). The site was considered a suitable location as it was peaceful, beautiful and serene – aspects of the landscape intimately associated with therapeutic potential and the values of moral

therapy.¹⁸ These landscape characteristics were also vigorously cultivated through the planting of 500 trees during the first year alone (Plug and Roos 1992:219). Furthermore, in 1893 a 2.5 hectare vegetable garden was laid out (Plug and Roos 1992:219) that directly formed part of the asylum's vocational activities – the tending and maintaining of the garden (Burrows 1958:290). Such activities were considered part of effective treatment on the assumption that they made constructive use of a patient's mental faculties (Plug and Roos 1992:219). The breadth of these stipulated interventions was so successful that a synonymy between the landscape design and its associated therapeutic potential became the official account of the asylum in 1895: 'a beautiful building very healthily situated, with large gardens and cultivated fields' (in Plug and Roos 1992:219). Remarkably, the emphasis on landscape design was actively pursued well into the early decades of the twentieth century, with approximately 2 000 trees and a luxuriant garden being planted. Such continued emphasis on landscaping led to the transformation of Weskoppies into a lush retreat (Edgar and Sapire 2000:64).

In the Colony of Natal, Town Hill Hospital was southern Africa's first asylum to be specifically commissioned and constructed for the accommodation of the insane (Parle 2007:4). The hospital's explicit relation to moral therapy followed from the appointment of Dr James Hyslop in 1882 as a full-time resident surgeon (Minde 1975a:323). Throughout his tenure he adhered to the principles of moral therapy as instituted by Scottish luminaries such as W.A.F. Browne, who commended patient occupation within an environment that was spacious, light, elevated and surrounded by extensive and prominent grounds and gardens. These ideals were realised under Hyslop's management (Parle 2007:45–46). Starting in 1883, he proceeded to develop the grounds by planting over 2 000 trees (Minde 1975a:323; Parle 2007:97). More trees were planted over the years and were supplied at first from the Botanic Society but later, from 1888, Hyslop started his own nursery for the development of the grounds (Minde 1975a:323). The improvements to the grounds were aided by the fact that Hyslop was a passionate landscape gardener, and closely followed Browne's recommendation for the value of patient occupation in the treatment of

insanity (Parle 2007:96). Through Browne's influence, Hyslop encouraged patients to become involved in working in the gardens. Such work, according to Hyslop, was most suitable for the patients and offered the benefits of moral therapy (Parle 2007:105).¹⁹ In accordance with the nineteenth-century tenets of moral therapy, occupation in the gardens was not of secondary importance but a cornerstone in treatment – something which is evident in Hyslop (in Parle 2007:105) stating that he considered 'useful employment for inmates of an Asylum as quite as important as medicine'. As a result of Hyslop merging his passion for horticulture with moral therapy – in its regimes of outdoor work by patients – by the 1890s, the grounds were well planted with trees and shrubs (1) and came to resemble a country estate (Parle 2007:284).

The Fort England Asylum was not a purpose-built asylum, but was converted from military barracks. The suitability of converting the barracks was not based on its physical structures but on its location in 50 acres of well-watered and wooded countryside, suitable for both cultivation and pasturage, on an elevated ridge overlooking the Kowie River. Such features are distinctive of moral therapy, as they were so effectively deployed that they were even credited in asylum reports with contributing to patients' health

(Swanson 1994:12–13). The grounds were further extended and developed in 1883 by the planting of a boundary hedge, and a boundary walk was laid out for patients' use (2). Shrubs and annuals were planted within view of the asylum buildings (Swanson 1994:24). By 1894, more land was purchased by the government and the farm gardens were extended (Swanson 1994:25).

In the Cape Colony the position of Inspector of Asylums was created with the purpose of implementing moral therapy at the Cape. William Dodds, a British-trained doctor with extensive asylum experience in Scotland, was appointed in this role – a position he held from 1889 to 1913 (Swartz 1995:[np]). Part of Dodd's responsibility was to supervise the development of a new asylum in Cape Town along European lines – a development which culminated in Valkenberg (Marks 1999:272). The site of Valkenberg was originally a farm belonging to Cornelius Valk, and it was from him that the asylum took its name (Swartz 1996:33). Shortly after his appointment, Dodds put forward a motion for the construction of up-to-date buildings to replace the already existing buildings of Valkenberg, which were ill suited for the care and treatment of the insane. In accordance with international asylums, moral therapy was to be accompanied by moral architecture, and Sydney Mitchell,

1 The extensive grounds of Town Hill Hospital (ca 1900s). Reproduced by permission of the Local History Museums Collection, Durban.

2 The gardens of Fort England Asylum (ca 1890s). Reproduced by permission of the Western Cape Archives and Records Service, reference number: A.G. 374.

Consulting Architect to the Scottish Board of Lunacy, who built the Royal Edinburgh Infirmary, was commissioned to design a new hospital (Marks 1999:273; Minde 1974b:2232). The architecture of Valkenberg was but one component of moral therapy in its endeavour to realise the curative capacity of the asylum; another component included providing patients with outdoor work in pleasant surroundings (Marks 1999:273; Swartz 1995:[np]; Swartz 1996:32). Consequently, treatment at Valkenberg consisted primarily of regular occupations such as farming or gardening on the 200-acre estate (Minde 1974b:2232; Swartz 1996:34). Along with developing Valkenberg, Dodds was determined to bring the colony's other asylums into line with the best in Europe. He constantly stressed the need to provide humane care in a regimen that included pleasant work and recreation in a serene setting (Swartz 1995:[np]; Swartz 1996:32).

The South African asylums referred to all shared a belief in the therapeutic potential of the landscape. This conviction was the most influential factor guiding the design of the asylum's landscape. Yet there remains scope for further investigation into South African asylums that identify and/or indicate: patient recreation within the asylum landscape;

the visual analysis of the images of asylum landscapes; and the specificities of the South African context. These issues raised will be discussed next.

Patient recreation within the asylum landscape

The therapeutic potential of the landscape was not just forged in its design but also in its use – i.e. through patients undertaking recreational and vocational activities. Although the sample of South African asylums refers to such activities, a number of problems arise when solely investigating such recreational activities. Rutherford (2003:210) raises two points. One problem is that information on patient interaction within the asylum landscape is mostly in terms of work activities, and what is omitted is the connection to recreational activities. The second point Rutherford (2003:209) makes is that such information gleaned from the annual reports of the medical superintendents should be treated with caution, as they were written partly for official promotional purposes. Taking cognisance of this latter observation, this article offers an additional investigation of Valkenberg in terms of patient recreation within the asylum landscape. The proceeding analysis focuses on

the archived inspection reports of Valkenberg conducted by Dr Jane Waterston from 1898 to 1904, which provide a potentially more useful and less biased indicator of patient recreation and interaction in the asylum landscape.²⁰

Waterston provided detailed reports of the daily lives of patients as well as a focus on the importance of the landscape, by paying a great deal of attention to the aesthetics and maintenance of the grounds (Marks 1999:274–275). In the inspection report of 1898, Waterston (1898b) described the pleasing growth and health of the hedges, trees, shrubs and flowers. In her report of 1901 (Waterston 1901) she was struck by Valkenberg's 'increasing beauty of the surroundings' and in a later report of the same year (Waterston 1902) she noted: 'The trees and shrubs have grown wonderfully and the bare wind-swept hill on which the asylum was placed is now fast being converted into wooded slopes.' Additionally, Waterston (1901) elucidated the design features of Valkenberg's landscape, such as the walking trails 'where it is possible to give the lunatics exercise ...'.

Apart from the increasing aesthetic beauty and provision for activities at Valkenberg, Waterston's reports emphasise the recreational interaction of the patients within the landscape. In the 1898 report, Waterston (1898a) states: 'Patients are being kept as much as possible outside, weather permitting, and efforts

constantly made to interest them in games etc.' This quote clearly outlines the caregivers' roles in offering both outside and recreational activities. Additionally, moral therapy's ethos of non-restraint is evident in Waterston (1898b) recounting how at Valkenberg 'you always meet some harmless lunatics sauntering about and enjoying themselves'. Such descriptions call attention to patients' unrestrained and unrestricted movements and interactions with the outdoors – interactions that included patients meandering for the sole purpose of pleasure. The focus on non-restraint and the benefits derived from the open environment were not reserved only for docile patients (Waterston 1900): 'Patients were being taken for exercises and instead of shutting up the more violent women lunatics they were being taken out carefully guarded and handled into the open air.' Moreover, the open environment had another therapeutic benefit for unruly patients, namely to relieve and rid them of the strong emotions of stress and anger: 'There is plenty of outside room at Valkenberg for excitable patients to, so to speak, blow off steam' (Waterston 1904). Not only are the benefits of landscape associated with improved patient behaviour, but also with keeping infectious diseases at bay and are credited with the low mortality of the patients at Valkenberg:

The grass squares and lawns a little worn here by patients sitting, lying and walking

3 View of Fort England Asylum (ca 1890s). Reproduced by permission of the Western Cape Archives and Records Service, reference number: A.G. 373.

4 Patients of the Fort England Asylum on a picnic at Burnt Krall (ca 1890s). Reproduced by permission of the Western Cape Archives and Records Service, reference number: A.G. 381.

on them, but not more than the winter will put right, and the good to the patients is too great for the wear to the grass being a grave consideration. Nowhere have I seen grass lawn and paddocks being made greater use of, and it is most probably the outdoor life that makes the death rate low and keeps tuberculosis away. (Waterston 1904)

Waterston's reports highlight the design of the landscape (beautifully pleasing grounds with walking trails) and its use by the patients (recreational activities) as key factors in the therapeutics offered by Valkenberg. These factors were also core components of the asylum's management of facilities (the maintenance of the grounds), caregiver roles and responsibilities (provision of activities), and statutes of care (freedom of movement and non-restraint).

A visual analysis

For the purposes of this article, a visual analysis of the Fort England Asylum photographs will be provided.²¹ The photograph titled *View of Fort England Asylum*, circa 1890s (3) is characteristic of the standard visual representation of asylums in the nineteenth century: the asylum has spacious and well-maintained grounds on an elevated ridge that provides unobstructed views of the surrounding landscape (Edginton 1994:377). In the following paragraphs, it will be argued

that this trope of representation not only signifies the curative potential of the asylum, but also functions to promote the asylum as suitable for the care of private patients.

Prior to the 1890s the asylum was reported to be lacking a regular system of curative treatment (Swanson 1994:18). The charge was further motivated by the fact that the asylum had mainly functioned as a custodial institution for criminals, paupers and vagrants. However, from 1890 a number of important changes arose following the appointment of Dr. Greenlees as the new medical superintendent. These changes were to shift negative public perceptions and attitudes about the asylum (Swanson 1994:19).

Some of the most notable changes included improvements to the existing buildings and the establishment of a boundary walk for patients' use (Swanson 1994:21; 24). These improvements were markers of moral therapy which was believed to have therapeutic potential. Apart from such possibilities, moral therapy was also championed for creating better standards of care and treatment for the insane. In particular, it was this association of moral therapy with enlightened ways of thinking and care that led to it being regarded in the Cape Colony as a 'touchstone of metropolitan progress' (Marks 1999:272) and as an 'icon of civilization' (Deacon 2003:51). Thus, the embodiment of moral therapy within the improvements of the asylum can arguably be based on two purposes. First, it provided a

possible cure for insanity; and second, the local prejudice and negative attitudes about colonial asylums were brought to an end by bringing the asylum in line with practices offered in Britain (Swanson 2001:27). The above context allows one to read the photograph *View of Fort England Asylum* in terms of providing proof of the asylum's commitment to the ideology of moral therapy as a cure (the therapeutic benefits of landscape features as instruments in recovery) and as a modern and humane regime of care.

The improvements and advances made by Greenlees were so successful that he received the praise of Dr Dodds, the Inspector of Asylums to the Colony. In particular, Dodds (in Swanson 1994:23) found that the asylum was 'now suitable accommodation for private patients of both sexes and it is satisfactory to find that it is more and more taken advantage of by this class of patients'. The large number of private patients helped make Fort England Asylum the most cost-efficient asylum in the Cape Colony. By 1893 it showed a profit of 2 000 pounds which was in large part attributed to payments received from private patients (Marks 1999:276; Swanson 1994:21).

Greenlees offered a number of facilities and services to cater for private patients. These included a range of recreational and leisure activities such as rides in a horse and carriage and picnics, as depicted in the photograph (4) titled 'Patients of the Fort England Asylum on a picnic at Burnt Kral' (Swanson 1994:82; Swanson 2001:134). In addition, wealthy patients were provided with personalised care in private suites which, in some circumstances, even included the provision of champagne (Swanson 2001:134). From such accounts, the asylum can be described as closely resembling a convalescent home that offered private patients the activities and amenities their respective social classes were accustomed to (Swanson 1994:82). Thus, the care offered at the asylum was not only concerned with treatment or therapy, but also with catering for the material needs and social activities of private patients.

The above activities describe an asylum that strove hard to keep its private patients satisfied. But equally important was the promotion of the asylum amongst prospective private patients. One means available for prospective patients to determine the standard

of care offered by an asylum was through the appearance of the asylum's grounds (Wynter 2011). To elucidate further, it was a common practice at international asylums to attract wealthy patients through showcasing the well-maintained appearance. For example, Kirkbride deemed that luxurious, well-tended grounds made the asylum inviting for patients and specifically attracted wealthy families and patients (Ziff 2004:37). Even in the United Kingdom the Stafford Asylum relied on its appearance to attract patronage (Wynter 2011:43). In light of this, it can be argued that the grounds of the Fort England Asylum performed not only a therapeutic function but contributed to the intake of private patients. Accordingly, the photograph of the grounds provided not only a record or illustration, but also served to promote the asylum amongst prospective private patients. Expressed differently, the photograph of the well-kept grounds of the Fort England Asylum served to propagate and market an image of the asylum as being dedicated to providing an appropriate setting in which patients could regain their serenity.

A characteristic of Greenlees' appointment was that he focused on catering to the class interests of patients. The reason for such focus was Greenlees' striving to attract and gain private patients (Swanson 2001:17). This meant that the humanitarian and enlightened care he offered private patients included provision for the comforts and activities associated with their social class. In other words, the asylum did not strip the private patient of the social and class privileges of their life prior to institutionalisation. Rather, one can argue that moral therapy recognised the importance of maintaining prevailing societal class norms, in order to underscore ideas pertaining to humanitarianism, health and healing. Therefore, the discourses of cure, reform and therapeutics evident in the Fort England Asylum photographs are explicitly connected to the social class interests of the private patients. In this formation, these photographs constructed a public image of the asylum that reflected the tastes, proclivities and activities of private patients.

The specificities of the South African context

The article has discussed at length the parallels between South African asylums and their international counterparts. Yet, there are certain specificities of the colonial situation that make South African asylums stand out in relief (Vaughan 1991:101). In particular, the ways in which the moral therapy practised at the asylum came to be affected by the race of the patient (Swartz 1995; Swartz 2008:286; Swartz 2009:71).

Under the management of Greenlees, the Fort England Asylum commenced not only with the privileging of class interests, but with the differential treatment of black patients (Swanson 2001:17; 134). At the Fort England Asylum, Greenlees effectively created two asylums, each with its own distinctive ethos. On the one hand, it offered white paying patients a milieu that was therapeutic, comfortable and based on social class values. On the other, for black patients the asylum was primarily aligned to custodial aspects (Swanson 1994:25–26).

Differential treatment was not an idiosyncrasy of Greenlees alone, but came to define the provision of care in Cape asylums. Moral therapy offered remedial occupation and recreation, yet both options were not available to all patients. White patients (the majority of whom were private patients) were predominantly occupied with recreational activities – from sport, indoor games, plays, dances and excursions – while black patients were limited to remedial occupations such as farm work and doing laundry (Swartz 1995). In this formation, black patients were deployed by medical superintendents as an unpaid labour force within the asylum. Consequently, this meant that white patients regarded any kind of manual labour as socially beneath them, as it was usually carried out by blacks (Swartz 1995; Swartz 1999:154).

With particular reference to the Fort England Asylum, black men were excluded from recreational facilities and were limited to providing manual labour for the asylum, undertaken in the guise of occupational therapy. Black women were confined to the asylum buildings where they performed domestic duties such as cooking, cleaning, washing and ironing (Swanson 1994:24; Swanson 2001:134). These domestic duties

were so essential to the optimal running of the asylum that they surpassed the benefits of regular outdoor recreation for black female patients. This is most apparent in Greenlees failing to ensure that black female patients were given daily walks, by pointing out that this would interrupt their work in the laundry, and therefore interfere with the operational needs of the asylum (Swartz 1995).

The basis for limiting black patients to remedial occupation was that it was generally considered that they were more responsive to physical than mental treatment. The reason put forward for such responsiveness was that blacks were deemed less refined and less civilised than whites (Deacon 1999:104). This belief is explicitly evident in the head of the Robben Island Asylum reporting in 1880 that whites were more amenable to the influences of scenery than blacks, owing to the greater 'sensitivity' of their nervous systems (Butchart 1998:113). Consequently, black patients were not considered suitable candidates for moral therapy. This belief put in place practices that had racist consequences (Swartz 2009:71). One such practice was the building of separate institutions for blacks and whites. These included Valkenberg (established for whites only) and Fort Beaufort Asylum (reserved exclusively for black patients). Asylums that cared for white patients received a higher concentration of resources and access to the therapeutics of the well-designed landscape and architecture of the asylum. In contrast, Fort Beaufort Asylum was primarily viewed as offering cheap custodial care for black patients (Deacon 1999:116–118; Minde 1974b:2232; Swanson 2001:16; Swartz 1996:30–31; Swartz 2009:71).

The above discussion of the racial practices and treatment of black patients in South African asylums can be further investigated as expressions of panopticism.²² As already mentioned, Foucault identified a number of structures that were fundamental to the panopticism that operated within the nineteenth-century asylum, namely observation and classification, and judgement. In terms of the former structure, the principle of classification is clearly evident in the Fort England Asylum segregating its treatment programmes along racial lines. This act of classification by race fulfilled a twofold purpose: first, it separated black patients from the privileges offered to white private

patients. Although black patients were seen to benefit from moral therapy's provision for remedial occupation, they were not seen as suitable for appreciating the recreational and leisure activities offered by the very same therapy. Second, black patients were removed from having any contact with white patients. The reason for this was to ensure that white patients received the asylum's promise of a cure (Swanson 2001:32). To elucidate further, in moral therapy it was believed that contact and relations with patients of a different race and class would hamper the healing process and be offensive to the sensibilities of white patients (Swartz 1995). Thus, the asylum space was 'divided, policed and regulated' (Swanson 2001:32) in order to safeguard a cocoon of luxury, tranquillity and restoration for white private patients.

Foucault's structure of judgement is evident in the Fort England Asylum through two markers: first, the asylum offered a programme of rewards and punishments, whereby extra food or tobacco rations were awarded to patients for good behaviour or withheld for uncooperative behaviour; and second, the asylum management believed that a symbol of recovery in black patients was their ability to work (Swanson 2001:134). In a Foucauldian reading, these two markers denote neither a non-repressive system nor a symbol of recovery. Rather, they denote docility and the cooperation of black patients with the asylum's programmes of manual labour. A docile black labour force was desirable to maintain the high degree of standards required for the provision and care of white private patients – one expression of which is Greenlees' admonition that the labour provided by black female patients in the laundry superseded offering them recreational activities. In this regard, for black women in an asylum, 'to be "doing well" meant to accept colonial forms of menial work and female docility. To be "cured" was to become a pliable, docile, domesticated worker' (McClintock 2001:28).

Conclusion

In the nineteenth century, asylums across the West sought a country location with ample grounds and an unobstructed view of a surrounding landscape that was both tranquil and picturesque. Such landscaped vistas provided therapeutic experiences. Furthermore,

substantial portions of the asylum site were cultivated as gardens and farms for the purpose of providing occupational therapy and exercise for patients – an intrinsic component of the therapeutic regimen practised at the asylum. Thus, the landscape design of the asylum was not intended for appearances only, but had an explicit role in the treatment of patients. Stated differently, the location, grounds and design of asylums were indicative of moral therapy with all its associations – healing, curative and regenerative.

In South Africa, asylums of the nineteenth century bear a number of similarities to their international counterparts. The asylums reviewed here were situated on the outskirts of towns and cities, on commanding locations with panoramic views, in botanical gardens and on farms and were encircled by grounds ornamented with lawns, trees, flowers and shrubs. These grounds were actively cultivated, shaped and arranged by the planting of trees and shrubs; the creation of gardens and walks; and the formation of lush, landscaped settings. All these interventions were essential for the construction of the picturesque scenery that was prized by moral therapy. Thus, numerous efforts to improve the natural environment, consciously employed through landscape design, were undertaken to heighten the therapeutic potential and meet the aims of moral therapy. These curative aims were supported by the asylum's programmes and regimens that valued patient interaction – vocational and recreational – within the landscape.

Apart from the abovementioned similarities, the colonial context in South Africa did have a significant bearing on how moral therapy came to be influenced by the race of the patient. For white patients, the asylum offered a milieu that was therapeutic and embedded in the comforts of social class values. Yet, for black patients the asylum was aligned to custodial aspects and/or providing an unpaid workforce for the operational running of the asylum. In other words, the exploitation of black patients under the guise of occupational therapy 'made it possible for White patients to enjoy the benefits of living, as far as insanity would allow, as a privileged class, surrounded by tamed countryside and replete with recreational opportunities' (Louw and Swartz 2001:21). To uphold such racial segregation and differential treatment and/or standards of

care, the Fort England Asylum made use of the structures of panopticism, namely observation and classification, and judgement. In terms of the former structure, the observation of black patients by the asylum staff created and maintained in the patients an awareness of being continually monitored. This constant surveillance aimed to ensure that the conduct of black patients was in accordance with the norms of the institution – that they remained segregated from white patients, while dutifully providing manual labour for the asylum. In order to ensure the docility and cooperation of black patients to such institutional norms, the asylum offered a system of rewards and punishments (this is precisely how panopticism's structure of judgement operates). The rewards were provided to black patients who conformed to the models of behaviour and activities set by the asylum. In sum, the operations of panopticism at the Fort England Asylum resulted in the self-disciplining of black patients to the asylum's ideals and ideologies.

Notes

- 1 Modern psychiatric hospitals, also known as mental hospitals, evolved from and eventually replaced lunatic asylums. For the purposes of this article, only the term 'asylum' and not 'lunatic asylum' is used.
- 2 Although Foucault's texts initiated studies in the asylum, they have not been credited as necessarily being historically accurate. His work has been analysed by a number of scholars and the undisputed finding is that it is deeply problematic in terms of specific historical facts and interpretation (see Gutting 1994:332; Melling 1999:18; Porter 2003; Scull 1993:5). As such, historians have embarked on revising, refining and correcting the historical inaccuracies of Foucault's asylum research (see Melling 1999:2; Porter 1987; Porter 2003:4; Scull 1999:298).
- 3 Whig history is an approach to historiography that constructs the past as an inevitable advancement towards enlightenment.
- 4 Moral therapy was influential in reforming the institutional care of the insane. Its influence is marked from the last decades of the eighteenth century through to the nineteenth century (Curtis 2004:197; Parle 2007:45; Piddock 2007:39; Thompson and Goldin 1975:54; 71).
- 5 This study is limited to the landscape conceived as a therapeutic tool in the nineteenth-century asylums. For a discussion on the degree to which the outdoors has been utilised by psychiatric care facilities over historical periods,

please see Marcus and Barnes (1999) as well as Sachs (1999).

- 6 Most scholarly work on the asylum as therapeutic focuses on the architecture, design, structure and use of the asylum's buildings. In this regard, see Piddock (2007).
- 7 These elements remained a part of the design of psychiatric institutions until the mid-twentieth century (Hickman 2007). Thereafter, the basic elements of moral therapy became adjuncts to mental health treatment under new terminologies such as occupational therapy, restorative gardening, milieu therapy, art therapy, horticulture therapy and humanistic psychology (Beam 2001:13; Sutton 1986:36; Ziff 2012:24).
- 8 An investigation that thoroughly unpacks and explores the picturesque features in the design of asylum landscapes is beyond the scope of this article. For an investigation of the picturesque elements in the asylum landscape, see Hickman (2005).
- 9 The notion that the visual stimulus of the landscape has an influence on the mind was also evident in the writings of landscape design within the eighteenth century (see Hickman 2009:426).
- 10 A notable study that explores moral therapy and its relation to the visual experience of gardens and the landscape is highlighted in Hickman (2009). The author provides an interdisciplinary approach which includes the analysis of literary texts as well as the writings from art, medical and landscape history in order to locate the visual role of the asylum landscape within a broad context.
- 11 The description of the Victorian asylum on elevated ground and surrounded by pastoral detail has been argued to bear similarities to a Constable painting and even to an English country house. Such arguments demonstrate that the setting of the asylum reflected the artistic zeitgeist of the time (see Hickman 2009:429). Additionally, it also suggests that there was 'a definite crossover from aesthetic judgements about what was pleasing to the eye in buildings and landscapes, to moral prescriptions about how certain scenes were more likely to soothe, and even to cure, the minds of mad people than were others' (Philo in Hickman 2009:429).
- 12 Browne's recommendation for the airing courts to be stocked with domestic and other social animals with which the patients could interact to revive or improve their social skills, is also evident in Conolly's commendation for the provision of pets for patient enjoyment (Rutherford 2003:123, 187). Both Browne and Conolly's statements are a direct reiteration of Tuke's (1813:96) recommendation that each

- court should be supplied with a number of small animals for patients whose walks on the asylum grounds are circumscribed. For Tuke (1813:96), the purposes of these animals 'are not only [for] the means of innocent pleasure; but that the intercourse with them, sometimes tends to awaken the social and benevolent feelings'.
- 13 On its opening, the hospital was called 'De Krankzinnigen Gestichtte Pretoria' but when the British occupied the Transvaal after the South African War, they called it the Pretoria Lunatic Asylum. In 1911, it was renamed the Pretoria Mental Hospital, and in 1947 it became Weskoppies Hospital (Minde 1975b:367).
 - 14 Originally known as the Lunatic Asylum, Pietermaritzburg.
 - 15 Originally called the Grahamstown Lunatic Asylum, then the Grahamstown Mental Hospital, and it is now known as Fort England Hospital (Minde 1974b:2230).
 - 16 The majority of the sources offer a Foucauldian reading of the asylum that reveals its repressive aspects and how its programmes result in the self-disciplining of patients.
 - 17 Such therapeutic aspirations started to cease from 1900 onwards. Most of the optimism across the majority of the South African asylums concerning the efficiency of reforms in asylum practices and regimes gave way to disillusionment owing to the shortfall in income, shortage of staff and severe overcrowding (Marks 1999:275; Parle 2007:12; 50). Such aspects, and their association with stagnation and decline, have come to characterise most of the asylum's twentieth-century history (Marks 1999:275).
 - 18 The aspects of moral therapy evident at Weskoppies were in line with the attitudes, approach and policies of asylums in Europe (Plug and Roos 1991:218; 221). For further discussion on the links between Weskoppies and European asylums, see Plug and Roos (1991).
 - 19 Although vocational work was encouraged, some patients were uncooperative, resistant and regarded such activities as labour (see Parle 2007:105). More specifically, most white patients often refused to work on the asylum grounds and gardens (Parle 2007:100).
 - 20 Although the inspection reports hold the potential for a less biased indicator of patients' recreation and interaction in the asylum landscape, what is still missing is the patients' very own experience and interaction therein. However, there are a number of difficulties in 'hearing the clinical subject speak' (Swartz 2005:521). In particular, the difficulties pertain to the fact that the documents in the asylum archive and patient folders reveal information about the doctors who wrote them, about institutional practices and governance (see

Swartz 2005:513), but 'the subaltern voice, the subject of it all – the patient – is herself a black hole in the centre of the archive' (Swartz 2008:291). The possibilities of addressing this silence of the patients' experiences are outlined in Swartz (2005; 2008).

- 21 The photographs of the Fort England Asylum are housed in the Cape Town Archives Repository. The images were archived without notes, records or indications of the photographer, purpose and relation to other archived documents. In the absence of recorded information, the photographs are analysed within the context of Dr. Greenlees' commission to reform public attitudes towards the asylum and to increase the number of admissions of private patients.
- 22 At Valkenberg panopticism operated along social class lines. The non-paying patients were accommodated in dormitories which were installed with observation hatches for the attendants to watch the patients. In contrast, private patients were provided with private bedrooms and decorated wards (Louw and Swartz 2001:13; 16).

References

- Allderidge, P. 1990. Hospitals, madhouses and asylums: Cycles in the care of the insane. In *Lectures on the history of psychiatry*, ed. R.M. Murray and T.H. Turner, 28–46. London: Gaskell.
- Beam, A. 2001. *Gracefully insane: Life and death inside America's premier mental hospital*. New York: PublicAffairs.
- Browne, W.A.F. 1991. What asylums were, are, and ought to be. In *The asylum as utopia*. W.A.F. Browne and the mid-nineteenth century consolidation of psychiatry, ed. A Scull, 1–240. London: Tavistock/Routledge.
- Burrows, E.H. 1958. *A history of medicine in South Africa up to the end of the nineteenth century*. Cape Town: A.A. Balkema.
- Butchart, A. 1998. *The anatomy of power: European constructions of the African body*. Pretoria: Unisa Press.
- Caluya, G. 2010. The post-panoptic society? Reassessing Foucault in surveillance studies. *Social Identities* 16(5):621–633.
- Curtis, S. 2004. *Health and inequality: Geographical perspectives*. London: Sage.
- Deacon, H. 1999. Racial categories and psychiatry in Africa: The asylum on Robben Island in the nineteenth century. In *Race, science and medicine, 1700–1960*, ed. W. Ernst and B. Harris, 101–122. London: Routledge.
- _____. 2003. Insanity, institutions and society: The case of the Robben Island Lunatic Asylum, 1846–1910. In *The confinement of the insane: International perspectives, 1800–1965*, ed.

- R. Porter and D. Wright, 20–53. Cambridge: Cambridge University Press.
- Deacon, H.J. 1996. Madness, race and moral treatment: Robben Island Lunatic Asylum, Cape Colony, 1846–1890. *History of Psychiatry* 7:287–297.
- Digby, A. 1985. *Madness, morality and medicine: A study of the York Retreat, 1796–1914*. Cambridge: Cambridge University Press.
- Edgar, R.R. and H. Sapire. 2000. *African apocalypse: The story of Nontetha Nkwenkwe, a twentieth-century South African prophet*. Johannesburg: Witwatersrand University Press.
- Edginton, B. 1994. The well-ordered body: The quest for sanity through nineteenth-century asylum architecture. *Canadian Bulletin of Medical History* 11(2):375–386.
- _____. 1997. Moral architecture: The influence of the York Retreat on asylum design. *Health & Place* 3(2):91–99.
- Ernst, W. and B. Harris, eds. 1999. *Race, science and medicine, 1700–1960*. London: Routledge.
- Foucault, M. 1991(1977). *Discipline and punish: The birth of the prison*. Trans. A. Sheridan. London: Penguin.
- _____. 2009(1967). *Madness and civilization: A history of insanity in the age of reason*. Trans. R. Howard. London: Routledge.
- Gutting, G. 1994. Michel Foucault's *Phänomenologie des Krankengeistes*. In *Discovering the history of psychiatry*, ed. M.S. Micale and R. Porter, 331–347. Oxford: Oxford University Press.
- Hawkins, K. 1991. The therapeutic landscape: Nature, architecture, and mind in nineteenth-century America. PhD thesis, University of Rochester.
- Hickman, C. 2005. The picturesque at Brislington House, Bristol: The role of landscape in relation to the treatment of mental illness in the early nineteenth-century asylum. *Garden History* 33(1):47–60.
- _____. 2007. Therapeutic landscapes: The design and use of nineteenth-century lunatic asylum grounds. <http://www.parksandgardens.ac.uk/274/explore-31/feature-articles-151/therapeutic-landscapes-the-design-and-use-of-nineteenth-century-lunatic-asylum-grounds-546.html> (accessed 2 June 2011).
- _____. 2009. Cheerful prospects and tranquil restoration: The visual experience of landscape as part of the therapeutic regime of the British asylum, 1800–1860. *History of Psychiatry* 20(4):425–441.
- Kirkbride, T.S. 1854. *On the construction, organization and general arrangements of hospitals for the insane, with some remarks on insanity and its treatment*. Philadelphia: Pennsylvania Hospital for the Insane.
- Louw, J. and S. Swartz. 2001. An English asylum in Africa: Space and order in Valkenberg Asylum. *History of Psychiatry* 4(1):3–23.
- Marcus, C.C. and M. Barnes. 1999. Introduction: Historical and cultural perspective on healing gardens. In *Healing gardens: Therapeutic benefits and design recommendations*, ed. C.C. Marcus and M. Barnes, 1–26. New York: John Wiley & Sons.
- Marcus, C.C. and M. Barnes, eds. 1999. *Healing gardens: Therapeutic benefits and design recommendations*. New York: John Wiley & Sons.
- Marks, S. 1999. 'Every facility that modern science and enlightened humanity have devised': Race and progress in a colonial hospital, Valkenberg Mental Asylum, Cape Colony, 1894–1910. In *Insanity, institutions and society, 1800–1914: A social history of madness in comparative perspective*, ed. J. Melling and B. Forsythe, 268–291. London: Routledge.
- _____. 2000. Foreword. In *African apocalypse: The story of Nontetha Nkwenkwe, a twentieth-century South African prophet*, R.R. Edgar and H. Sapire. Johannesburg: Witwatersrand University Press.
- McClintock, A. 2001. *Double crossings: Madness, sexuality and imperialism*. Vancouver: Ronsdale Press.
- Meiring, H. 1980. *Pretoria 125*. Pretoria: Human & Rousseau.
- Melling, J. 1999. Accommodating madness: New research in the social history of insanity and institutions. In *Insanity, institutions and society, 1800–1914: A social history of madness in comparative perspective*, ed. J. Melling and B. Forsythe, 1–30. London: Routledge.
- Melling, J. and B. Forsythe, eds. 1999. *Insanity, institutions and society, 1800–1914: A social history of madness in comparative perspective*. London: Routledge.
- Micale, M.S. and R. Porter, eds. 1994. *Discovering the history of psychiatry*. Oxford: Oxford University Press.
- Minde, M. 1974a. The history of mental health services in South Africa, Part II: During the British occupation. *South African Medical Journal* 48:1629–1632.
- _____. 1974b. The history of mental health services in South Africa, Part III: The Cape Province. *South African Medical Journal* 48:2230–2234.
- _____. 1975a. The history of mental health services in South Africa, Part V: Natal. *South African Medical Journal* 49:322–326.
- _____. 1975b. The history of mental health services in South Africa, Part VI: The Transvaal. *South African Medical Journal* 49:367–374.
- Murray, R.M. and T.H. Turner, eds. 1990. *Lectures on the history of psychiatry*. London: Gaskell.

- Parle, J. 2007. *States of mind: Searching for mental health in Natal and Zululand, 1868–1918*. Scottsville: University of KwaZulu-Natal Press.
- Philo, C. 1989. 'Enough to drive one mad': The organization of space in 19th-century lunatic asylums. In *The power of geography: How territory shapes social life*, ed. J. Wolch and M. Dear, 258–290. Boston: Unwin Hyman.
- Piddock, S. 2007. *A space of their own: The archaeology of nineteenth-century lunatic asylums in Britain, South Australia and Tasmania*. New York: Springer.
- Plug, C. and J.L. Roos. 1992. Weskoppies Hospital, founded 1892 – the early years. *South African Medical Journal* 81:218–221.
- Porter, R. 1987. *Mind-forg'd manacles: A history of madness in England from the Restoration to the Regency*. London: Athlone Press.
- _____. 2003. Introduction. In *The confinement of the insane: International perspectives, 1800–1965*, ed. R. Porter and D. Wright, 1–19. Cambridge: Cambridge University Press.
- Porter, R. and D. Wright, eds. 2003. *The confinement of the insane: International perspectives, 1800–1965*. Cambridge: Cambridge University Press.
- Prandoni, J.R. and S. Kanhouwa. 2005. St. Elizabeth's Hospital: Photos from 150 years of public service. *Washington History* 17(1):4–25.
- Rothman, D.J. 1971. *The discovery of the asylum: Social order and disorder in the New Republic*. Boston: Little, Brown & Company.
- Rutherford, S. 2003. The landscapes of public lunatic asylums in England, 1808–1914. PhD thesis, De Montfort University, Leicester.
- Sachs, N.A. 1999. Psychiatric hospitals. In *Healing gardens: Therapeutic benefits and design recommendations*, ed. C.C. Marcus and M. Barnes, 235–322. New York: John Wiley & Sons.
- Scull, A. 1991. Introduction. In *The asylum as utopia: W.A.F. Browne and the mid-nineteenth century consolidation of psychiatry*, ed. A. Scull, vii–xxvii. London: Tavistock/Routledge.
- _____. 1993. *The most solitary of afflictions: Madness and society in Britain 1700–1900*. London: Yale University Press.
- _____. 1999. Rethinking the history of asylumdom. In *Insanity, institutions and society, 1800–1914: A social history of madness in comparative perspective*, ed. J. Melling and B. Forsythe, 295–315. London: Routledge.
- Scull, A., ed. 1991. *The asylum as utopia: W.A.F. Browne and the mid-nineteenth century consolidation of psychiatry*. London: Tavistock/Routledge.
- Sutton, S.B. 1986. *Crossroads in psychiatry: A history of the McLean Hospital*. Washington: American Psychiatric Press.
- Swanson, F. 1994. Colonial madness: The construction of gender in the Grahamstown Lunatic Asylum, 1875–1905. Honours thesis, University of Cape Town.
- _____. 2001. 'Of unsound mind': A history of three Eastern Cape mental institutions, 1875–1910. Master's thesis, University of Cape Town.
- Swartz, S. 1995. The black insane in the Cape, 1891–1920. *Journal of Southern African Studies* 21(3):sp.
- _____. 1996. Colonialism and the production of psychiatric knowledge in the Cape, 1891–1920. D. Phil thesis, University of Cape Town.
- _____. 1999. Lost lives: Gender, history and mental illness in the Cape, 1891–1910. *Feminism & Psychology* 9(2):152–158.
- _____. 2005. Can the clinical subject speak? Some thoughts on subaltern psychology. *Theory Psychology* 15(4):505–525.
- _____. 2008. Colonial lunatic asylum archives: Challenges to historiography. *Kronos* 34(1):285–302.
- _____. 2009. Madness and method: Approaches to the history of mental illness. *Psychology in Society* 37:70–74.
- Thompson, J.D. and G. Goldin. 1975. *The hospital: A social and architectural history*. New Haven & London: Yale University Press.
- Tomes, N. 1994. *The art of asylum-keeping: Thomas Story Kirkbride and the origins of American psychiatry*. Philadelphia: University of Pennsylvania Press.
- Tuke, S. 1813. *A description of The Retreat, an institution near York, for insane persons*. York: W. Alexander.
- Vaughan, M. 1991. *Curing their ills: Colonial power and African illness*. Oxford: Polity Press.
- Walsh, J., C. Stevenson, J. Cutcliffe and K. Zinck. 2008. Creating a space for recovery-focused psychiatric nursing care. *Nursing Inquiry* 15(3):251–259.
- Waterston, J. 1898a. Inspector of asylum reports, dated: 07/07/1898. (Cape Town Archives Repository) CO 7324.
- _____. 1898b. Inspector of asylum reports, dated: 13/10/1898. (Cape Town Archives Repository) CO 7321.
- _____. 1899. Inspector of asylum reports, dated: 11/01/1899. (Cape Town Archives Repository) CO 7324.
- _____. 1900. Inspector of asylum reports, dated: 30/09/1900 (Cape Town Archives Repository) CO 7326.
- _____. 1901. Inspector of asylum reports, dated: 17/06/1901 (Cape Town Archives Repository) CO7323.
- _____. 1902. Inspector of asylum reports, dated: 04/01/1902 (Cape Town Archives Repository) CO 7324.

- _____. 1904. Inspector of asylum reports, dated: 08/08/1904 (Cape Town Archives Repository) CO 7326.
- Wolch, J. and M. Dear, eds. 1989. *The power of geography: How territory shapes social life*. Boston: Unwin Hyman.
- Wynter, R. 2011. 'Good in all respects': Appearance and dress at Staffordshire County Lunatic Asylum, 1818–1854. *History of Psychiatry* 22(1):40–57.
- Yanni, C. 2003. The Linear Plan for insane asylums in the United States before 1866. *Journal of the Society of Architectural Historians* 62(1):24–49.
- Ziff, K. 2012. *Asylum on the hill: History of a healing landscape*. Athens: Ohio University Press.
- Ziff, K.K. 2004. Asylum and community: Connections between the Athens Lunatic Asylum and the village of Athens, 1867–1893. PhD dissertation, Ohio University.