Psychiatry's 'Golden Age': Making Sense of Mental Health Care in Uganda, 1894-1972

Yolana Pringle

Jesus College

Thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy in the Faculty of History at the University of Oxford

Hilary Term 2013

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Short Abstract

This thesis investigates the emergence of an internationally renowned psychiatric community in Uganda. Starting at the beginning of colonial rule in 1894, it traces the changing nature of mental health care both within and beyond the state, examining the conditions that allowed psychiatry to develop as a significant intellectual tradition in the years following Independence in 1962. This 'golden age' of psychiatry saw Uganda establish itself as a leader of mental health care in Africa, an aspect of history that is all the more marked for its contrast with the almost complete collapse of mental health care after the expulsion of the Asian population by Idi Amin in 1972. Using a wide range of new source material, including interviews with psychiatrists, traditional healers, and community elders, this thesis pushes the history of psychiatry in Africa beyond the examination of government policy and colonial hegemony. It brings together the history of psychiatry with the histories of missionary medicine, medical education, and international health by asking: what types of people, institutions, and organisations were involved in the provision of mental health care; how important the growth of Makerere Medical School was for intellectual and institutional psychiatry; and how 'African' mental health care had become by the end of the period. It presents a history of mental health care in a country that has tended to be overshadowed by Kenya in the historiography, yet whose engagement with medical missionaries and efforts to advance medical training meant that the trajectory of psychiatry came to be quite different. Focusing in particular on the significance of western-trained Ugandan medical practitioners for mental health care, the thesis not only analyses African psychiatrists as historical actors in their own right, but represents the first attempt to examine the development of psychiatric education in Africa.

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Long Abstract

This thesis investigates the emergence of an internationally renowned psychiatric community in Uganda. Starting at the beginning of colonial rule in 1894, it traces the changing nature of mental health care both within and beyond the state, examining the conditions that allowed psychiatry to develop as a significant intellectual tradition in the years following Independence in 1962. This 'golden age' of psychiatry saw Uganda establish itself as a leader of mental health care in Africa, an aspect of history that is all the more marked for its contrast with the almost complete collapse of mental health care after the expulsion of the Asian population by Idi Amin in 1972.

The history of psychiatry in Africa has been the subject of a small but growing area of inquiry for historians over the last thirty years. Until very recently, these historians have focused overwhelmingly on aspects of power and governance, using psychiatry as a way of shedding light on broader aspects of colonial rule. Such themes of difference, power, and control have prompted valuable insights into the subtleties and contradictions inherent in colonial rule, as well as the interplay between race, gender, and medicine. By focusing on colonial hegemony, however, historians have tended to emphasise colonial peculiarities—what made psychiatry

‘colonial’—rather than how psychiatry operated as one part of a much wider range of options for mental health care.

This thesis argues that such an approach limits our understanding of the complexity of responses to mental ill-health both within and beyond the state. By examining the roles played by medical missionaries, traditional healers, Makerere Medical School, and the families of the mentally ill, among others, this thesis pushes the history of psychiatry in Africa beyond the examination of government policy and colonial hegemony. Bringing together the history of psychiatry with the histories of missionary medicine, medical education, and international health, this thesis asks what types of people, institutions, and organisations were involved in the provision of mental health care; how important the growth of Makerere Medical School was for intellectual and institutional psychiatry; and how ‘African’ mental health care had become by the end of the period.

The thesis draws on a wide range of new source material, bringing together the types of records used frequently by historians of psychiatry—patient records, government correspondence, scientific reports, and newspapers—with those that are often overlooked, such as missionary correspondence, university administrative records, and letters from families. In addition, the thesis draws extensively from personal communication with psychiatrists who worked in Uganda during the 1960s and 1970s, and oral history interviews with Ugandans who shared their experiences of living or dealing with mental ill-health. The use of such interviews in a history of psychiatry in Africa represents a significant departure in research method from much of the historiography, which has tended to draw primarily on written source material.

The thesis is divided broadly into two parts. The first three chapters focus primarily on the colonial period, exploring the rise of institutional and intellectual

psychiatry, as well as the roles played by families, mission hospitals, traditional healers, and marketplace medicines. The second takes the story into the post-colonial period, examining the importance of Makerere Medical School for intellectual and institutional psychiatry, the emergence of African psychiatrists, and the activities of a new generation of expatriate and Ugandan psychiatrists from the late 1960s. One of the distinctive features of the thesis is the inclusion of two case studies (Chapters III and V). Drawing on patient case notes and oral history interviews, these case studies address the complexities of psychiatric diagnoses in the past, as well as the complicated relationship between medical practitioners and their patients.

Chapter I traces the development of institutional and intellectual psychiatry in colonial Uganda. Between 1894 and 1962 provision for the mentally ill evolved from the occasional and haphazard isolation of troublesome 'lunatics' to an established system of certification, confinement, and repatriation. The perception that the mentally ill would be best treated at Kampala, coupled with a series of scandals, forced the colonial administration to acknowledge responsibility for the mentally ill. The geographical siting of a new mental hospital on Mulago hill in 1935 brought psychiatry into the intellectual space of Makerere Medical School, the concerns of which set the development of psychiatry on a different path to that taken elsewhere in East Africa. In examining these developments, the chapter establishes some of the themes that recur throughout the thesis—the role of missionary and government medical communities in Kampala in driving psychiatry and shaping policy, the importance of medical education for Africans, and the problematic relationship between psychiatry and colonial rule. In so doing, the chapter starts to explore the reasons why the history of psychiatry and mental health care in Uganda requires a

more nuanced narrative than one constrained by discourses of colonial governance and their impact on colonial subjects.

Chapter II follows by focusing on the experiences of families who negotiated different types of mental health care in Uganda. It argues that while the developments examined in Chapter I were significant for the long-term trajectory of the discipline of psychiatry in Uganda, it was of limited importance for those families who endured the pressures and fears of mental ill-health on an everyday basis. Using letters from families found in district archives from across Uganda, this chapter looks at the burden of mental illness for families and communities, the reasons why some families felt they needed to turn to confinement, and their experiences of the mental hospital once a relative had been admitted. The chapter also examines a number of other ways families attempted to deal with mental ill-health, looking at traditional medicine, mission hospitals, and tonics and remedies in turn. In so doing, it demonstrates that families were not passive actors in mental health care. They turned to, and interacted with, a range of different methods of healing.

Chapter III uses a case study approach to examine the complexity and contradictory nature of diagnoses like neurasthenia in colonial Africa. Neurasthenia was a condition of nervous and mental exhaustion, and was an illness that took on extended racial connotations when it was transported from America and Europe into the colonial context. Variously labelled as 'neurasthenia in the tropics' or 'tropical neurasthenia', the condition was associated almost exclusively with the mental and physical breakdown of white colonisers. Drawing on the case notes of European and African patients diagnosed with neurasthenia at the CMS Mengo Hospital, this chapter argues that in practice, and outside of the colonial asylum in particular, the doctoring of mental ill-health was more nuanced than histories of psychiatry and

empire might imply. It was a diagnosis that was negotiated in hospital examination rooms as much as in medical journals and government medical boards. Significantly, it was also a diagnosis that was not always reserved exclusively for white colonisers—at Mengo Hospital from the early 1900s, neurasthenia was diagnosed in African patients too. In exploring the content of the case notes for neurasthenia, the chapter places patients and their relationships with doctors at the forefront of investigation.

Chapter IV takes the theme of the cultural difficulties faced by both doctor and patient in the examination room as the starting point for a discussion about why the training of Africans in psychiatry became increasingly important. It examines the education and status of Uganda's first psychiatrists, Benjamin H. Kagwa and Stephen Bosa, as well as the establishment of a Department of Psychiatry at Makerere Medical School in 1966. The expatriates who joined the new Department of Psychiatry, together with their African colleagues, attempted to bring the question of mental health care to the forefront of general medical practice, and initiated a 'golden age' for psychiatry in Uganda. In exploring these developments, the chapter contrasts the role of Makerere Medical School with that of the Uganda Government. It argues that the decision to establish a Department of Psychiatry at Makerere Medical School came as a relief to the Uganda Government; plagued by financial troubles and a lack of staff, the creation of the new department meant that the development of mental health care was no longer their sole responsibility.

Chapter V examines competing explanations for epidemics of mass hysteria in the early 1960s. As the second case study in the thesis, it offers a rare opportunity to interrogate the nature of early post-colonial psychiatry by incorporating the voices of both psychiatrists and patients into the analysis. These epidemics were significant

enough to be remembered by people living in eastern Uganda in 2011 as a 'disease of that time', and focused enough for eighteen Bagisu elders to share their fears, anxieties, and experiences of a specific event in interviews. This chapter juxtaposes these interviews with a report by one of Uganda's first psychiatrists in order to explore a range of different perspectives on mental illness, as well as the ideas and practices of Africa's first generation of psychiatrists. In so doing, the chapter argues that the epidemics demonstrate the limits rather than the strengths of Ugandan psychiatry in the early post-colonial period. There remained a distance between psychiatrists and their patients that was only reinforced by the methods of examination, the explanations used, and the treatments suggested.

The final chapter explores the activities of psychiatrists outside of the mental hospital in order to examine the roles psychiatrists attempted to create for themselves in early post-colonial Uganda. From 1966 to 1972, a small group of psychiatrists turned their attention to a range of educational activities, including the establishment of the Uganda National Association for Mental Health (UNAMH), training courses for police officers and lawyers, and a television series entitled 'The Sick Mind'. These activities aimed not only at spreading western ideas about mental ill-health to the wider Ugandan public, but to mobilise supportive professionals in order to extend the reach of psychiatry beyond that which could have been achieved by the psychiatrists alone. In so doing, as the chapter argues, the psychiatrists worked tirelessly to improve what they perceived to be problems with the treatment and handling of the mentally ill across Uganda. However, this involved creating a 'modern' psychiatry, with little room for alternative healing systems or beliefs.

This thesis departs from the historiography by choosing not to take Independence from the British as a historical endpoint. It presents a history of mental

health care in a country that has tended to be overshadowed by Kenya in the historiography, yet whose engagement with medical missionaries and efforts to advance medical training meant that the trajectory of psychiatry came to be quite different. Focusing in particular on the significance of western-trained Ugandan medical practitioners for mental health care, this thesis not only analyses African psychiatrists as historical actors in their own right, but represents the first attempt to examine the development of psychiatric education in Africa.

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List of Abbreviations

ACMM	Albert Cook Memorial Library, Makerere University
AMO	African Medical Officer
BMA	British Medical Association
CMS	Church Missionary Society
DC	District Commissioner
DMO	District Medical Officer
DMS	Director of Medical Services
DMSS	Director of Medical and Sanitary Services
DPM	Diploma in Psychological Medicine
EAMJ	*East African Medical Journal*
ECT	Electro-Convulsive Therapy
GMC	General Medical Council, United Kingdom
GPI	General Paralysis of the Insane
HMC	Henry Martyn Centre, Cambridge
JCRC	Joint Clinical Research Centre, Mbale
JDA	Jinja District Archives
KDA	Kabale District Archives
KHR	Kabarole Hospital Records
MDA	Mbale District Archives
MMU	Mountains of the Moon University, Fort Portal
MO	Medical Officer
MSDA	Masindi District Archives
NAMH	National Association for Mental Health, United Kingdom

NCRL	Natural Chemotherapeutics Research Laboratory
PMO	Principal Medical Officer
RHO	Rhodes House Library, Oxford
SCMA	Archives of the Supreme Court, Mengo
SDA	Soroti District Archives
SHO	Senior House Officer
TNA	The National Archives, Kew
UoBSC	University of Birmingham Special Collections
UMOHA	Uganda Ministry of Health Archives, Kampala
UMOHL	Uganda Ministry of Health Library, Kampala
UNA	Uganda National Archives, Entebbe
UNAMH	Uganda National Association for Mental Health
WHO	World Health Organization
WHOA	World Health Organization Archives, Geneva
WHOL	World Health Organization Library, Geneva

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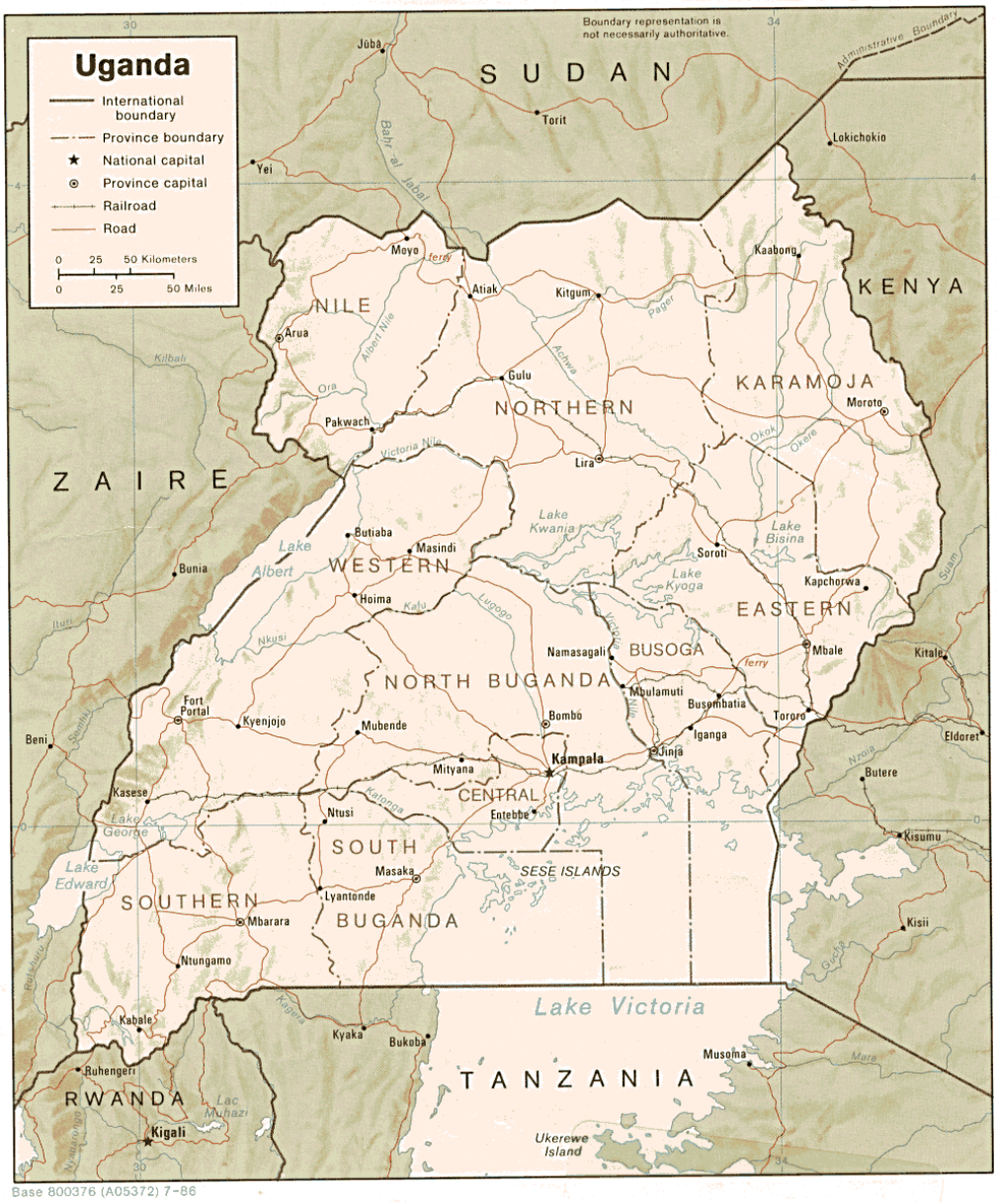

Image 1: Map of Uganda, 1986
Credit: Central Intelligence Agency, 'Perry-Castañeda Library Map Collection: Uganda Shaded Relief Map', University of Texas at Austin

Introduction

Medical practitioners have described the years immediately leading up to 1972 as a 'golden age' for psychiatry in Uganda. F.J. Bennett, a former Professor of Preventive Medicine at Makerere University, described Uganda as 'one of the countries in Africa with the most effective and innovative programmes for control of mental illness'. He listed research that had been undertaken into the epidemiology of maternal mental illness, child psychiatry, and the mental health problems of university students. He also highlighted training programmes in psychiatry and psychology available for medical students and psychiatric nurses.[1] Looking beyond the university, John Orley, a psychiatrist and social anthropologist, claimed in 1970 that Butabika Hospital, Uganda's national mental hospital, 'is now regarded as the natural replacement for the stocks of old. It is rare in these days to see patients shackled, although they are often tied with rope'.[2] Such was the importance of the institution, Orley asserted, that 'the immediate reaction to anyone who shows signs of what is thought to be unreasonable violence is to try to get them to Butabika Hospital, and while there is any sign that this behaviour might recur, the family are extremely reluctant to take the patient back home'.[3]

What follows in this thesis is a historical investigation into the emergence of an internationally renowned psychiatric community in Uganda. Starting at the beginning of colonial rule in 1894, it traces the changing nature of mental health care

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[1] F.J. Bennett, as cited in Cole P. Dodge and Paul D. Wiebe (eds), *Crisis in Uganda: The Breakdown of Health Services* (Oxford: Pergamon Press, 1985), p. 50.
[2] John Orley, *Culture and Mental Illness* (Nairobi: East African Publishing House, 1970), p. 30.
[3] Ibid., p. 41.

both within and beyond the state, examining the conditions that allowed psychiatry to develop as a significant intellectual tradition in the years following Independence in 1962. This 'golden age' of psychiatry saw Uganda establish itself as a leader of mental health care in Africa, an aspect of history that is all the more marked for its contrast with the almost complete collapse of mental health care after the expulsion of the Asian population by Idi Amin in 1972.

Bringing together the history of psychiatry with the histories of missionary medicine, medical education, and international health, this thesis asks what types of people, institutions, and organisations were involved in the provision of mental health care; how important the growth of Makerere Medical School was for intellectual and institutional psychiatry; and how 'African' mental health care had become by the end of the period. In so doing, the thesis draws on a wide range of new source material, bringing together the types of records used frequently by historians of psychiatry—patient records, government correspondence, scientific reports, and newspapers—with those that are often overlooked, such as missionary correspondence, university administrative records, and letters from families. In addition, the thesis draws extensively from personal communication with psychiatrists who worked in Uganda during the 1960s and 1970s, and oral history interviews with Ugandans who shared their experiences of living or dealing with mental ill-health. The use of such interviews in a history of psychiatry in Africa represents a significant departure in research method from much of the historiography, which has tended to draw primarily on written source material.[4]

[4] The exception here is Lynette A. Jackson, *Surfacing Up: Psychiatry and Social Order in Colonial Zimbabwe, 1908-1968* (Ithaca & London: Cornell University Press, 2005).

The history of psychiatry in Africa has been the subject of a small but growing area of inquiry for historians over the last thirty years.[5] Until very recently, these historians have focused overwhelmingly on aspects of power and governance, using psychiatry as a way of shedding light on broader aspects of colonial rule.[6] '[T]he study of "madness"', as Lynette Jackson asserted in 2005, has come to mean 'the study of barriers to understanding. The study of "colonial madness" is the study of such barriers magnified by race-, economic-, and culture-based resistance to communicating with and understanding the colonized Other'.[7] Such themes of difference, power, and control have prompted valuable insights into the subtleties and contradictions inherent in colonial rule, as well as the interplay between race, gender, and medicine. By focusing on colonial hegemony, however, historians have tended to

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[5] This literature includes: Leland Bell, *Mental and Social Disorder in Sub-Saharan Africa: The Case of Sierra Leone, 1787-1990* (New York: Greenwood Press, 1991); Gail C. Beuschel, 'Shutting Africans Away: Lunacy, Race and Social Order in Colonial Kenya, 1910-1963' (unpublished PhD thesis, School of Oriental and African Studies, 2001); Harriet Jane Deacon, 'Madness, Race and Moral Treatment: Robben Island Lunatic Asylum, Cape Colony, 1846-1890', *History of Psychiatry* 7 (1996), pp. 287-97; Matthew M. Heaton, 'Stark Roving Mad: The Repatriation of Nigerian Mental Patients and the Global Construction of Mental Illness, 1906-1960' (unpublished PhD thesis, The University of Texas at Austin, 2008); Jackson, *Surfacing Up*; Will Jackson, 'Bad Blood: Poverty, Psychopathy and the Politics of Transgression in Kenya Colony, 1939–59', *Journal of Imperial and Commonwealth History* 39(1) (2011), pp. 73-94; Richard C. Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago: University of Chicago Press, 2007); Sloan Mahone, 'The Psychology of Rebellion: Colonial Medical Responses to Dissent in British East Africa', *Journal of African History* 47(2) (2006), pp. 241-58; Sloan Mahone, 'The Psychology of the Tropics: Conceptions of Tropical Danger and Lunacy in British East Africa' (unpublished DPhil Thesis, University of Oxford, 2004); Sloan Mahone and Megan Vaughan, *Psychiatry and Empire* (Basingstoke, Hampshire: Palgrave Macmillan, 2007); Shula Marks, "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 Joseph Melling and Bill Forsythe (eds), *Insanity, Institutions, and Society, 1800-1914* (London: Routledge, 1999); Jock McCulloch, *Colonial Psychiatry and 'the African Mind'* (Cambridge, UK: Cambridge University Press, 1995); Jonathan Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Berkeley & Los Angeles, 1999); Nina Salouâ Studer, 'The Hidden Patients: North African Women in French Colonial Psychiatry, 1883-1962' (unpublished PhD thesis, University of Zurich, 2012); Sally Swartz, 'Changing Diagnoses in Valkenberg Asylum, Cape Colony, 1891-1920: A Longitudinal View', *History of Psychiatry* 6 (1995), pp. 431-51; Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Cambridge, UK: Polity Press, 1991), ch. 5; Megan Vaughan, 'Idioms of Madness: Zomba Lunatic Asylum, Nyasaland, in the Colonial Period', *Journal of Southern African Studies* 9(2) (1983), pp. 218-38.

[6] Julie Parle provides a notable exception here: Julie Parle, *States of Mind: Searching for Mental Health in Natal and Zululand, 1868-1918* (Scottsville, South Africa: University of KwaZulu-Natal Press, 2007).

[7] Jackson, *Surfacing Up*, p. 2.

emphasise colonial peculiarities—what made psychiatry 'colonial'—rather than how psychiatry operated as one part of a much wider range of options for mental health care.

This thesis argues that such an approach limits our understanding of the complexity of responses to mental ill-health both within and beyond the state. By examining the roles played by medical missionaries, traditional healers, Makerere Medical School, and the families of the mentally ill, among others, this thesis pushes the history of psychiatry in Africa beyond the examination of government policy and colonial hegemony. It presents a history of mental health care in a country that has tended to be overshadowed by Kenya in the historiography, yet whose engagement with medical missionaries and efforts to advance medical training meant that the trajectory of psychiatry came to be quite different. Focusing in particular on the significance of western-trained Ugandan medical practitioners for mental health care, this thesis not only analyses African psychiatrists as historical actors in their own right, but represents the first attempt to examine the development of psychiatric education in Africa.

Psychiatry and colonial rule in Africa

In *Madness and Civilization*, first published in English in 1967, Michel Foucault argued that in seventeenth- and eighteenth-century Europe 'madness' became separated from 'reason'; it was then reined in, 'torn from that imaginary freedom' and 'bound to Reason, to the rule of morality'.[8] With this separation, Foucault contended, came the 'great confinement', which consisted of 'moral rule; a limitation of liberty, a submission to order, an engagement of responsibility….The

[8] Michel Foucault, *Madness and Civilization* (London & New York: Routledge, 2001), p. 60.

absence of constraint in the nineteenth-century asylum is not unreason liberated, but madness long since mastered'.[9] Foucault's work has been the subject of considerable debate by historians, many of whom have rejected *Madness and Civilization* as a 'dazzlingly written prose poem, but one resting on the shakiest of scholarly foundations'.[10] Historians have nevertheless taken up and extended the questions posed by Foucault about power and medicine, as well as the relationship between insanity, psychiatry, and social control.[11] These questions have found their most fertile ground in the historiography of colonial psychiatry, where institutional and intellectual psychiatry has offered tantalising insights into the meaning and operation of colonial power.[12]

Megan Vaughan's 1983 article on Zomba Lunatic Asylum, which prompted renewed interest in the history of colonial psychiatry, opened by noting that '[i]n the colonial context, 'reason' and 'unreason' were already separated. The 'savage's'

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[9] Ibid., pp. 233-9.
[10] Andrew Scull, as cited in Gary Gutting, 'Michel Foucault's *Phänomenologie Des Krankengeistes*', in Mark S. Micale and Roy Porter (eds), *Discovering the History of Psychiatry* (New York & Oxford: Oxford University Press, 1994), p. 332. See also Winifred Barbara Maher and Brendan Maher, 'The Ship of Fools: *Stultifera Navia* or *Ignis Fatuus*?', *American Psychologist* 37(7) (1982), pp. 756-61; Allan Megill, 'The Reception of Foucault by Historians', *Journal of the History of Ideas* 48(1) (1987), pp. 117-42.
[11] Colin Jones and Roy Porter, 'Introduction', in Colin Jones and Roy Porter (eds), *Reassessing Foucault: Power, Medicine and the Body* (Abingdon, Oxon: Routledge, 2006). For examples of this trend, see especially Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (New York: Cambridge University Press, 1987); Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven: Yale University Press, 1993).
[12] In addition to Africa, the literature on colonial psychiatry also spans South Asia and Australasia. Examples include: Waltraud Ernst, 'Idioms of Madness and Colonial Boundaries: The Case of the European and "Native" Mentally Ill in Early Nineteenth-Century British India', *Comparative Studies in Society and History* 39(1) (1997), pp. 153-181; Shruti Kapila, 'The Making of Colonial Psychiatry, Bombay Presidency, 1849-1940' (unpublished PhD thesis, School of Oriental and African Studies, University of London, 2002); Jacqueline Leckie, 'Unsettled Minds: Gender and Settling Madness in Fiji', in Sloan Mahone and Megan Vaughan (eds), *Psychiatry and Empire* (Basingstoke, Hampshire: Palgrave Macmillan, 2007); M. Lewis, *Managing Madness. Psychiatry and Society in Australia 1788-1980* (Canberra: Australian Government Publishing Service, 1988); Philippa Martyr, "Behaving Wildly': Diagnoses of Lunacy among Indigenous Persons in Western Australia, 1870-1914', *Social History of Medicine* 24(2) (2011), pp. 316-33; James Mills, *Madness, Cannabis, and Colonialism: The "Native-Only" Lunatic Asylums of British India, 1858-1900* (New York: St. Martin's Press, 2000); Lee-Ann Monk, *Attending Madness: At Work in the Australian Colonial Asylum* (Amsterdam & New York: Editions Rodopi B.V., 2008); Jonathan Saha, 'Madness and the Making of a Colonial Order in Burma', *Modern Asian Studies* 47(2) (2013), pp. 406-35.

incapacity to 'see things clearly and see things whole', his underdeveloped personality, his different system of causal explanation, all demonstrated the impossibility of dialogue between the two systems of thought'.[13] Madness, in this context, 'was made out of the occasional stammering attempts at direct communication between the two cultures'—African and European—in which Africans whose 'delusions' spoke of motor cars, bicycles, and kings of England were regarded as an insult and a threat to British superiority.[14] Building on these ideas in *Curing Their Ills: Colonial Power and African Illness*, Vaughan argued that Africans, as colonial subjects, were already objectified and distanced in the form of 'Other', something which led to the privileging of definitions of 'normal' characteristics over 'abnormal' occurrences.[15] As a result, the category of the mad African 'more often included the colonial subject who was insufficiently 'Other' – who spoke of being rich, of hearing voices through radio sets, of being powerful, who imitated the white man in dress and behaviour and who therefore threatened to disrupt the ordered non-communication between ruler and ruled'.[16]

Vaughan's work on 'difference' and 'Othering' has been considerably influential, drawing strength from the acknowledgement that Foucault can only be applied in Africa with considerable limitations.[17] Certainly, as Vaughan and other historians have pointed out, there was no 'great confinement' in Africa: not only were the number of lunatics admitted to mental hospitals relatively small, but psychiatry was a low priority for colonial administrators.[18] The resulting literature

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[13] Vaughan, 'Idioms of Madness', pp. 218-9.
[14] Ibid., p. 219.
[15] Vaughan, *Curing Their Ills*.
[16] Ibid., p. 101.
[17] Ibid., pp. 8-12.
[18] Beuschel, 'Shutting Africans Away', p. 10; Sadowsky, *Imperial Bedlam*, p. 29; Vaughan, *Curing Their Ills*, p. 120.

has focused primarily on institutional case studies, examining the paths taken to asylums and the exercise of psychiatric power in distinct settings. At their best, these histories have shed fascinating light on the priorities and concerns of colonial rule; at their worst, mental ill-health has been reduced to a discursive concept in which there is little room for the acknowledgement of the realities of physical, emotional, and psychological distress.

Jonathan Sadowsky's *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria*, represents some of the most nuanced work on the theme of confinement and control. Acknowledging the minor role asylums played in the exertion of state power in colonial Nigeria, Sadowksy illustrated how the processes of confinement and the labelling of insanity relied on cultural differences and the political context of colonial rule.[19] The colonial asylum was explored thematically and through a microhistorical analysis of the 'Case of Isaac O.', the strength of which lay not only in showing the difficulties of using evidence that is fundamentally flawed due to Isaac's insanity, but how the contradictions of asylum policy and psychiatric theory worked in a specific case.[20] Linking the case to the wider social and political issues explored in *Imperial Bedlam*, Sadowsky demonstrated compellingly that Isaac's 'delusion' that he purchased a car for a million pounds constituted a political threat, as 'he appropriated two prominent symbols of British power and encroachment (money and cars) at one stroke'.[21]

The influence of Foucault is more overt in Jackson's study of Ingutsheni Lunatic Asylum, which explored the socio-economic appropriation of space and meaning in Southern Rhodesia. In addition to tracing the institutional history of

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[19] Sadowsky, *Imperial Bedlam*.
[20] Ibid., pp. 78-96.
[21] Ibid., 90.

Ingutsheni, Jackson used court transcripts and asylum case notes to trace the 'footsteps' of Africans and Europeans to the asylum. For both men and women, Jackson argued, 'detention was linked to a suspect's mobility and location on the European colonizer's spatial, social, and economic map'.[22] Yet while 'African men were more likely than African women to be admitted to the colonial mental hospital because of their formal incorporation into colonial institutional frameworks…African women were admitted for precisely the opposite reason: their lack of incorporation'.[23]

Alongside the institutional case studies stands Jock McCulloch's *Colonial Psychiatry and 'the African Mind'*, in which McCulloch highlighted the unified nature of many of the ideas of psychiatrists such as J.C. Carothers, B.J.F. Laubscher, and Wulf Sachs. Although they worked in intellectual isolation, McCulloch argued, these psychiatrists shared a 'coherent set of ideas about race, class and gender'.[24] By looking at the ways in which these psychiatrists were unified, however, McCulloch's work at times overlooks the vastly contradictory ways in which ideas were developed, received, and applied. Indeed, as Sloan Mahone has pointed out, psychiatry was not 'a discrete and unproblematic entity, a uniform discipline, or a set of cogent ideas'.[25] Tracing the ways in which psychiatric ideas provided an intellectual rationale for colonial rule in East Africa, and specifically in Kenya, Mahone asserted that 'psychiatric ideas often found their expression outside of the medical domain as administrators and high-level government officials assessed African behaviour in psychological terms that sometimes countered general medical

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[22] Jackson, *Surfacing Up*, p. 102.
[23] Ibid., pp. 102-3.
[24] McCulloch, *Colonial Psychiatry*, p. 137.
[25] Mahone, 'The Psychology of the Tropics', p. 18.

opinion'.[26] This thesis extends the arguments made by McCulloch and Mahone by opting to examine the ways in which ideas about mental ill-health were understood and applied by a variety of historical actors, including that of the western-trained African medical practitioner, the families of the mentally ill, and mission doctors.

The limits of 'colonial' psychiatry

The focus of historians on colonial power and governance has produced a historiography that, as Matthew Heaton has noted, is 'remarkably consistent…[but]…has until very recently been isolated in scope'.[27] The emphasis on colonial hegemony has been characteristic of studies of colonial medicine more generally, but critiques such as those by Shula Marks, Waltraud Ernst, and Warwick Anderson that historians 'are still writing a minor literature' are no longer valid.[28] Historians such as Ryan Johnson, Walima T. Kalusa, and James Mills, have been increasingly sensitive to competing interests in different professional and social contexts, and in particular to the ways African and Indian medical practitioners brought their own understandings and ambitions to their work.[29] While historians of

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[26] Sloan Mahone, 'East African Psychiatry and the Practical Problems of Empire', in Sloan Mahone and Megan Vaughan (eds), *Psychiatry and Empire* (Basingstoke, Hampshire: Palgrave Macmillan, 2007), p. 42.

[27] Heaton, 'Stark Roving Mad', p. 19. Waltraud Ernst has also made this point for the South Asian context: Waltraud Ernst, 'Crossing the Boundaries of 'Colonial Psychiatry'. Reflections on the Development of Psychiatry in British India, c. 1870-1940', *Culture, Medicine and Psychiatry* 35 (2011), pp. 536-45.

[28] Warwick Anderson, 'Where is the Postcolonial History of Medicine?', *Bulletin of the History of Medicine* 72(3) (1998), pp. 522-30 at p. 523; Waltraud Ernst, 'Beyond East and West: From the History of Colonial Medicine to a Social History of Medicine(s) in South Asia', *Social History of Medicine* 20(3) (2007), pp. 505-24 at p. 514; Shula Marks, 'What is Colonial about Colonial Medicine? And what has happened to Imperialism and Health?', *Social History of Medicine* 10(2) (1997), pp. 205-19 at p. 215.

[29] Ryan Johnson, '"An All-White Institution": Defending Private Practice and the Formation of the West African Medical Staff', *Medical History* 54 (2010), pp. 237-54; Walima T. Kalusa, 'Language, Medical Auxiliaries, and the Re-Interpretation of Missionary Medicine in Colonial Mwinilunga, Zambia, 1922-51', *Journal of Eastern African Studies* 1(1) (2007), pp. 57-78; James Mills, '"Left in the Hands of Subordinates": Medicine, Language, and Power in the Colonial Medical Institutions of Egypt and India', in Ryan Johnson and Amna Khalid (eds), *Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health, 1850-1960* (New York: Routledge, 2012).

psychiatry, as we shall see in the following section, have also started to expand their attention away from institutional settings, they have generally been slower to do so, perhaps because the links between confinement, medical knowledge, and state power are so apparent in psychiatry.[30] As Ernst has noted for the South Asian context, '[i]n terms of historical methodology and conceptual scope, there is a big leap from histories of colonial medicine that focus on colonial governmentality and hegemony, and their impact on indigenous medicines, to those that look at medicines in south Asia—various strands of 'indigenous' and 'western' alike'.[31]

This thesis does not deny that psychiatry was at times used as a tool of social control, as least in so far as it existed to control disturbing behaviour; nor does it dispute arguments made by historians that psychiatric ideas provided an intellectual basis for colonial rule. It contends, however, that the use of psychiatry as a lens through which to view colonialism can distort our understanding of the role of psychiatry, however limited, as a means of relief for those suffering from mental ill-health, as well as the range of historical actors who took an interest in mental health care. Indeed, those actors who do not fall under the categories of administrator, medical officer, or patient, such as the medical missionary, western-trained African medical practitioner, or independent tradesman, have tended to be sidelined or relegated to auxiliary roles.[32] The inclusion of historical actors who are usually

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[30] Notable among these histories are Catharine Coleborne, *'Madness' in the Family: Insanity and Institutions in the Australasian Colonial World 1860s-1914* (New York: Palgrave Macmillan, 2010); Ernst, 'Crossing the Boundaries'; Parle, *States of Mind*.
[31] Ernst, 'Beyond East and West', p. 514.
[32] With medical missionaries, at least, this could be due to an older tendency of historians to place missionaries in a historiographical vacuum. Jeffrey Cox, 'Audience and Exclusion at the Margins of Imperial History', *Women's History Review* 3(4) (1994), pp. 501-14. Only Sadowsky and Diefenbacher have considered the potential value of missionary sources for a history of psychiatry in Africa. A. Diefenbacher, 'The Lunatic Asylum Lutindi: A Contribution to the History of the Mentally Ill Africans in the Colony of German East Africa', in Leonie de Goei and Joost Vijselaar (eds), *Proceedings of the 1st European Congress on the History of Psychiatry and Mental Health Care, 24-6 October 1990* (The Netherlands: Erasmus Publishing, 1993); Sadowsky, *Imperial Bedlam*, pp. 17-22. Sadowsky and

overlooked by historians of psychiatry, notably medical missionaries and African doctors, is one of the main contributions of this thesis.

Moving beyond the state

In recent years historians of psychiatry have started to move away from the theme of colonial hegemony to consider the wider medical, social, and political contexts in which psychiatry and mental health care operated. In Africa, the most important of these historians has been Julie Parle, whose *States of Mind: Searching for Mental Health in Natal and Zululand, 1868-1918*, offered a nuanced examination of responses to mental ill-health. Starting with an institutional history of Natal Government Asylum, Parle located psychiatry within a broader range of strategies for dealing with mental ill-health, including African herbalists and diviners, Christian faith healing, and marketplace remedies. In the context of medical pluralism, she argued, psychiatry was often a last resort for sufferers desperately seeking relief. In so doing, Parle incorporated a range of historical actors that have previously been hidden in histories of psychiatry in Africa. These included women and girls suffering from *indiki* possession—discussed in this thesis in Chapter V—and cases of suicide among Indians working as labourers in Natal.[33]

Sadowsky's *Imperial Bedlam* is also significant for its brief discussion of the potential uses of missionary sources for a history of psychiatry in Africa.[34] Using Church Missionary Society (CMS) records, Sadowksy examined missionary

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Heaton have considered the importance of Nigeria's first general of psychiatrists, notably T.A. Lambo, but not the general medical practitioners who preceded them. Matthew M. Heaton, '"Traditional" Healers and "Modern" Psychiatry in Nigeria, 1954-79', unpublished conference paper presented at the African Studies Association 54th Annual Meeting, Washington, DC, 17-9 November 2011; Sadowsky, *Imperial Bedlam*.

[33] Parle, *States of Mind*.

[34] Sadowsky, *Imperial Bedlam*, pp. 17-22.

conceptions of and approaches to the African mind in nineteenth-century southwest Nigeria. One notable feature, Sadowksy noted, was the 'lack of significant discussion of difference in the manifestation of madness. Far from regarding madness as a radically relative phenomenon, European missionaries perceived it as something they could recognize'.[35] This is important, as Sadowsky argued, as it highlights how 'in different historical circumstances and with different interests in mind, different historical actors can emphasize the degree of relativity differently'.[36] This thesis takes up and extends this insight by considering the implications of the involvement of a wide range of historical actors in the provision of mental health care for our understanding of the place of psychiatry in Uganda, and the experiences of those who sought relief from mental ill-health. Sadowsky's arguments are also employed directly in an examination of diagnoses of neurasthenia in a mission hospital context in Chapter III.

Outside of Africa, Catharine Coleborne's *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914*, has been important in recasting assumptions about the relationship between institutions and wider communities. While Coleborne's main contention that histories of psychiatry need to be viewed as a series of 'transcolonial entanglements' is not particularly convincing, her exploration of the role of families is both rigorous and conceptually sophisticated. Looking at the ways families provided extra-institutional care, shaped the processes of diagnosis and committal, and responded to mental illness after confinement, Coleborne demonstrated the extent to which 'the boundaries between the asylum and

[35] Ibid., p. 21.
[36] Ibid.

the outside world were highly porous—the family was 'inside' the asylum, appearing in patient case notes and official asylum documents.[37]

What these works highlight is that institutions and medical practitioners did not operate in a vacuum—they were working in contexts rich in actors and politics of their own. Indeed, even patients 'confined in that most colonial of contexts', as Mills has reminded us, 'could make decisions about their own interaction with the world without regard for their position as subjects of colonial power.[38] This thesis contributes to this growing body of literature by considering some of the wider medical contexts within which psychiatry and mental health care operated in Uganda, the nature of which will be considered in the following section.

Medicine in Uganda

Medical missions

One of the distinctive features of medical practice in early colonial Uganda was a strong medical missionary presence that was marked by a high level of collaboration between mission doctors and the Colonial Medical Service.[39] Albert Ruskin Cook arrived in Uganda in February 1897, marking the start of an increasing CMS preoccupation with medical work in Central Africa. By 1933, CMS medical work in Uganda included four mission hospitals—at Kabale, Fort Portal, Mengo, and

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[37] Coleborne, *'Madness' in the Family*.
[38] Mills, *Madness, Cannabis, and Colonialism*, p. 173.
[39] Jan Kuhanen, *Poverty, Health and Reproduction in Early Colonial Uganda* (Joensuu, Finland: University of Joensuu Publications in the Humanities 37, 2005), p. 247; Yolana Pringle, 'Crossing the Divide: Medical Missionaries and Government Service in Uganda, 1897-1940', in Anna Greenwood (ed.), *Beyond the State: The Colonial Medical Services in British Africa* (Manchester: Manchester University Press, forthcoming).

Ng'ora—numerous dispensaries, leprosy settlements, and a Maternity Training School (Image 2).[40]

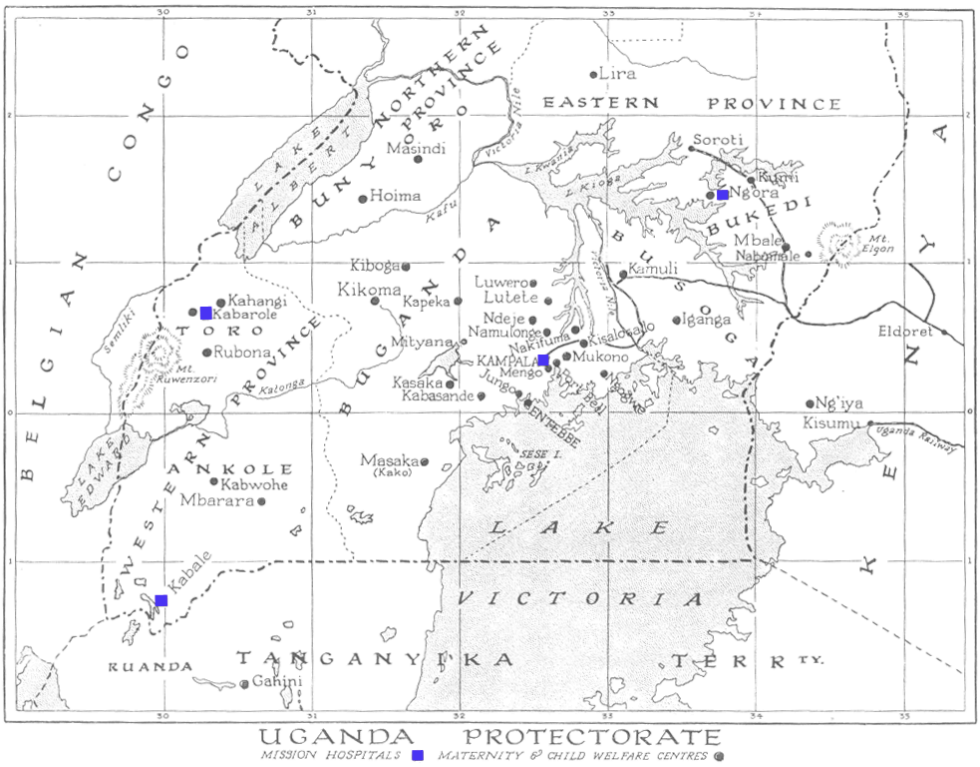

Image 2: Map of CMS medical work in the Uganda Protectorate, 1933
Credit: *Report of the C.M.S. Mengo Medical Mission* (London, 1933)

In the period before 1940, a number of CMS doctors also negotiated dual roles as missionaries and colonial medical officers. An even greater number participated in and managed government health campaigns, or were engaged unofficially by the administration in an advisory capacity. The reasons for collaboration were diverse: some wished to extend the reach of missionary work, some to advance professionally, while others were determined to boost what they felt to be meagre missionary stipends. By undertaking this work, the mission doctors went beyond filling a gap in state provision: they contributed specialist knowledge, language skills,

[40] *Report of the C.M.S. Mengo Medical Mission* (Kampala: Church Missionary Society, 1933).

equipment and personnel that shaped the practice of medicine in Uganda as much as it supplemented it. The relationship was never clearly defined, however. Stemming in part from the inability to draw an absolute line between 'missionary' and 'government' medical work, missionaries and colonial administrators reacted to local circumstances, formulating guidelines in a largely *ad hoc* manner.[41]

In Uganda, the contribution of missionaries to the development of medical services has not been downplayed or marginalised to the extent it has been elsewhere in colonial Africa.[42] This is due in part to early historians of medicine in Uganda, admittedly some themselves missionaries, who have stressed the debt of the colonial administration to the pioneer medical work and research started by Albert Ruskin Cook.[43] It also stems from the extensive collection of records deposited by the CMS in archives at the University of Birmingham, the Wellcome Library, Uganda Christian University (Mukono, Uganda), and the Albert Cook Library (Makerere University, Uganda).[44] This has resulted in a bias in the historical literature towards CMS activities, and specifically those initiated by Cook. Roman Catholic missionaries attached to the White Fathers, Franciscan Missionary Sisters for Africa,

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[41] Pringle, 'Crossing the Divide'.

[42] For reviews of the ways in which the historiography of medical missions has been plagued by generalisations and misconceptions, see especially Michael Jennings, "A Matter of Vital Importance': The Place of the Medical Mission in Maternal and Child Healthcare in Tanganyika, 1919-39', in David Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam & New York: Rodopi, 2006); Michael Jennings, '"This Mysterious and Intangible Enemy': Health and Disease Amongst the Early UMCA Missionaries, 1860-1918', *Social History of Medicine* 15(1) (2002), pp. 65-87.

[43] These have included: W.R. Billington, 'Albert Cook: A Biographical Note', *East African Medical Journal* 10(28) (1951), pp. 397-422; W.D. Foster, *The Early History of Scientific Medicine in Uganda* (Nairobi: East African Literature Bureau, 1970); H.C. Trowell, 'The Medical Pioneers and Explorers of East Africa', *East African Medical Journal* 34(8) (1957), pp. 417-30.

[44] Historians who have drawn on these archives include T.M. Daniel, 'The Early History of Tuberculosis in Central East Africa: Insights from the Clinical Records of the First Twenty Years of Mengo Hospital and Review of Relevant Literature', *International Journal of Tuberculosis and Lung Disease* 2(10) (1998), pp. 784-90; Holger Bernt Hansen, *Mission, Church and State in a Colonial Setting* (London: Heinemann, 1984); Carol Summers, 'Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925', *Signs* 16(4) (1991), pp. 787-807; Michael William Tuck, 'Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda' (unpublished PhD thesis, Northwestern University, 1997); Diane L. Zeller, 'The Establishment of Western Medicine in Buganda' (unpublished PhD thesis, Columbia University, 1971).

and the Mill Hill Mission were also engaged in a number of medical projects, including leprosy and maternal health, but the difficulties historians have experienced in accessing archival material has resulted in little critical analysis of their work.[45] For these reasons, this thesis focuses primarily on CMS, as opposed to Catholic, engagement with mental ill-health, and the lack of Catholic perspectives remains a limitation of the research.

Medical training and Makerere Medical School

Of the contributions made by CMS medical missionaries in Uganda, the early training of Africans in western medicine ranks among the most important. Native assistants, or 'tribal dressers', were trained informally at Mengo Hospital from the early 1900s, and in 1917, with funding from the Uganda Government, the CMS opened a small medical school on their hospital grounds. The mission doctors who trained them had intended African medical assistants to take on basic clinical duties and to go out into 'untouched' regions to fight 'heathenism' and the traditional 'medicine-man'.[46] In practice, the relationship between Africans and western medicine was more ambiguous, and African medical practitioners would struggle with the CMS and the Colonial Medical Service over their status, duties, and right to private practice for the next thirty years.[47]

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[45] Vongsathorn has attempted to overcome this challenge by incorporating materials from Uganda's district archives. Kathleen Vongsathorn, "Things That Matter': Missionaries, Government, and Patients in the Shaping of Uganda's Leprosy Settlements, 1927-1951' (unpublished PhD thesis, University of Oxford, 2012), pp. 21-2.

[46] E.N. Cook, 'A Medical Mission in War Time', *Mercy and Truth* 216 (1914), pp. 392-4 at p. 394.

[47] John Iliffe, *East African Doctors: A History of the Modern Profession* (Kampala: Fountain Publishers, 2002), ch. 3; Maryinez Lyons, 'The Power to Heal: African Medical Auxiliaries in Colonial Belgian Congo and Uganda', in Dagmar Engels and Shula Marks (eds), *Contesting Colonial Hegemony: State and Society in Africa and India* (London: British Academic Press, 1994). On African medical practitioners elsewhere, see especially Anne Digby, 'Early Black Doctors in South Africa', *Journal of African History* 46 (2005), pp. 427-54; Johnson, '"An All-White Institution"'; Kalusa, 'Language, Medical Auxiliaries'.

In 1922, the Uganda Government decided to start their own medical school, which opened on Mulago hill in 1923.[48] While the establishment of a government medical school prompted the eventual demise of Mengo Medical School, medical missionaries were not completely excluded from the new endeavour. Recognising their need for experienced teachers, the Colonial Medical Service requested the 'loan or transfer' of mission doctor Ernest Cook for medical education work at the Government Medical School from 1925. Keen to have someone on the inside of the new school, the CMS agreed.[49]

By the time the government opened their own medical school at Mulago Hospital in 1923—referred to as Mulago Medical School from 1927 and Makerere Medical School from 1939—there was only one other medical school for Africans on the continent, located at Dakar in Senegal.[50] While the initial group of students were intended for training as hospital assistants, the first medical tutor, H.B. Owen, had rather higher ambitions, and in 1924 Owen set four Baganda students on a four-year course in medicine, extending the period of study to five years in 1926.[51] By the end of 1935, 29 students had passed their final examinations, of which two were in the service of the Zanzibar Government, one had died, and the remainder had entered the

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[48] W.D. Foster, 'Makerere Medical School: 50th Anniversary', *British Medical Journal,* 14 September 1974, pp. 675-8 at p. 676.

[49] UoBSC, CMS G3 A7/O 1926 (Uganda Mission Outgoing Correspondence), f. 13, minutes of 'A special meeting of the Medical Sub-Conference', 24 December 1925; UNA, A46/2629 (Medical School at Mulago).

[50] Medical schools were opened in Senegal in 1918, Uganda in 1923, Sudan in 1924, Cameroon in 1928, and Nigeria in 1930. Medical schools in South Africa did not accept black Africans until the 1940s. Digby, 'Early Black Doctors', pp. 29-30; Iliffe, *East African Doctors*, pp. 60-2; Adell Patton, *Physicians, Colonial Racism, and Diaspora in West Africa* (Gainesville, FL: University Press of Florida, 1996), p. 24.

[51] H.B. Owen, 'Medical Education in Uganda', *Tropical Diseases Bulletin* 30 (1933), pp. 659-68. The ambitions of Owen were reflected more generally by Makerere College, which recognised that their plans for medical, veterinary, and agricultural training would necessitate 'a large permanent staff of Europeans'. UNA, A46/2537 (Makerere College - Courses of Instruction), f. 1, memorandum by the Acting Director of Agriculture, 11 September 1922.

Uganda Protectorate African Civil Service.[52] These numbers were, as John Iliffe has pointed out, small—by 1935 the Khartoum School of Medicine, opened in 1924, had trained 53 staff to a similar level—but they were still greater than in Nigeria, where the first students completed their course in 1935, and in Kenya and Tanganyika, which had yet to see any students finish the course at Mulago Medical School.[53]

Despite the small numbers, the training of Africans in medicine quickly became one of the defining features of the Colonial Medical Service in Uganda, and, for some physicians, a point of comparison with Kenya.[54] While European medical officers did not always regard their African colleagues as equals, they nevertheless believed that their training programmes set Uganda apart as more liberal than other colonies, and in particular from Kenya. By 1939, when the school came under the partial control of Makerere College Council, Makerere Medical School, according to Carol Sicherman, 'had been "imperceptibly transformed into a university faculty of medicine"; its graduates were denominated medical officers, and medical assistants were not trained by the government Medical Department'.[55] As I demonstrate in this thesis in Chapters I, II, and III, the prominence of medical missions in early colonial Uganda and the emphasis on training African medical practitioners had significant implications for the ways mental health care operated in Uganda, as well as the range of options for relief.

During the 1950s and 1960s, Makerere Medical School went on to develop an internationally renowned reputation, placing it, if not quite 'among the best medical

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[52] Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1935* (Entebbe: Government Printer, Uganda, 1936), p. 55.
[53] Iliffe, *East African Doctors*, p. 62.
[54] On the history of medical education in Uganda, see especially Foster, 'Makerere Medical School'; Iliffe, *East African Doctors*; Lyons, 'The Power to Heal'; A.M. Odonga, *The First Fifty Years of Makerere Medical School and the Foundation of Scientific Medical Education in East Africa* (Kampala: Marianum Press, 1989); Carol Sicherman, *Becoming an African University: Makerere, 1922-2000* (Trenton, NJ: Africa World Press, Inc., 2005), ch. 8.
[55] Sicherman, *Becoming an African University*, p. 152.

schools in the world', as W.D. Foster has claimed, then at least among the best in Africa.[56] The annual intake of medical students grew substantially over the following years—from seventeen in 1962 to ninety in 1965—and it attracted over £280,000 in medical research grants between 1964-7.[57] New departments and institutes were set up in paediatrics, oncology, and psychiatry, and some of the theories developed at Makerere Medical School gained international recognition.[58] It is against this background that the development of psychiatric education and the activities of a new generation of expatriate and Ugandan psychiatrists are examined in Chapters IV, V, and VI. This thesis represents the first attempt to examine the development of psychiatric education in Africa. As such, it makes an important contribution both to Ugandan history and to the history of medical education in Africa.

Psychiatry and mental ill-health

Psychiatry made an unceremonious entry into Africa—often an after-thought, its institutions grew haphazardly, its staff plagued by lack of prestige and support. The basic history of psychiatry in Uganda is well known. Hoima Prison was designated as a Lunatic Asylum in 1921, with minimal attempt made to offer patients anything more than custodial care. In 1935, a new, purpose-built mental hospital opened near Mulago Hospital, promising to treat mental illness by psychiatric means for the first time. By the late 1940s, overcrowding had reached such an extent that plans were made to build a new mental hospital at Butabika, seven miles outside Kampala. The first patients were transferred to Butabika Hospital in 1955, and in

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[56] Foster, 'Makerere Medical School'.
[57] Sicherman, *Becoming an African University*, p. 153.
[58] See, for example: Roy E. Brown and Barbara I. Wright, 'Malignancies in African Children. How Do These Differ from Malignancies in the United States?', *Clinical Pediatrics* 6(2) (1967), pp. 106-15; H.G. Egdell and J.P. Stanfield, 'Paediatric Neurology in Africa: A Ugandan Report', *British Medical Journal,* 26 February 1972, pp. 548-52.

1964, Mulago Mental Hospital was closed for good.[59] During this time, the first attempts were also made at out-patient and voluntary care: a mental health clinic was opened at Mulago Hospital in 1962, and two years later 'Ward 16' was designated for the treatment of a small selection of mental patients.[60]

Beyond this broad institutional outline, however, very little is known about psychiatry in colonial Uganda. Diane Zeller touched on mental illness in her history of the establishment of western medicine in Buganda, but her observations were limited to an acknowledgement that Baganda healers were 'quite successful in treating mental conditions', particularly if a patient believed they had been bewitched.[61] This handling of the subject, Zeller has noted, was because she could 'not find historical data on the subject', and in her interviews, 'none of the Western-trained Baganda physicians brought the subject up'.[62] Mahone has gone considerably further, arguing that the roots of institutional psychiatry in Uganda, as in Kenya and Tanganyika, lay in responses to a perceived 'crime and disorder problem'.[63] Mahone also examined understandings of mental illness and ideas about 'the tropics', emphasising the regional character of the psychiatric and psychological literature.[64]

While this thesis builds on research undertaken by Mahone, it departs from it by focusing instead on the ways in which psychiatry and mental health care operated within the distinct political and medical context of Uganda. It is my contention that a regional approach is not always useful for a discipline like psychiatry, where the

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[59] Sloan Mahone, 'Psychiatry in the East African Colonies: A Background to Confinement', *International Review of Psychiatry* 18(4) (2006), pp. 327-32; Interview with Seggane Musisi (MUS-01), Mulago Hospital, Uganda, 29 July 2011; Interview with Sheila Ndyanabangi (NDY-01), Ministry of Health, Kampala, Uganda, 3 May 2011; J.F. Wood, 'A Half Century of Growth in Ugandan Psychiatry', *Uganda Atlas of Disease Distribution* (Kampala: Makerere University College, 1968).
[60] Wood, 'A Half Century of Growth', p. 119.
[61] Zeller, 'The Establishment of Western Medicine', p. 384.
[62] Personal communication with Diane L. Zeller, 13 July 2011.
[63] Mahone, 'Psychiatry in the East African Colonies'.
[64] Mahone, 'The Psychology of the Tropics'.

notoriety of Kenya's psychiatrists—notably J.C. Carothers—has tended to skew the historiography towards Kenya. Yet, for reasons that will be explored in this thesis, during the 1960s and 1970s psychiatry in Uganda developed into a significant intellectual tradition that was quite distinct from that in Kenya. A new Department of Psychiatry at Makerere Medical School established a reputation for teaching and research that was not only well grounded in international psychiatric theory, but politically relevant to health and development in East Africa. At the same time, Uganda started to build up a mental health care system that was not only innovative, but among the best in Africa. These developments accelerated into the early 1970s, and contrast with the almost complete collapse of mental health care after the expulsion of the Asian population by Idi Amin in 1972.

African psychiatrists, colonial psychiatry and decolonisation

The history of psychiatry in late colonial and early post-colonial Africa is marked by the emergence of African psychiatrists. These psychiatrists, who were all men, have been credited with transforming the nature of psychiatry within their own countries, and with it, the relationship between psychiatry, psychiatrists, and power.[65] Among the first of Africa's indigenous-born psychiatrists were T. Adeoye Lambo (Nigeria), Tolani Asuni (Nigeria), El Tigani El Mahi (Sudan), Benjamin H. Kagwa (Uganda), and Stephen Bosa (Uganda). Despite their often isolated working conditions, this group of individuals shared similar social and educational backgrounds, and, with the exception of Stephen Bosa, whose flying phobia

[65] Heaton, '"Traditional" Healers and "Modern" Psychiatry'.

prevented him from travelling, they met regularly at pan-African symposiums and conferences on mental health.[66]

Nearly all of Africa's first generation of psychiatrists were sent for specialist training at the Maudsley Hospital, which had opened formally in 1923. By the 1950s the Maudsley was the major psychiatric teaching research centre in the United Kingdom, preparing students for Conjoint and Academic Diplomas in Psychological Medicine (DPMs), and attracting research grants from the Rockefeller Foundation, the Wellcome Trust, and the Nuffield Foundation among others.[67] Little is known about the experience of these overseas students at the Maudsley, but it is probable that like other colonial students in London, they would have encountered some degree of disillusionment with 'the Mother-country', isolation, and racism.[68] Nevertheless, overseas students clearly formed a significant group within the medical school.[69] In 1959-60, 129 of the school's 315 postgraduate students came from outside of the British Isles, including 17 from Africa (1 from British Guiana, 3 from Nigeria, 11 from South Africa, 1 from Sudan, and 1 from Uganda).[70]

Despite the transformative role given to this new generation of psychiatrists by historians, particularly in Nigeria, relatively little scholarly attention has been paid to them as a group or to the development of psychiatric education more generally.

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[66] G. Allen German, 'Steven Bosa: Formerly, Inter Alia, Advisor Psychiatrist to the Government of Uganda and the Ministry of Health', *Psychiatric Bulletin* 24(9) (2000), p. 356.
[67] On the history of the Maudsley Hospital, see especially: Jonathan Andrews *et al.*, *The History of Bethlem* (London & New York: Routledge, 1997), ch. 30; Katherine Angel, Edgar Jones, and Michael Neve (eds), *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital and the Rockefeller Foundation in the 1930s* (London: The Wellcome Trust Centre for the History of Medicine at UCL, 2003); John L. Crammer, 'Training and Education in British Psychiatry 1770-1970', in Hugh Freeman and German Berrios (eds), *150 Years of British Psychiatry* (London: Athlone, 1996).
[68] A.T. Carey, *Colonial Students: A Study of the Social Adaptation of Colonial Students in London* (London: Secker & Warburg, 1956).
[69] D.L. Davies, 'Postgraduate Education in London', in D.L. Davies and M. Shepherd (eds), *Psychiatric Education: A Symposium Held at the Institute of Psychiatry, the Maudsley Hospital, London, on 14-15th March 1963* (London: Pitman Medical Publishing Co. Ltd, 1963).
[70] *Institute of Psychiatry Report, 1st August, 1959, to 31st July, 1960* (London: The Maudsley Hospital, 1960), pp. 16-7.

Femi Oyebode, Professor of Psychiatry at the University of Birmingham, has praised the first western-trained African psychiatrist, Lambo, as being free from 'any perverse colonial ideology'.[71] Matthew Heaton, moreover, has argued that Lambo's work was 'instrumental in changing attitudes about the relationship between race, culture and mental disorder' by unpicking the more racist assumptions of colonial psychiatry and developing a more culturally sensitive method of diagnosis and treatment.[72] Looking specifically at Senegal, Alice Bullard has similarly argued that with independence, '[c]olonial psychiatry transformed into a diverse range of practices, ranging from collaborations with traditional healing to biomedical, pharmaceutical-based psychiatry'.[73] Yet these practices divided the new psychiatrists as much as they united them, in this case most obviously between the African and European psychiatrists. As Bullard noted:

> The French researchers were labouring under the weight of colonial racism, and trying to approach Senegalese cultures with open, appreciative minds. The Senegalese doctors and nurses face the task of assuming the status of 'scientist' and of embodying the authority of medical science over and against the authority of healers. In this they are working through an Oedipal drama writ large'.[74]

In Senegal, according to Bullard, it was only with the departure of French psychiatrist Henri Collomb in 1978 that psychiatry 'embarked on a new, more solidly Senegalese post-colonialism'.[75]

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[71] F. Oyebode, 'History of Psychiatry in West Africa', *International Review of Psychiatry* 18(4) (2006), pp. 319-25.
[72] Heaton, 'Stark Roving Mad', p. 106.
[73] Alice Bullard, 'Imperial Networks and Postcolonial Independence: The Transition from Colonial to Transcultural Psychiatry', in Sloan Mahone and Megan Vaughan (eds), *Psychiatry and Empire* (Basingstoke, Hampshire: Palgrave Macmillan, 2007), p. 197.
[74] Ibid., p. 210.
[75] Ibid.

The dynamics of the ways psychiatry continued to operate into the post-colonial period has yet to be explored in any detail in East Africa. John Iliffe's work on the history of the medical profession in East Africa stressed the 'professional solidarity and organisation' among East Africa's doctors, particularly in Kenya and Uganda, where at independence they established control over 'institutions of colonial medicine – the ministries, international representation, disciplinary bodies, and professional associations'. His monograph, however, deliberately avoided looking at specialisms such as psychiatry.[76] Sicherman, too, has briefly traced the establishment of the Department of Psychiatry at Makerere Medical School, but a lack of primary source material has resulted in limited analysis and numerous errors of fact.[77]

One of the main aims of this thesis is to examine the emergence of Ugandan psychiatrists and academic psychiatry in order to re-write these historical actors into the history of psychiatry and mental health care in Uganda. This subject will form a major part of the thesis, especially in Chapters IV, V, and VI. In so doing, the thesis consciously chooses not to take independence as a historical endpoint in itself.

Terms and definitions

Psychiatry and mental health care

The first professional psychiatrist arrived in Uganda in 1949, making the use of the term 'psychiatry' before this date problematic.[78] As we shall see in Chapter I, not only were the mentally ill frequently confined in buildings staffed by non-

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[76] Iliffe, *East African Doctors*, pp. 1, 118. At the time of writing, Marissa Mika, University of Pennsylvania, was completing a PhD thesis provisionally titled 'Surviving Experiments: Cancer Research in Uganda 1950s to the Present'.
[77] Sicherman, *Becoming an African University*, ch. 8, and especially p. 155.
[78] George Campbell Young, DPM, was appointed as Specialist Alienist in June 1949. Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1949* (Entebbe: Government Printer, Uganda, 1950), p. 53.

specialists, but the terms 'psychiatry' and 'psychiatrist' were rarely used until the 1930s.[79] While historians of psychiatry and empire have generally acknowledged the limits of the term 'psychiatry', they have nevertheless tended to refer to 'colonial psychiatry' as a term capturing, in Shruti Kapila's words, 'various terms of reference….a series of practices, ideas and the institutional contexts that enabled the coherence of an emergent medicine of the mind'.[80] Indeed, as Gail Beuschel noted for the Kenya context, 'psychiatry functioned without psychiatrists for over thirty years….throughout the period, colonial doctors spoke the language of European psychiatry and exercised a variety of forms of control over the mentally ill which ranged from the directly coercive and custodial to the more or less subtle imposition of social norms through therapeutic and clinical practice'.[81]

This thesis follows Mahone in acknowledging that 'colonial psychiatry' was not a united force.[82] The individuals, institutions, and organisations that assumed authority over the mentally ill did not always share the same interests or agendas. Moreover, in moving away from a focus on the 'colonial' aspects of psychiatry, this thesis consciously avoids the term 'colonial psychiatry'. Instead, it employs the term 'psychiatry' when referring to specialist institutional practices, whether in the colonial or early post-colonial era, and 'mental health care' when looking more broadly at the range of actors who assumed authority over the mentally ill.

Mental ill-health

This thesis uses the term mental ill-health in order to emphasise the wide variety of symptoms and behavioural problems experienced by people in the past. It

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[79] This was the case in Europe, too. Crammer, 'Training and Education in British Psychiatry', p. 209.
[80] Kapila, 'The Making of Colonial Psychiatry', p. 7.
[81] Beuschel, 'Shutting Africans Away', p. 10.
[82] Mahone, 'The Psychology of the Tropics', p. 18.

encompasses mental diseases such as dementia, schizophrenia, depression, and psychosis, as well as milder forms of mental distress such as anxiety, worry, and 'nerviness', which might not necessarily have been given a psychiatric diagnosis but caused distress to the person suffering from it. At no point do I deny that mental illness or mental ill-health is real, and that people experience mental distress. Rather than attempting to verify the 'truth' of these cases, my research is instead concerned with the multiple ways individuals, communities, and organisations understood and responded to what they believed to be signs of mental ill-health.

The state

In this thesis I am less concerned with attempting to differentiate between 'state' and 'non-state' contexts than with examining the relationships between multiple historical actors, and the ways in which those involved in mental health care often had overlapping or competing interests. Nevertheless, the question of what constitutes 'the state' in relation to psychiatry remains important, and is one that is complicated by the rise of Makerere University College and Makerere Medical School.[83] Mulago Hospital, for example, whose physicians assumed responsibility for the mentally ill for much of the period under consideration, was at once both a government institution and a university teaching hospital. Even after a formal agreement in 1951, when Makerere University College assumed full control over the medical school, there remained an ambiguity over who could control appointments to Mulago Hospital, and how responsibilities for teaching and clinical work were to be divided between Mulago Hospital's specialists.[84]

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[83] Makerere went through a series of name changes during this period: Makerere College (1922-49); Makerere University College (1949-70); Makerere University (1970-present).
[84] UMOHA, ECC.29 (Consultants / Specialists - General), letter from I.S. Kadama, Chief Medical Officer, to Ian McAdam, Makerere Medical School, 6 September 1967; ibid., minute from M/H to

Moreover, in a statement that is as relevant for psychiatry as it is for public health, Ryan Johnson and Amna Khalid have reminded us that the extent to which 'intermediary and subordinate staff' were able to shape public health policy 'highlights the disaggregated nature of the colonial state….From local political leaders and interpreters, to medical auxiliaries, nurses, matrons, hospital orderlies, pupil midwives, asylum attendants, and sweepers, the cooperation of intermediate and subordinate personnel was key to the functioning of most colonies' public health machinery'.[85] As such, this thesis employs the term 'the state' to refer primarily to the colonial administration and the later independent Uganda Government, while also recognising that the boundaries of the state were not always clear.

Sources

The research for this thesis has been carried out in libraries and archives in the United Kingdom, Geneva, and Uganda. In the United Kingdom I examined collections at the National Archives, Kew; Rhodes House, Oxford; the Henry Martyn Centre, Cambridge; Birmingham University; the Wellcome Library; and the British Library. In addition, I spent five days at the WHO archives, Geneva, where I drew on unpublished field reports from East Africa and files relating to financial assistance given to Makerere Medical School. Medical journals such as the *British Medical Journal*, *The Lancet*, and the *East African Medical Journal*, proved particularly useful for tracing changing ideas about mental ill-health throughout the period, and

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Chief Medical Officer, 8 January 1963; TNA, BW 90/190 (Makerere University, Mulago Medical School and Hospital), letter from A. Williams to I.C.M. Maxwell, Inter-University Council, London, 29 April 1959; Iliffe, *East African Doctors*, p. 67. These tensions will be explored further in Chapter IV.

[85] Amna Khalid and Ryan Johnson, 'Introduction', in Ryan Johnson and Amna Khalid (eds), *Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health, 1850-1960* (New York: Routledge, 2012), p. 3.

indicated the extent to which medical officers and psychiatrists in Kenya were the most vocal proponents of theories about educability, 'detribalisation', and race.

The research in Uganda was conducted over the course of two trips: June-September 2010 and April-November 2011. Doing history in Uganda can be a challenging task, requiring time, energy, and perseverance. Since contact details were often impossible to locate in advance, and emails rarely answered, I practised what Sicherman has referred to as the 'ambush method': I spent much of my time visiting offices, institutions, and hospitals, talking to anyone who was available and willing to listen. The time and generosity of many of the people I met resulted in a number of fascinating discussions, some unexpected questions, and more suggestions for avenues of research than I had time to adequately follow up on.

One of the main methodological challenges was deciding where to set the boundaries of the research. Having recognised that government records could only take me so far, I focused initially on medical mission records, drawing heavily on a series of patient case notes from the Church Missionary Society (CMS) Mengo Hospital, 1897-1950, located at the Albert Cook Library, Makerere University, and Mengo Hospital, Kampala. Over the period of a few months, I went through every volume recording notes on each case of mental ill-health, broadly defined. The decision to include a particular case was based on an understanding of contemporary psychiatric nosology, and in particular from my reading of German Berrios and Roy Porter's *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*.[86] The diagnoses given by the doctors and the detail put into the case notes

[86] German Berrios and Roy Porter (eds), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London & New Brunswick, NJ, 1995).

tended to vary by the race of the patient, as well as the interest, knowledge, and time of the doctors.

These records raised questions about the importance of western-trained African medical practitioners in mental health care, as well as the specificities of medical practice in Uganda. Following up on these questions, I employed a local research assistant—a recent graduate from Makerere University—to go through a small selection of Luganda newspapers and the records of the Principal Court of Buganda, looking for any reference to mental ill-health. I also decided to search district, national, and hospital archives for files on transport, migration, education, missions, Asian communities, Makerere College, the judiciary (specifically those files marked 'lunacy' or 'lunatics'), and medicine in general. This approach was more time consuming—some files contained nothing that related to mental ill-health—but it has allowed for the inclusion of a wide range of source material, and a more nuanced analysis of psychiatry and mental health care in Uganda.

The structure and content of this thesis has been strongly influenced by the files and people I was able to locate. The unexpected discovery of two files in a pile of discarded documents in a Ministry of Health warehouse, for example, enabled me to bring the story forward to 1972, and to examine the activities of African and expatriate psychiatrists in the late 1960s in detail. A meeting with the eldest son of Stephen Bosa, Joseph Bossa, in 2011, also led to communication with a number of the psychiatrists who had worked in Uganda at the time. Among these psychiatrists were G. Allen German and Jim Wood, who not only patiently answered all of my questions, but sent me an invaluable collection of unpublished papers relating to psychiatry and mental health care.

Much of this thesis is supported by oral history interviews, a feature that sets it apart from much of the historiography. Contacts were made over a period of a few months through Makerere University, grassroots charity Mental Health Uganda, traditional healers' association PROMETRA, the Church of Uganda (Rukungiri), and the Joint Clinical Research Centre (JCRC), Mbale. With the aid of a translator, the purpose of my project and their involvement was explained to each respondent, and oral consent was obtained. Respondents were not paid for interviews, but were given small gifts of sugar at the end of the interviewing process. Due to the sensitive nature of the subject matter, respondents are not named in this thesis but identified by basic demographic information and interview number. The exceptions are traditional healers and mental health professionals, who agreed to be named.

Reflecting on her approach to collecting the life histories of *!Kung* women in Botswana, Marjorie Shostak described how she 'tried to elicit specific incidents rather than generalized statements'. 'Discreet memories', she asserted, 'were more likely to capture the texture of the women's experiences and to highlight the variations among the different women in their life stories and in their interpretations of these stories'.[87] I approached my interviews in a similar way, aiming to understand how individuals and communities responded to specific incidents of mental ill-health rather than asking for broad statements about 'madness' in the past. This method allowed me to contexualise responses and for personal stories to come through. The benefits of the approach are particularly apparent in Chapter V, where interviews with eighteen Bagisu elders provide a rare opportunity to explore the fears, anxieties, and experiences of an epidemic of mass hysteria from the perspective of the patients

[87] Marjorie Shostak, "What the Wind Won't Take Away': The Genesis of *Nisa - the Life and Words of A !Kung Woman*', in Robert Perks and Alistair Thomson (eds), *The Oral History Reader* (London: Routledge, 1998), p. 404.

and communities affected. In the analysis of these oral histories I have recognised, as Elizabeth Tonkin has noted, that 'one cannot detach the oral representation of pastness from the relationship of teller and audience in which it was occasioned'.[88]

A large number of historical documents have been destroyed, if not by the departing colonial administrators in the 1960s, then under Idi Amin in the 1970s, or in the civil strife that followed his rule in the 1980s. Record keeping is also poor, particularly in hospitals, where administrators do not always appreciate the value of records, and have few resources to preserve them. Those records that do exist are often to be found in long forgotten cupboards, damaged by water, silverfish, and mice. Collections at district archives in Kabale, Fort Portal, Jinja, and Soroti, have recently been made more accessible to researchers, and I was able to locate a small but useful collection of documents pertaining to mental health care. I was less successful at Mbale, Mbarara, Hoima, Lira, Tororo, Masindi, Lira, Gulu, and Arua, where in some cases no records from the colonial or early post-colonial period have survived.

The National Archives, Entebbe was in the process of being re-catalogued during my second visit to Uganda. Only a few relevant materials were located from the old catalogues, which stop in the 1920s, and list a large number of files that appear to have gone 'missing'. Initial attempts to enquire into the nature of the uncatalogued files were met at first with disdain, but eventually one of the archivists agreed to accompany me down into the basement to look through their collections. This proved invaluable to my search for government records on mental health care and education.

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[88] Elizabeth Tonkin, *Narrating Our Pasts: The Social Construction of Oral History* (Cambridge: Cambridge University Press, 1999), p. 2.

While in the United Kingdom libraries and archives have developed their own access policies for historical material, in Uganda, only the National Archives imposed restrictions on access by adhering to a blanket '50 year rule'. Elsewhere in Uganda, access to documents was usually accomplished through a process of negotiation with district administrators, hospital superintendents, and records officers. In the absence of restrictions on access, I had to use my own judgment, asking whether the information in a file might aid our understanding of psychiatry and mental health care in past. During my first research trip in 2010 I was shocked by the ease with which I was granted access to hospitals and patient records collections. On one occasion I was informed that while the hospital had destroyed all records prior to 1996, there were a couple of mentally ill patients in the wards, and would I like to see their records and then be introduced to them? On my second research trip in 2011, it was almost with relief that three of the hospitals I returned to—Toro Hospital, Mengo Hospital, and Butabika Hospital—referred me to their ethics committees.

The physical difficulties of working in archives in Uganda has meant that the materials I have gathered represent only a small proportion of what was once available. No administrative or patient records were found at Butabika Hospital, for example. Records from the late 1960s were located at Mulago Hospital Mental Health Clinic, but the poor state of the records room made any investigation of patient case notes impossible. Nonetheless, the time invested in searching for materials in these archives has allowed my research to look at communities from across Uganda, and represents the first attempt to examine mental health care using files from the districts and Uganda's Ministry of Health. Until very recently, historical literature on Uganda has focused overwhelmingly on Buganda. In looking

at mental ill-health outside Uganda, and in particularly in those areas formerly known as Kigezi, Toro, and Bugisu Districts, this thesis also contributes to the literature that looks beyond Buganda.[89]

Thesis outline

The thesis is divided broadly into two parts. The first three chapters focus primarily on the colonial period, exploring the rise of institutional and intellectual psychiatry, as well as the roles played by families, mission hospitals, traditional healers, and marketplace medicines. The second takes the story into the post-colonial period, examining the importance of Makerere Medical School for intellectual and institutional psychiatry, the emergence of African psychiatrists, and the activities of a new generation of expatriate and Ugandan psychiatrists from the late 1960s. One of the distinctive features of the thesis is the inclusion of two case studies (Chapters III and V). Drawing on patient case notes and oral history interviews, these case studies address the complexities of psychiatric diagnoses in the past, as well as the complicated relationship between medical practitioners and their patients.

Chapter I traces the development of institutional and intellectual psychiatry in colonial Uganda. Between 1894 and 1962 provision for the mentally ill evolved from the occasional and haphazard isolation of troublesome 'lunatics' to an established system of certification, confinement, and repatriation. The perception that the

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[89] This literature includes: Ronald R. Atkinson, *The Roots of Ethnicity: The Origins of the Acholi of Uganda* (Philadelphia: University of Pennsylvania Press, 1994); Grace Carswell, *Cultivating Success in Uganda: Kigezi Farmers and Colonial Policies* (Oxford: James Currey, 2007); Shane Doyle, '"The Child of Death": Personal Names and Parental Attitudes Towards Mortality in Bunyoro, Western Uganda, 1900-2005', *Journal of African History* 49(1) (2008), pp. 361-82; Shane Doyle, *Crisis and Decline in Bunyoro: Population and Environment in Western Uganda, 1860-1955* (Oxford: James Currey, 2006); Mark Anthony Leopold, *Inside West Nile: Violence, History & Representation on an African Frontier* (Oxford: James Currey, 2005); Richard Vokes, *Ghosts of Kanungu: Fertility, Secrecy & Exchange in the Great Lakes of East Africa* (Kampala, Uganda: Fountain Publishers, 2009); Vongsathorn, "Things That Matter".

mentally ill would be best treated at Kampala, coupled with a series of scandals, forced the colonial administration to acknowledge responsibility for the mentally ill. The geographical siting of a new mental hospital on Mulago hill in 1935 brought psychiatry into the intellectual space of Makerere Medical School, the concerns of which set the development of psychiatry on a different path to that taken elsewhere in East Africa. In examining these developments, the chapter establishes some of the themes that recur throughout the thesis—the role of missionary and government medical communities in Kampala in driving psychiatry and shaping policy, the importance of medical education for Africans, and the problematic relationship between psychiatry and colonial rule. In so doing, the chapter starts to explore the reasons why the history of psychiatry and mental health care in Uganda requires a more nuanced narrative than one constrained by discourses of colonial governance and their impact on colonial subjects.

Chapter II follows by focusing on the experiences of families who negotiated different types of mental health care in Uganda. In so doing, it argues that while the developments in psychiatry examined in Chapter I were significant for the long-term trajectory of the discipline in Uganda, it was of limited importance for those families who endured the pressures and fears of mental ill-health on an everyday basis. Using letters from families found in district archives from across Uganda, this chapter looks at the burden of mental illness, the reasons why some families felt they needed to turn to confinement, and their experiences of the mental hospital once a relative had been admitted. The chapter also examines a number of other ways families attempted to deal with mental ill-health, looking at traditional medicine, mission hospitals, and tonics and remedies in turn. In so doing, it argues that families were not passive

actors in mental health care. They turned to, and interacted with, a range of different methods of healing.

Chapter III uses a case study approach to examine the complexity and contradictory nature of diagnoses like neurasthenia in colonial Africa. Neurasthenia was a condition of nervous and mental exhaustion, and was an illness that took on extended racial connotations when it was transported from America and Europe into the colonial context. Variously labelled as 'neurasthenia in the tropics' or 'tropical neurasthenia', the condition was associated almost exclusively with the mental and physical breakdown of white colonisers. Drawing on the case notes of European and African patients diagnosed with neurasthenia at the CMS Mengo Hospital, this chapter argues that in practice, and outside of the colonial asylum in particular, the doctoring of mental ill-health was more nuanced than histories of psychiatry and empire might imply. It was a diagnosis that was negotiated in hospital examination rooms as much as in medical journals and government medical boards. Significantly, it was also a diagnosis that was not always reserved exclusively for white colonisers—at Mengo Hospital from the early 1900s, neurasthenia was diagnosed in African patients too. In exploring the content of the case notes for these patients, the chapter places patients and their relationships with doctors at the forefront of investigation.

Chapter IV takes the theme of the cultural difficulties faced by both doctor and patient in the examination room as the starting point for a discussion about why the training of Africans in psychiatry became increasingly important. It examines the education and status of Uganda's first psychiatrists, Benjamin H. Kagwa and Stephen Bosa, as well as the establishment of a Department of Psychiatry at Makerere Medical School in 1966. The expatriates who joined the new Department of

Psychiatry, together with their African colleagues, attempted to bring the question of mental health care to the forefront of general medical practice, and initiated a 'golden age' for psychiatry in Uganda. In exploring these developments, the chapter contrasts the role of Makerere Medical School with that of the Uganda Government. It argues that the decision to establish a Department of Psychiatry at Makerere Medical School came as a relief to the Uganda Government; plagued by financial troubles and a lack of staff, the creation of the new department meant that the development of mental health care was no longer their sole responsibility.

Chapter V examines competing explanations for epidemics of mass hysteria in the early 1960s. As the second case study in the thesis, it offers a rare opportunity to interrogate the nature of early post-colonial psychiatry by incorporating the voices of both psychiatrists and patients into the analysis. These epidemics were significant enough to be remembered by people living in eastern Uganda in 2011 as a 'disease of that time', and focused enough for eighteen Bagisu elders to share their fears, anxieties, and experiences of a specific event in interviews. This chapter juxtaposes these interviews with a report by one of Uganda's first psychiatrists in order to explore a range of different perspectives on mental illness, as well as the ideas and practices of Africa's first generation of psychiatrists. In so doing, the chapter argues that the epidemics demonstrate the limits rather than the strengths of Ugandan psychiatry in the early post-colonial period. There remained a distance between psychiatrists and their patients that was only reinforced by the methods of examination, the explanations used, and the treatments suggested.

The final chapter explores the activities of psychiatrists outside of the mental hospital in order to examine the roles psychiatrists attempted to create for themselves in early post-colonial Uganda. From 1966 to 1972, a small group of psychiatrists

turned their attention to a range of educational activities, including the establishment of the Uganda National Association for Mental Health (UNAMH), training courses for police officers and lawyers, and a television series entitled 'The Sick Mind'. These activities aimed not only at spreading western ideas about mental ill-health to the wider Ugandan public, but to mobilise supportive professionals in order to extend the reach of psychiatry beyond that which could have been achieved by the psychiatrists alone. In so doing, as the chapter argues, the psychiatrists worked tirelessly to improve what they perceived to be problems with the treatment and handling of the mentally ill across Uganda. However, this involved creating a 'modern' psychiatry, with little room for alternative healing systems or beliefs.

Using a wide range of new source material, including interviews with psychiatrists, traditional healers, and community elders, this thesis pushes the history of psychiatry in Africa beyond the examination of government policy and colonial hegemony. It brings together the history of psychiatry with the histories of missionary medicine, medical education, and international health by asking what types of people, institutions, and organisations were involved in the provision of mental health care; how important the growth of Makerere Medical School was for intellectual and institutional psychiatry; and how 'African' mental health care had become by the end of the period.

The thesis departs from the historiography by choosing not to take Independence from the British as a historical endpoint. It presents a history of mental health care in a country that has tended to be overshadowed by Kenya in the historiography, yet whose engagement with medical missionaries and efforts to advance medical training meant that the trajectory of psychiatry came to be quite different. Focusing in particular on the significance of western-trained Ugandan

medical practitioners for mental health care, the thesis not only analyses African psychiatrists as historical actors in their own right, but represents the first attempt to examine the development of psychiatric education in Africa.

Chapter I:

The Importance of Place: Institutional and Intellectual Psychiatry in Uganda, 1894-1962

> Many years ago there were no Mental Hospitals in Africa and mad people just went walking about and sometimes died, and sometimes they killed people and set fire to houses and stole and did damage to other peoples [sic.] property.
>
> Sometimes they were caught and chained up in a little house and kept there until they died or got better.
>
> Conditions like these are very troublesome both for the people who look after mad people and for the mad people themselves, so Uganda like all other African countries came to have a Mental Hospital because lunatics are less troublesome and the country is much safer when lunatics are kept in a place by themselves where they are properly looked after and where they will have the best chance to recover.[90]

In this lecture to hospital attendants in the early 1940s, Charles Baty, mental nurse and Superintendent of Mulago Mental Hospital, presented the mental hospital as a sign of progress—a gift bestowed on Uganda by the British. The tale implied a unity and purpose to psychiatry that both privileged the power of individual psychiatrists and ignored the multiple ways families attempted to care for the mentally ill. For most of the colonial period, 'psychiatry' consisted of a fragmented group of prison warders, hospital and government administrators, and African and European physicians who assumed authority over the mentally ill. It was the interests

[90] RHO, Mss.Afr.s.1589 (Charles Baty Papers), 'Lectures & Treatments', f. 9, 'Lecture 1 - On Study' (nd.).

and concerns of these individuals, rather than any overarching scheme for psychiatry, that came to shape both the processes of confinement, and the intellectual paths that psychiatry was to take.

Between 1894 and 1962 provision for the mentally ill evolved from the occasional and haphazard isolation of troublesome lunatics to an established system of certification, confinement, and repatriation. The perception that the mentally ill would be best treated at Kampala, coupled with a series of scandals, forced the colonial administration to acknowledge responsibility for the mentally ill. As in other parts of Africa, the asylum was presented as a logical method of dealing with madness in a civilised society—a 'colonial institutional convention', of sorts.[91] Yet beyond the underlying conviction that there should be an institution for the confinement and treatment of the mentally ill, there was no one understanding of the role these institutions were to have. Just as psychiatry in England developed as a dialectical process, 'whereby the separation of the insane into madhouses and asylums helped to create the conditions for the emergence of an occupational group laying claim to expertise in their care and cure',[92] so the separation of the mad in colonial Africa foregrounded the need to define how they might best be treated, and set up the means by which the nature of African psychopathology could be explored.

If there was no overarching scheme for psychiatry, it was not because it was isolated from wider medical, social, or political developments. Indeed, as this chapter argues, the geographical siting of a new mental hospital at Mulago in 1935 brought psychiatry into the intellectual space of Makerere Medical School, the concerns of

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[91] Vaughan, 'Idioms of Madness', p. 220.
[92] Scull, *Most Solitary of Afflictions*, pp. 41-2.

which set the development of institutional and intellectual psychiatry on a different path to that taken elsewhere in East Africa.

The chapter starts by looking at the relationship between mental illness and sleeping sickness (trypanosomiasis), highlighting the importance of the CMS Mengo Hospital in identifying disease. It then turns to the development of Hoima Lunatic Asylum and Mulago Mental Hospital, bringing out the scandals and opinions that prompted reform. The rest of the chapter considers the significance of psychiatry's new 'place' at Mulago by establishing some of the themes that recur throughout the thesis—the role of missionary and government medical communities in Kampala in driving psychiatry and shaping policy, the importance of medical education for Africans, and the problematic relationship between psychiatry and colonial rule. In so doing, the chapter starts to explore the reasons why the history of psychiatry and mental health care in Uganda requires a more nuanced narrative than one constrained by discourses of colonial governance and their impact on colonial subjects.

An institution for confinement

In 1901, brothers and fellow CMS doctors Albert and Jack Cook notified the colonial government and the medical community in Britain of concerns over the growing number of sleeping sickness cases arriving at their hospital, sparking international interest in a disease that was to devastate local communities on the shores of Lake Victoria.[93] The role assumed by the mission doctors at Mengo Hospital, and the manner in which they informed and advised the Colonial Medical

[93] Albert Ruskin Cook, *Uganda Memories, 1897-1940* (Kampala: Uganda Society, 1945), p. 1; Foster, *The Early History of Scientific Medicine*, pp. 93-107; Douglas M. Haynes, 'Framing Tropical Disease in London: Patrick Manson, *Filaria Perstans*, and the Uganda Sleeping Sickness Epidemic, 1891-1902', *Social History of Medicine* 13(3) (2000), pp. 467-93; Deborah Neill, 'Paul Ehrlich's Colonial Connections: Scientific Networks and Sleeping Sickness Drug Therapy Research, 1900-1914', *Social History of Medicine* 22(1) (2008), pp. 61-77.

Service, was to shape medical practice in Uganda, including that related to mental ill-health, for the next thirty years.

The epidemic, which killed an estimated 250,000 people, prompted the forcible depopulation by the government of areas infested with tsetse flies, the establishment of government sleeping sickness camps, and the rapid development of a Colonial Medical Service aimed at understanding and limiting the disease.[94] Given this context, it is unsurprising that early discussion of mental pathology in Uganda was linked to sleeping sickness. Preoccupied by the volume of sleeping sickness patients who exhibited signs of mental degeneration in the later stages, other types of mental illness were rendered almost invisible. As the author of an early draft of the 'Blue Book and Report' of 1908-9 commented: 'Mania and dementia apart from [in] sleeping sickness are so uncommon that their presence leads to the suspicion of the existence of that disease'.[95]

Special provision for late-stage sleeping sickness patients within government camps pre-dated the establishment of a lunatic asylum by over twenty years. These patients frequently exhibited violent or unpredictable behaviour, and as such their separation was deemed necessary for camp security. In an official report on sleeping sickness measures at the end of 1909, the Governor of Uganda, Henry Hesketh-Bell, noted that the 'large number of sick who became demented….gave considerable trouble and frequently attempted to set fire to their quarters'. Not only were these patients difficult to manage, but their confinement contributed to a more general

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[94] Kirk Arden Hoppe, *Lords of the Fly: Sleeping Sickness Control in British East Africa, 1900-1960* (Westport, CN: Praeger, 2003), p. 1. On the development of the Colonial Medical Service in Uganda during this period, see Ann Beck, *A History of the British Medical Administration of East Africa: 1900-1950* (Cambridge, MA: Harvard University Press, 1970), ch. 2.
[95] TNA, CO 536/32, 62 (Blue Book + Report. 1908-9).

perception that sleeping sickness camps were places to be looked on with 'dread and aversion'.[96]

While medical practitioners and administrators recognised that there was a distinction between the effects of late-stage sleeping sickness and other forms of mental illness, descriptions of sleeping sickness patients tended to conflate the two. Following a visit to the camp at Kyetume, just over four miles from Mukono, in 1909, Albert Cook described to missionary supporters in the United Kingdom how:

> One compound was set apart for the treatment of maniacal cases, and here were half a dozen or so who had their legs shackled together to prevent them doing harm to themselves or others. They seemed far from melancholy. One was trying to dance, another was beating with a stick on an old tin can in lieu of a drum, another came hobbling towards us to find out who we were.[97]

Writing for a similar audience, J.C.M. Baker, wife of Clement Baker, a Medical and Sanitary Officer and camp administrator, also recounted how one night:

> New sounds bore into my brain, ears are awake and strained instantly. Cries far away, quick, high-pitched, lapping over each other like ripples—the cries of alarmed natives.
>
> I call the Bwana. We listen—but hear nothing. "A leopard, do you think?" I say.
>
> "More likely those 'lunies': we must hurry on that ward for them." (Many "sleepers" go through a mad stage.)[98]

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[96] TNA, CO 536/31, 38571 (Sleeping Sickness), 'Official report on the measures adopted by the Uganda Administration in dealing with "Sleeping Sickness" in the Protectorate, 17 November 1909', para. 52.
[97] Albert Ruskin Cook, 'A Visit to a Branch Dispensary and a Sleeping Sickness Camp in Uganda', *Mercy and Truth* no. 148 (1909), pp. 105-9 at p. 108.
[98] RHO, Mss.Afr.s.1091 Box 3 File 1 (Baker Papers), f. 11, 'A Night and Day in a "Sleeping Sickness" Camp', p. 3.

Both missionary and Colonial Medical Service authors recognised that mental derangement was just one 'stage' of sleeping sickness, but the presence of these cases nevertheless provided opportunities for comments to be made on the nature of African mental pathology—these patients were loud, wild, and required restraint. This was not unique to Uganda: in the Belgian Congo, which took a more militaristic approach to the epidemic, medical officers went even further in their interpretation of late-stage sleeping sickness, stressing how the 'insanity' of African sleeping sickness patients was characterised by identical obsessive and irrational ideas about confinement.[99]

The sleeping sickness epidemic demonstrated to the authorities in Uganda that diseased Africans could be dangerous and unpredictable, but it had little impact on policies towards the mentally ill, which remained reactive until the mid-1940s. When the first Lunacy Ordinance was passed in 1906, it was done to provide a legal basis through which to handle European, rather than African lunatics.[100] Unlike with sleeping sickness, where physicians, administrators, and chiefs were charged with directing patients towards camps, neither the medical department nor the prisons service wanted responsibility for the few African mentally ill patients who came to their attention. In 1913, the Inspector General of Police and Prisons complained that Hoima Prison had developed a reputation as a dumping ground for physically and mentally ill prison inmates.[101] This, he stressed, was unacceptable:

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[99] Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940* (Cambridge, UK: Cambridge University Press, 1992), pp. 121-3. For a fuller treatment of the role of ideas about sleeping sickness and mental illness in East and Central Africa, see Mahone, 'The Psychology of the Tropics', pp. 125-34.

[100] TNA, CO 536/6, 49 (Ordinance No 4 1906 "Bankruptcy and Lunacy" Submits). In this year four people were certified as insane under the new legislation. TNA, CO 536/14, 110 (Report on Legal Dept. 1906. Judge Carter).

[101] UNA, A46/1120 (Hoima Prison: Leper and Lunatic Prisoners), letter from Captain Chiddick, Commissioner of Prisons, Kampala, to Chief Secretary, Entebbe, 24 July 1913.

> To intern the demented, the diseased, and those in full possession of their health and senses in one and the same building when that building is lacking the means of complete segregation, is a measure so diametrically opposed to the precepts both of Prison and Medical Administration that I should be shrinking from duty and responsibility if I failed to deal with the matter in this Report.[102]

If measures for segregation at Hoima were less than ideal, they were at least better than at Kampala Central Jail, where overcrowding prevented any segregation at all, and suicidal inmates were almost impossible to manage.[103] The number of lunatics intended for confinement at Hoima Prison was also small—comprising eleven men in 1914-5.[104] With these considerations in mind, Hesketh-Bell sanctioned the use of Hoima Prison as a holding ground for leper prisoners, with lunatics following suit.[105]

There was no doubt that provision for the mentally ill at Hoima Prison, in western Uganda, was completely inadequate. A report into conditions in prisons in Uganda in 1920 highlighted how administrative and medical supervision was minimal: the positions of District Commissioner (DC) and Assistant District Commissioner were both vacant, and the nearest medical officer lived thirty-seven

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[102] TNA, CO 536/62, 42541 (Prisons - Inspection Report 1912), 'Report of the Inspector General of Police and Prisons on the Uganda Government Prisons for the year 1912', para. 2. Hoima was a centre for British troops during the colonial conquest of Bunyoro in the 1890s, but remained small throughout the colonial period. Hoima Prison was opened in 1909, and by 1913 the town also had a native hospital with eight beds, a meteorological station, and two mission-run schools. UNA, J5 (Lunatic Asylums - General), minute addressed to His Excellency, 30 January 1929; A.R. Dunbar, *A History of Bunyoro-Kitara* (Nairobi: East African Institute of Social Research / Oxford University Press, 1965), p. 126.

[103] TNA, CO 536/58, 4532 (Report on Prisons 1911), paras. 12-4; UNA, J5/4 part I (Accommodation for Lunatics), f. 1, letter from the Commissioner of Prisons, Kampala, to Chief Secretary, Entebbe, 19 February 1930, pp. 1-2; TNA, CO 536/62, 42541 (Prisons).

[104] Uganda Protectorate, *Blue Book for the Year Ended 31st March, 1915* (Entebbe, Uganda: Government Printer, 1915).

[105] TNA, CO 536/62, 42541 (Prisons), letter from Hesketh-Bell to the Secretary of State for the Colonies, 13 November 1913, pp.1-2.

miles away.[106] The inspectors, led by C.A. Wiggins, the Principal Medical Officer (PMO), noted how:

> The arrangements for the correct nursing and general comfort of the sick are as will be seen from the above are very primitive. There is no padded cell. Violent inmates are hand cuffed (or leg cuffed or both) to the bars of the doors of their cells. There is no matron, although female patients are admitted to the asylum.[107]

The report concluded that it was essential that an asylum be constructed at Kampala, where medical facilities and the High Court, Entebbe, would be easily accessible.[108] What eventually prompted reform, however, was scandal arising from the logistics of certification rather than any complaint about accommodation.

In August 1920 two 'harmless lunatics' confined in Kampala Jail collapsed and died, having been too weak to survive travel or imprisonment.[109] In a move that highlighted the absurdity of arrangements for lunatics, they had been brought over 140 miles (a distance that took on average two full days by motor-van) from western Uganda to Kampala for observation and certification, and would no doubt have been taken back to the west for confinement at Hoima had they lived.[110] Concern was later expressed that the inability to get a reception order for lunatics via telephone had resulted in serious irregularities, but it was the travelling and confinement in

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[106] TNA, CO 536/104, 604 (Death Rate among Prisoners), letter from C.A. Wiggins to Chief Secretary, Entebbe, 30 September 1920; ibid., 'Report on Lunatic Asylum, Hoima'.
[107] Ibid.
[108] Ibid. This recommendation was not new. In 1913, Wiggins had presented a case for three separate asylums sited within one enclosure to house European, Asian, and African lunatics. TNA, CO 536/60, 279 (Lunatic Asylum), copy of letter from C.A. Wiggins, Acting Principal Medical Officer, Entebbe, to Chief Secretary, Entebbe, 23 June 1913. In 1916 the Acting Chief Secretary had also asked whether military buildings at Bombo, approximately twenty miles from Kampala Township, might be suitable for a lunatic asylum, leper asylum or a venereal diseases hospital, but the answer from A.D.P. Hodges, the Principal Medical Officer, was an emphatic 'no', and nothing further was mentioned on the subject. UNA, A46/1476 (Military - Bombo Buildings: Utilization of for Lunatic Asylum &c.).
[109] UNA, C0524 (Miscellaneous - Lunatics, Death of, in Kampala Jail).
[110] Ibid., letter from W.L. Webb, Medical Officer, Kampala, to Officer i/c Charge, Police Station, Kampala, 11 August 1920; Dunbar, *A History of Bunyoro-Kitara*, pp. 121-2.

Kampala Jail that was deemed to have done 'considerable harm'.[111] In reviewing the correspondence on the deaths a few months later, the Chief Secretary noted that:

> I am afraid that until some proper provision is made in the Protectorate for the care and treatment of mental cases, irregularities such as are brought to light in the attached correspondence are bound to occur. The Attorney General, I am satisfied, acted with the best intentions and did the best he could in the circumstances and the death of these men in unlawful custody in the Gaol is to be regretted. The matter should, however, have been reported to Headquarters and not suppressed. I cannot help feeling that more care and attention should be bestowed on the unfortunate inmates of Hoima.[112]

Two weeks later, the colonial government considered provisions for a new Lunacy Ordinance that aimed specifically at reducing the distance lunatics would be forced to travel. District Magistrates were granted the power to certify lunatics, and in remote parts of Uganda, where medical personnel were thin on the ground, only one medical report would be required in cases involving natives.[113] The new Lunacy Ordinance was gazetted in 1921, and at the same time Hoima Jail was officially re-designated as a place for the reception of lunatics.[114]

The importance of Kampala

In 1923, ordinary prisoners were removed from Hoima Jail, leaving the criminal and ordinary lunatics in the remaining prison buildings.[115] In the same year, medical services across Uganda started to be reorganised. Faced with the exorbitant

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[111] UNA, C0524 (Lunatics, Death of, in Kampala Jail), letter from Police Prison Surgeon, Kampala, to Superintendent of Jails, Kampala, 21 August 1920.
[112] Ibid., minute from Superintendent of Jails, Kampala, to Governor, Entebbe, 11 November 1920.
[113] TNA, CO 536/104, 576 (Lunacy Ordinance), letter from R.T. Coryndon, Governor, Entebbe, to Secretary of State for the Colonies, London, 26 November 1920.
[114] No. 476 of 1921, 'The Lunacy Ordinance 1921 Notice', *The Uganda Official Gazette* (Entebbe, 1921), 15 September 1921.
[115] Uganda Protectorate, *Annual Medical and Sanitary Report for the Year Ended 31st December, 1923* (Entebbe: Government Printer, Uganda, 1924), pp. 9-10.

cost of maintaining specialist anti-venereal disease clinics, moves were made to combine general and specialist medical work along the lines of Mulago Hospital, Kampala, which had opened as a general native hospital earlier in the year.[116] The native hospital at Hoima benefited from this new policy, and in a move that brought the mentally ill firmly under medical control, a European Superintendent was appointed with dual responsibility for the hospital and lunatic asylum.[117]

The centralising tendencies of the medical administration of the 1920s prompted renewed calls for a lunatic asylum at Kampala. In the view of G.J. Keane, Director of Medical and Sanitary Services (DMSS), the ideal to be achieved was that created by medical missionaries at Mengo Hospital, where all medical units were under one administrative head.[118] A mental hospital at Kampala would reduce the amount of travelling required by patients and staff, and allow for easy access to medical facilities.

The decision to locate the new mental hospital at Kampala, the centre of European residence, was hardly unusual. Mathari Asylum, in neighbouring Kenya, was built on the outskirts of the Nairobi Municipal Area.[119] Ingutsheni Mental Hospital, too, was situated one and a half miles from Bulawayo's central business district, which at the time of Ingutsheni's opening in 1908 was a hub of mining,

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[116] TNA, CO 536/140 (History of Ugda Medical Reforms); TNA, CO 536/129 (Medical Department. Coordination of Services and General Reorganisation); Beck, *A History of the British Medical Administration*, ch. 4; Uganda Protectorate, *Annual Medical and Sanitary Report 1923*, pp. 8, 63; Audrey W. Williams, 'The History of Mulago Hospital and the Makerere College Medical School', *East African Medical Journal* 29(7) (1952), pp. 253-63.

[117] TNA, CO 536/131 ((1) Office Supt and Storekeeper, Hoima Native Hosp. (2) Vacancy for European Supt, Mulago. (3) Vacancy for Clerk, Agric Dept.), letter from G.F. Archer, Governor, Entebbe, to Secretary of State for the Colonies, London, 16 June 1924;UNA, J5/3 (Medical: Lunatic Asylums: Administration of); Uganda Protectorate, *Annual Medical and Sanitary Report for the Year Ended 31st December, 1924* (Entebbe: Government Printer, Uganda, 1925), p. 6.

[118] UNA, C1266 (Medical. Organisation of Medical Units at Kampala), memorandum by Major Keane entitled 'Asiatic Hospital - Kampala', May 1928. Such was the importance of the tendency towards centralisation that in 1936 officials considered relocating the Medical Headquarters to Kampala. See UNA, J1/23 (Medical Headquarters - Transfer of, to Kampala).

[119] Beuschel, 'Shutting Africans Away', p. 127.

cattle, and railway activity.[120] What was to give the new mental hospital at Kampala historical significance was the decision to place it next to the small but growing teaching hospital on Mulago hill.

In looking for a site for the new mental hospital, Keane solicited the opinions of a range of medical and legal practitioners, including Albert Cook, whose role in advising the Colonial Medical Service informally on aspects of medical practice, hygiene, sanitation, and town planning, demonstrates both the influence of mission doctors within government circles and the ways in which the reach of missionary medicine extended beyond curative services.[121] In a letter in September 1930, Keane set out the pros and cons of two potential sites. The new mental hospital, he explained, was to replace Hoima Lunatic Asylum, with provision 'for about 100 Africans, two or three Asiatic and two European patients':

> The first [site] is at Luzira, not in too close proximity to the gaol. The advantages of this site are that it is remote from European occupation and thus avoids the annoyance of the possible noise made by maniacal cases, and that it is conveniently situated with regard to pipe water supply. The disadvantages are its proximity to the gaol, thus perpetuating the association of ideas which has arisen between crime and lunacy which it is desirable to end; and it is remote from a hospital, and additional expense would be incurred by the necessity of providing resident medical staff and separate common services.
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> …The second site is on Mulago on the northern slopes remote from Kampala and Makerere and beyond the site of the new Isolation Hospital. The disadvantages of this site are its proximity to European habitation, particularly Mulago, Makerere and the northern outskirts of Kampala. It is felt that this disadvantage could be overcome by the construction of sound proof cells for noisy patients. The advantage of

[120] Jackson, *Surfacing Up*, p. 24.
[121] UNA, J5 (Lunatic Asylums), f. 5, letter from Chief Secretary to DMSS, 12 February 1929. The Albert Cook Collection at ACMM contains a large collection of letters requesting advice and information from Cook. See, for example, ACMM (Sir Albert Cook Records: Mengo Hospital Correspondence), letter from C.A. Wiggins to Dr Cook, 23 December 1914; ibid., letter from J.M. Collyns to Dr Cook, 22 July 1915; ibid., letter from G.O. Stratham to Dr Cook, 14 February 1916; ibid., letter from C.J. Baker, Medical and Sanitary Officer, to Albert Cook, 31 August 1916; ibid., letter from L. Allworth to A. Cook, 2 March 1914.

> this site is its proximity to Mulago and Kampala Hospitals, allowing regular treatment of cases and daily and nightly supervision by medical staff. An economy would be effected by the sharing of common services (kitchen, laundry, conservancy etc.) between the two institutions.[122]

Both sites were on the outskirts of Kampala Township, but, as Keane stressed, the two had very different implications—for ideas about insanity, administrative responsibility for mental illness, and treatment of the patients themselves. It is unclear why Mulago was finally chosen, but it seems likely that it was the preferred choice of practitioners like Cook, who had responded to Keane's request with the remark 'Mulago'.[123]

The siting of the new mental hospital at Kampala forced the medical administration to consider the management of the mentally ill, for the first time, in more than just practical terms. Consideration now had to be given to the public perception of crime and disorder. This was not linked to an increase in numbers—at the beginning of 1930, the number of lunatics at Hoima Lunatic Asylum totalled only 61 (all African).[124] Nor was there any public outburst of alarm over the presence of 'raving maniacs' on the streets, as was seen in Nigeria.[125] Yet ideas about the dangers of the mentally ill ran through correspondence on the topic throughout the 1930s and 1940s. In February 1942, for example, the Commissioner of Police weighed in on an argument between the Uganda Transport Company and the DMS over the transportation of mental patients, stressing that it was 'most undesirable for lunatics

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[122] ACMM (Mengo Hospital Correspondence), letter from Major Keane, Director of Medical and Sanitary Services, Entebbe, Uganda, to Dr. Cook, 11 September 1930.
[123] 'Institution for the Insane', *Uganda Herald,* 24 October 1930.
[124] ACMM (Mengo Hospital Correspondence), letter from Major Keane, Director of Medical and Sanitary Services, Entebbe, Uganda, to Dr. Cook, 11 September 1930.
[125] Sadowsky, *Imperial Bedlam*, ch. 2.

to be conveyed in public vehicles, especially buses'. In his opinion, a 'screaming, raving lunatic should never be exposed to the public'.[126]

The physicians and administrators who chose to situate the new mental hospital at Mulago could not win: on the one hand its location allowed for the mentally ill to receive specialist medical care; on the other, its proximity to Europeans living in Kampala Township and African in-patients at the general hospital meant that at the very least the hospital would require heavily sound proofed cells. Indeed, psychiatrist Jim Wood recounted an anecdote in 1968 that had it 'that the site was chosen by sending a large group of hospital employees and their wives on a noisy progress from the General Hospital, and, when their din could no longer be heard at the General Hospital, the site for the new hospital was marked'.[127]

When Mulago Mental Hospital was opened in 1935, it was publicised as a most progressive way of dealing with the mad. 'Like all modern institutions of its kind', the Uganda Herald reported:

> the 'padded cell' is done away with as it is understood that really obstreperous patients are treated with drugs. This building is up to-date in its inception and lay out, and will fill a long felt want in the Protectorate. All the walls of the wards have been painted with a special paint to ensure smoothness, while all windows are fastened from the outside. There are no fittings inside the wards whatsoever. The male and female wards are entirely separate and also have separate sets of keys, although the Master will have a skeleton key which will fit all locks.
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> Ample space is provided for recreation and the buildings are so erected that it is not anticipated any noise will be heard by the patients in Mulago hospital.[128]

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[126] UNA, D107/12 (Lunatics: Transport of Mental Patients), ff. 4-5, letter from Lieut.-Colonel, Commissioner of Police, to Director of Medical Services, Entebbe, 10 February 1942.
[127] Wood, 'A Half Century of Growth', p. 118.
[128] 'Notes by the Way: A Weekly Commentary on Current Affairs', *Uganda Herald,* Wednesday 14 August 1935, p. 13.

While there was a strong emphasis on protecting society from the mentally ill, the opening of the mental hospital also marked the beginning of attempts to treat mental illness by psychiatric means. 1937 saw the start of basic 'occupational therapy' through the manufacture of woollen items.[129] By the late 1940s, this had expanded to include gardening, ward, kitchen, and laundry work, needlework, knitting, rug-making, cotton-growing, and pottery.[130] The colonial administration in turn used these activities to demonstrate their 'success' in managing the mentally ill to officials elsewhere in colonial Africa, as well as in the United Kingdom. The only two photographs of the mentally ill reproduced in the Annual Medical Reports, for example, show occupational therapy, rather than accommodation or physical therapies (Images 4 and 5).

[129] UNA, J142 (Mental Hospital: Occupational Therapy for the Treatment of Patients); Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1937* (Entebbe: Government Printer, Uganda, 1938), p. 51.
[130] Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1946* (Entebbe: Government Printer, Uganda, 1949), pp. 48-9; Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1948* (Entebbe: Government Printer, Uganda, 1950), p. 48; Uganda Protectorate, *Annual Report of the Medical Department, 1949*, p. 44.



Image 3: Mental Patients – Occupational Therapy, 1956
Credit: Uganda Protectorate, *Annual Report of the Medical Department, 1956*



Image 4: Mental Patients – Occupational Therapy, 1956
Credit: Uganda Protectorate, *Annual Report of the Medical Department, 1956*

From the mid-1940s, too, insulin therapy and electro-convulsive therapy (ECT) were given to selected patients—therapies that at the time were at the forefront of modern psychiatry.[131] These treatments were made possible by the proximity of the mental hospital to Mulago Hospital. In the early 1940s, J.P. Mitchell, Medical Superintendent of Mulago Hospital, and H.C. Trowell, Specialist Physician, were assigned to take charge of administration, diagnoses and treatment.[132] While it is questionable how much time Mitchell and Trowell were able to dedicate to treating mental patients, their involvement ensured that the mental hospital was not isolated from the wider concerns of those at Mulago. This in turn gave psychiatry a new 'place' in Uganda—one that would be shaped by the growth of an intellectual community at Makerere Medical School and their interest in the training of African physicians.

Intellectual communities and psychiatric knowledge, 1935-48

The 'East African School' of psychology and psychiatry

The personalities and theories of the 'East African School' of psychology and psychiatry have been well documented by historians.[133] Between the 1920s and 1950s, a body of research on African intellect, personality traits and psychopathology grew in the pages of the *East African Medical Journal* (*EAMJ*) and in discussions at

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[131] Uganda Protectorate, *Annual Report of the Medical Department, 1946*, p. 48; Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1947* (Entebbe: Government Printer, Uganda, 1949), p. 42; Uganda Protectorate, *Annual Report of the Medical Department, 1948*, p. 48.

[132] RHO, Mss.Afr.s.1872(144B) (Hugh Trowell Papers), 'Transcript of conversations between Hugh Trowell and Elizabeth Bray', p. 34; RHO, Mss.Afr.s.1589 (Charles Baty Papers), 'Correspondence - Uganda Govt.', letter from Crown Agents, London to Charles Baty, 9 March 1940.

[133] On this 'school', see especially Beuschel, 'Shutting Africans Away', ch. 7; Mahone, 'East African Psychiatry'; Mahone, 'Psychiatry in the East African Colonies'; H.J. Simons, 'Mental Disease in Africans: Racial Determinism', *Journal of Mental Science* 104 (1958), pp. 377-88; Vaughan, *Curing Their Ills*, pp. 110-2.

local branch meetings of the British Medical Association (BMA).[134] Research on 'the African mind', as it became known, stressed biological and cultural differences between Africans and Europeans, and was particularly noted for its practical implications for colonial rule. The failure of African cultures to incorporate the traits of individual control, abstract thought, and personal responsibility, it was theorised, meant that 'westernisation' or 'detribalisation' was particularly dangerous for Africans, and required the immediate extension of 'social protection and control'.[135]

The men who were most prominent in the East African school—F.W. Vint, H.L. Gordon and J.C. Carothers—worked primarily in Kenya, but saw no problem in extending their arguments out to the 'East African' and 'African' more generally. Gordon, Visiting Physician to Mathari Mental Hospital, 1930-7, stressed how his experience at Mathari had shown him that mental illness in Africans was primarily organic in origin, and that the peculiarities of African psychopathology could be explained by fundamental differences between Africans and European in brain size and growth.[136] Vint, a pathologist attached to the Pathological Research Laboratory, Nairobi, was particularly noted for his investigations into brain weights of Kenyan natives, which he asserted were on average ten per cent lighter than Europeans.[137] While Vint did not work with mental patients and was careful not to draw wider

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[134] Chloe Campbell, *Race and Empire: Eugenics in Colonial Kenya* (Manchester, 2007), ch. 3; Anna Crozier, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa* (New York: I.B. Tauris & Co. Ltd, 2007), pp. 96-7; Mahone, 'The Psychology of the Tropics', p. 111. This literature shows the extent to which Jock McCulloch's claim that psychiatrists and psychologists in Africa worked in intellectual isolation does not hold up in East Africa. McCulloch, *Colonial Psychiatry*, p. 11.

[135] J.C. Carothers, 'A Study of Mental Derangement in Africans, and an Attempt to Explain Its Peculiarities, More Especially in Relation to the African Attitude to Life', *East African Medical Journal* 25(5) (1948), pp. 197-219 at pp. 217-8; Vaughan, *Curing Their Ills*, ch. 5.

[136] H.L. Gordon, 'The Mental Capacity of the African: A Paper Read before the African Circle', *Journal of the Royal African Society* 33(132) (1934), pp. 226-42.

[137] F.W. Vint, 'The Brain of the Kenya Native', *Journal of Anatomy* 68(2) (1934), pp. 216-23 at p. 222. Vint's earlier work included F.W. Vint, 'A Preliminary Note on the Cell Content of the Prefrontal Cortex of the East African Native', *East African Medical Journal* 9(2) (1932), pp. 30-55.

conclusions from his work, his findings were used by others, notably Gordon, as evidence of the biological inferiority of Africans more generally.[138] Emphasising the importance of cultural, as opposed to biological, difference, Carothers also tended towards regional generalisations in his work, highlighting how his experience demonstrated that a number of mental illnesses frequently seen in Europe, such as depression and the neuroses, were completely absent in East Africa.[139] More overt forms of 'mental derangement', by contrast, were increasingly common, as 'detribalisation'—something that encompassed such diverse aspects as 'Christianization, secular education, working relationships with non-African employers, relationships with Government officials and with shop-keepers (the latter mostly Indian), life in townships, and the introduction of syphilis and alcoholic spirits and other drugs'—took hold.[140]

The physicians in Uganda certainly engaged with theories of African mentality and psychopathology being produced in Kenya and elsewhere in Africa. Even before the research community at Mulago Hospital became a significant force of its own in the 1950s, government and missionary physicians read and contributed to the *EAMJ* and attended inter-territorial meetings of the BMA.[141] In one such meeting in Kampala in 1936, prominent medical figures from Kenya, Tanganyika, Sudan and Uganda heard Gordon speak on the 'necessity of ascertaining normal values for the various biological features of Africans'.[142] Following his paper, Albert

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[138] Beuschel, 'Shutting Africans Away', p. 236.
[139] J.C. Carothers, 'Some Speculations on Insanity in Africans and in General', *East African Medical Journal* 17 (1940), pp. 90-105 at pp. 101-2.
[140] J.C. Carothers, 'A Study of Mental Derangement in Africans, and an Attempt to Explain Its Peculiarities, More Especially in Relation to the African Attitude to Life', *East African Medical Journal* 25(5) (1948), pp. 142-66 at pp. 153-4.
[141] RHO, Mss.Afr.s.1872(75) (R.S.F. Hennessey Papers), 'Learning about Disease in Uganda: 1929-44 and 1949-55', p. 10.
[142] 'Meetings of Branches and Divisions', *Supplement to the British Medical Journal,* 11 July 1936, p. 29.

Cook, recently retired from Mengo Hospital, and William Kauntze, Director of Medical Services (DMS), Uganda, proposed that Gordon undertake further research into the mental capacities and adjustment of East Africans. The proposal noted that:

> (1) that the preliminary inquiries into the physical and mental capacities of the East African have created a situation in regard to the adjustment of the East African to our educational methods that can no longer be left as it is: (2) that it is a matter of urgency for a solution of the question to be undertaken by means of a comprehensive co-operative research: and (3) that the lines already suggested by Dr. Gordon might well be adopted as a basis for the plan and organization of the research.[143]

The proposal spoke both to the focus on education in Uganda as well as to a much wider interest in research on intelligence and 'educability' in East Africa during the 1920s and 1930s. Kauntze, for example, was a firm supporter of Vint's research, and in particular of his investigation on the prefrontal cortex of East African natives.[144] Trowell, at the time in charge of admissions to Mulago Mental Hospital, also attended a number of race improvement meetings during his career in East Africa.[145] As Chloe Campbell has argued in her study of the eugenics movement in colonial Kenya, such was the support for research into intelligence and 'educability' among medical practitioners of the 1930s, 'that eugenic language seems omnipresent, even among people who would not necessarily have described themselves as eugenicists'.[146]

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[143] Ibid.
[144] Vint, 'A Preliminary Note', p. 53. As cited in Campbell, *Race and Empire*, p. 64.
[145] Campbell, *Race and Empire*, p. 68.
[146] Ibid., pp. 64-5.

Neurosyphilis and 'the African mind'

Despite an engagement with ideas about African mentality and psychopathology, the physicians in Uganda made few direct contributions to the literature. In the period before 1950, the only area that stimulated sustained interest was neurosyphilis, a condition that had its own local historical and medical significance.[147] Alarmed by apparently epidemic rates of syphilis and gonorrhoea in Uganda in the early 1900s, missionaries and Colonial Medical Officers had long attempted to combat venereal disease through medical and morality campaigns.[148] Mulago Hospital also had roots as a venereal disease clinic, the legacy of which manifested itself in the routine blood testing of every in-patient for syphilis until well into the 1930s.[149]

Research on neurosyphilis in Uganda reflected this local interest and a much wider intellectual debate on whether natives in the tropics could suffer from neurosyphilis at all. In their influential survey on neurological disease at Mulago Hospital in early 1940s, for example, Trowell and a Muganda African Medical Officer (AMO), Eria Muwazi, argued that Africans were by no means immune from neurosyphilis, and that it was more lack of knowledge and the difficulties of diagnosis that had resulted in this 'erroneous idea'.[150] W.R. Billington, a mission doctor at Mengo Hospital, similarly pointed out that the alleged rarity of

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[147] Tuck, 'Syphilis, Sexuality, & Social Control'; Zeller, 'The Establishment of Western Medicine', pp. 189-207.
[148] Maryinez Lyons, 'Medicine and Morality: A Review of Responses to Sexually Transmitted Diseases in Uganda in the Twentieth Century', in Philip W. Setel, Milton Lewis, and Maryinez Lyons (eds), *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa* (Westport, CT: Greenwood Press, 1999); Summers, 'Intimate Colonialism'; Vaughan, *Curing Their Ills*, ch. 6.
[149] RHO, Mss.Afr.s.1872(153A) (A.W. Williams Papers), 'East African Notes', Section A, p. 9.
[150] E.M.K. Muwazi and H.C. Trowell, 'Neurological Disease among African Natives of Uganda', *East African Medical Journal* 21(1) (1944), pp. 2-19 at p. 14. On Muwazi's background and future involvement in politics, see David E. Apter, *The Political Kingdom in Uganda: A Study of Bureaucratic Nationalism* (Princeton, NJ: Princeton University Press, 1967), p. 315.

neurosyphilis in the tropics did not stand up to scrutiny in Uganda, where he had found all the main forms of neurosyphilis to be 'comparatively common'.[151]

The proximity of the mental hospital to the general hospitals at Mulago and Kampala facilitated investigations into the presentation of neurosyphilis, both between Africans and Europeans, and between certified and non-certified cases. Using data from 217 patients at Mulago Mental Hospital from 1940-2, Trowell estimated that neurosyphilis, in its late stage form of General Paralysis of the Insane (GPI), accounted for approximately thirty percent of all certified cases of insanity in Uganda—'approximately three times as large a proportion as in Britain'.[152] The focus on difference did not stop there. As Trowell noted:

> Cases fell into two groups, firstly, those twenty-one cases who were admitted into the General Hospital as advanced bed-ridden patients, dirty in their habits, but so enfeebled mentally that the possibility of G.P.I. might easily be overlooked. Those of the second group were admitted to the Mental Hospital and showed all the classical signs of the disease; both the elated, maniacal, depressed and demented types were seen. Delusions of grandeur were present in the majority, but these tended to be less grandiose than in the European and followed a more humble African pattern.[153]

The examination of African 'delusions' was an aspect of mental illness that sparked particular interest among physicians and psychiatrists in colonial Africa. As Vaughan has noted, these delusions were usually divided into two categories—the 'European type' and the 'native type'. While the 'native type' tended to involve relatively harmless ideas linked to their 'primitive' and 'tribal' environments, the 'European type' was more worrying. It included 'those Africans whose 'brains had

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[151] W.R. Billington, 'Neurosyphilis in Natives of East Africa' (unpublished MD thesis, University of Cambridge, 1945), p. 3.
[152] Muwazi and Trowell, 'Neurological Disease', p. 12.
[153] Ibid., pp. 11-2.

been turned by a little schooling', the idioms of whose madness were motor cars, bicycles, kings of England and silver mines; who flung back at the conquerors their own images of superiority in disturbingly distorted forms'.[154]

By taking racial difference as its central organising principal the research on neurosyphilis fit neatly into theories and ideas being produced elsewhere in East Africa.[155] Despite this, Muwazi and Trowell drew on the budding relationship between the mental hospital, the intellectual community at Mulago and its medical school, to claim greater insight into African psychopathology than those working elsewhere. Not only did they highlight how their questioning of African medical students allowed them to explain some of the peculiarities of neurosis in Africans, but their survey was the only one of its kind to include an African physician as co-author. While it is clear that the majority of the article was written by Trowell, with the co-authorship as a rather paternalist attempt to promote Muwazi among his colleagues,[156] Muwazi had collected a significant proportion of the data used, and offered his opinion on individual cases. Trowell was keenly aware of the implications of the research on psychopathology emanating from Kenya, some of it explicitly eugenicist,[157] and his paper with Muwazi may have been directed at countering those ideas in particular. At the same time, the paper stands as an indication of the importance of the training of African physicians in Uganda, a concern that would, from the late 1940s, start to shape the nature of psychiatry.

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[154] Vaughan, 'Idioms of Madness', p. 219.
[155] Billington, 'Neurosyphilis in Natives of East Africa', p. 28; H.L. Gordon, 'Psychiatry in Kenya Colony', *Kenya and East African Medical Journal* 6 (1934), 316-24; Mahone, 'The Psychology of the Tropics', p. 102.
[156] RHO, Mss.Afr.s.1872(144B) (Trowell Papers), 'Transcript', pp. 34-5; Iliffe, *East African Doctors*, p. 87.
[157] Campbell, *Race and Empire*, ch. 3.

The beginnings of psychiatric education

By the end of the 1930s, the number of patients admitted to Mulago Mental Hospital had started to swell, prompting the construction of additional accommodation in 1940 to bring the total bed space to 168.[158] The number of patients continued to rise, however, and at the beginning of 1943, Carothers was invited to visit Mulago Mental Hospital to report on existing arrangements and to suggest future developments.[159] While Carothers had yet to achieve his reputation as Africa's foremost expert on mental diseases, he had already published locally in the *EAMJ*, where he speculated on the peculiarities of African 'normality'.[160] Rather than looking towards Kenya for any particular expertise, the invitation reflected the extent to which Uganda recognised the need for uniformity in mental health provision across East Africa, particularly in the legal and practical arrangements for European lunatics.[161]

Carothers' report confirmed much of what the medical authorities in Uganda already knew: the mental hospital was overcrowded, the accommodation inadequate (particularly for European cases, who were usually sent on to Kenya or South Africa), and therapies lacking.[162] But it also raised the question of the appointment of a full-time (European) Medical Officer (MO) willing to specialise in psychiatry.

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[158] Uganda Protectorate, *Annual Report of the Medical Department, 1946*, p. 46.
[159] RHO, Mss.Afr.s.1589 (Baty Papers), 'Correspondence', J.C. Carothers, 'Report on the existing organisation in Uganda for the care and treatment of persons of unsound mind and the question of the future development of this organisation', 1 February 1943.
[160] Carothers, 'Some Speculations on Insanity'. On Carothers' career, see especially Beuschel, 'Shutting Africans Away', pp. 246-57; McCulloch, *Colonial Psychiatry*, pp. 49-51.
[161] A complaint following the unlawful transfer of the European Cecil C. from Uganda to Mathari Mental Hospital in 1930, for example, had highlighted the difficulties that could arise across borders. In 1937, the Colonial Office initiated a survey of lunacy legislation in East and Southern African colonies, with these same issues in mind. TNA, CO 536/163/2 (Cecil Courtiss - Alleged Lunatic); TNA, CO 536/165/18 (Cecil Courtiss - Complaint re Treatment); TNA, CO 822/76/12 (Lunacy).
[162] RHO, Mss.Afr.s.1589 (Baty Papers), 'Correspondence', f. 11, copy of the 'Recommendations of the Mental Hospital Enquiry Committee', 11 February 1942. Complaints about the lack of accommodation for Europeans, for example, had been made in 1941 in UNA, D107/12 (Transport of Mental Patients).

While the MO was being recruited, Carothers added, an AMO would be welcome at Mathari for training as a Hospital Assistant.[163] Mitchell took issue with these last two points. Rather than appointing a MO directly to the hospital, he argued that 'an interested A.M.O. would suffice'. Not only was the treatment available at Mulago Mental Hospital limited, but there were not enough European patients to justify the appointment of a specialist.[164]

While this was only a minor difference in opinion, it was indicative of a more general disparity in views towards the role of Africans as medical practitioners, which was to become more apparent as the colonies headed towards independence.[165] In his memoirs, for example, Trowell recalled that a plan to train Africans in medicine in Kenya in the 1930s 'was received in dead silence at Medical Headquarters'.[166] Trowell later surmised that:

> Undoubtedly a certain group in Kenya wanted to believe that the future of the country lay in White settlement in the Highlands: Africans would remain hewers of wood and carriers of water to the end of time: another South Africa. Other settlers and many commercial Europeans took a more liberal view and encouraged the education and development of Africans, but they were a small minority.[167]

While the situation may have been more liberal than that in Kenya, the position of African physicians, both in relation to their European colleagues and within wider colonial society, was often acrimonious. As Iliffe has pointed out, they did not

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[163] RHO, Mss.Afr.s.1589 (Baty Papers), 'Correspondence', ff. 15-6, J.C. Carothers, 'Report on the existing organisation in Uganda for the care and treatment of persons of unsound mind and the question of the future development of this organisation', 1 February 1943, p. 4.
[164] Ibid., f. 14, letter from J. P Mitchell, Medical Superintendent, Mulago, to Director of Medical Services, Entebbe, 30 March 1943.
[165] These differences will be discussed in greater detail in Chapter IV.
[166] RHO, Mss.Afr.S.1872(144A) (Hugh Trowell Papers), 'Dr Hugh Trowell OBE, MD, FRCP', p. 12.
[167] Ibid., p. 10.

receive equal status as doctors until 1951, being instead 'merely assistants, embittered by subordinate status and unrewarding conditions of work'.[168]

The training given to African medical practitioners was broadly similar to that followed in London's medical schools. In England, medical education had by the 1920s incorporated psychiatry and psychological medicine as compulsory, if minor, elements of the Bachelor of Medicine degree.[169] Psychiatry was also a subject that appeared on the syllabus at Makerere Medical School, but in practice, and like other specialist subjects, training was only given when there was someone available to teach it.[170] In 1946, for example, Philip Hutton, Physician at Mulago Hospital, gave lectures on neurology, psychiatry, and therapeutics; in the following year, his absence from Mulago Hospital necessitated the removal of psychiatry from the syllabus altogether.[171]

In addition to formal lectures, the mental hospital acted as a training ground for psychiatry and psychiatric nursing. From the early 1940s, a small number of AMOs were assigned to Mulago Mental Hospital for periods of up to a few months. While this was not intended to increase their knowledge of psychological medicine, and it was felt that placements 'may not be in the best interests of the A.M.O.', it nevertheless allowed for practical experience with the mentally ill.[172] In addition to assisting in the routine physical and mental examination of all new patients, AMOs

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[168] Iliffe, *East African Doctors*, p. 60. For a fuller treatment of the difficulties facing African doctors in Uganda see ibid., chs. 4-5; Lyons, 'The Power to Heal'.
[169] Crammer, 'Training and Education in British Psychiatry', p.221-8.
[170] UNA, C1151 II (African Medical School, Mulago).
[171] TNA, BW 90/16 (East Africa - Medical School Mulago), memo by E.G. Holmes, Makerere College, 'Makerere College Medical School and Mulago Hospital – An appreciation of the present situation', 24 November 1947, pp. 2-3; *Report of the Council to the Assembly for the Year 1946* (Kampala: Makerere College / Uganda Printing & Publishing Co. Ltd., 1947), p. 11.
[172] UMOHA, C90/ACR (Bosa Stephen B - Consult. Psychiat.), f. 35, letter from W.A. Wilson to G. Campbell Young, 17 February 1953.

attached to the mental hospital made regular notes on the mental progress of patients and administered specialist treatments.[173]

Baty, as Superintendent, also made active attempts to educate hospital attendants during the early 1940s, an initiative that was introduced later in Kenya in 1948.[174] The content of Baty's lectures, which appear to have been spread over a number of years, included the role of attendants in setting examples for patients, first aid (taught in Luganda), the main types of mental illness and their symptoms, and the ways in which attendants were required to observe and remark on behaviour.[175] This last point was one Baty was particularly keen to impress on his staff, stressing that:

> It is the duty of the staff to observe the patients inside the wards and compounds, and prevent escapes and prevent the patients harming themselves and other patients and to see that the patients are properly cared for and clothed when in the compound.
>
> The patients are to be controlled by the staff. The staff must be firm and kind and explain to the patients the rules of the hospital.
>
> Order and discipline among the patients must be maintained.[176]

In addition, all hospital attendants were advised to obtain a copy of a book on nursing dementia from the female mental nurse, and encouraged to sit for a final examination.[177] While there is no evidence that indicates how these hospital attendants operated in practice, there were a considerable number of them (in 1946 there were 111 attendants to care for 168 patients),[178] and Baty's lectures suggest that like attendants elsewhere in the colonial world, these staff played a considerable role

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[173] RHO, Mss.Afr.s.1589 (Baty Papers), 'Hospital Routine', ff. 2-3, 'Instructions on routine to be carried out by A.M.O. attached to Mental Hospital, 28 March 1946'.
[174] On medical training at Mathari Mental Hospital see Beuschel, 'Shutting Africans Away', pp. 191-3.
[175] RHO, Mss.Afr.s.1589 (Baty Papers), 'Lectures'.
[176] Ibid., ff. 13-4, 'Objects of a Mental Hospital', nd., para. 5.
[177] Ibid., f. 19, 'Lectures for Attendants', nd.
[178] Uganda Protectorate, *Annual Report of the Medical Department, 1946*, p. 46.

in the everyday running of the mental hospital and in the treatment of the mentally ill.[179]

While Carothers' suggestion of the appointment of a specialist medical officer to the mental hospital was eventually accepted, the authorities at Mulago Hospital maintained that it would be useful to have a full-time AMO at Mulago Mental Hospital on a long-term basis. In October 1948, the AMO chosen was Stephen Bayo Bosa, a young Muganda doctor who had qualified in 1945.[180] By 1948, Bosa was working full-time in the women's wards at Mulago Hospital, where he was described as 'competent' but liable to carelessness, for which he was reprimanded on at least one occasion.[181] Considering the reports against him, it is possible that Bosa's transfer to mental work was a form of punishment, as career prospects for AMOs at Mulago Mental Hospital were almost non-existent. Luckily for Bosa, he appeared to have had an aptitude and interest for the work, and when George Campbell Young, a British psychiatrist, arrived in 1949, Bosa started to receive specialist training in psychiatry.[182]

The training of Africans as physicians created a new group of men through which psychiatry was able to operate in Uganda. While their knowledge of psychiatry and psychology was limited, it was hardly any less than that of most European MOs, whose medical training had left them ill-prepared for the types of mental illness they

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[179] Shula Marks, 'The Microphysics of Power: Mental Nursing in South Africa in the First Half of the 20th Century', in Sloan Mahone and Megan Vaughan (eds), *Psychiatry and Empire* (Basingstoke, Hampshire: Palgrave Macmillan, 2007); Mills, '"Left in the Hands of Subordinates"'; Monk, *Attending Madness*.

[180] According to Bosa's eldest son, Joseph Bossa, 'Bayo' (sometimes spelt 'Beyo'), was not a given name, but a nickname given to Bosa during his undergraduate studies at Makerere College, referring to his proficiency in Biology. It was a nickname Bosa decided to keep for the rest of his life. Interview with Joseph Bossa (BOS-01), Kampala, Uganda, 29 July 2011.

[181] UMOHA, C90/ACR (Bosa Stephen B), f. 1, 'Annual Confidential Report for the Year ending December 31st 1947'.

[182] Bosa's training and status at Mulago Mental Hospital will be discussed further in Chapter IV.

would face in their daily practice.[183] As the number of graduates grew, AMOs also formed an increasingly prominent part of the Colonial Medical Service in Uganda. While as a group of graduates they remained small until the 1960s, by the late 1930s, their numbers had begun to rival those of European MOs. In 1938, for example, there were 31 AMOs working in government service alongside 31 MOs, 5 Senior MOs, and an assortment of hospital superintendents, surgeons, and administrators.[184]

Such was the reliance on AMOs, particularly in remote out-stations, that in 1938 the colonial administration granted them limited powers in the certification of mental illness. In a move that was unique in sub-Saharan Africa at the time, the 1938 Mental Treatment Ordinance allowed registered African and Indian medical practitioners to provide one of the two medical reports required by a magistrate, the other being provided by a licensed European practitioner.[185] This amendment, it was noted, was necessary to provide 'more protection to the public', as 'in a number of outstations it would be impossible to assemble two registered practitioners quickly'.[186] In practice, this meant that while Europeans retained their superior status as 'licensed' doctors, responsibility for the mentally ill was increasingly devolved to the new group of western-trained African medical practitioners.

The early emphasis on medical training not only distinguishes Uganda from Kenya, but reminds us that institutions and European medical practitioners did not operate in a vacuum—they were working in contexts rich in actors and politics of their own. In Uganda, as elsewhere in Africa, African medical practitioners had their

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[183] Crammer, 'Training and Education in British Psychiatry'; H.C. Trowell, 'Training Medical Practitioners', *East African Medical Journal* 33(7) (1956), pp. 253-8 at p. 255.
[184] Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1938* (Entebbe: Government Printer, Uganda, 1939), pp. 67-8.
[185] TNA, CO 536/199/7 (Mental Treatment Legislation), 'Legal Report on an Ordinance entitled "The Mental Treatment Ordinance, 1938"', p. 2.
[186] Ibid.

own ambitions and agendas, which were as varied as those held by their European colleagues.

African medical practitioners and political dissent in 1940s Buganda

The presence of African medical practitioners within the Colonial Medical Service complicates any analysis of the relationship between psychiatry and colonial rule. If, as historians such as Jackson have argued, psychiatry was used to maintain the colonial order, then what of those Africans who themselves diagnosed mental illness and confined patients exhibiting disturbing behaviour to the mental hospital? As we shall see in the following chapter, the families of the mentally ill played an active role in providing extra-institutional care and in determining if and when to seek confinement. However, admissions remained involuntary until 1956,[187] and the process of committal, which included reports from families, chiefs, medical certificates, and a court order, remained skewed towards the admission only of the most violent patients.[188]

This section explores the position of African medical practitioners within these formal structures of psychiatry and confinement by drawing on examples from political dissent that emerged in Buganda during the 1940s. The attempted removal from office in 1944 of Samwiri Wamala, Katikiro (Prime Minister) of Buganda, on the grounds that he was suffering from a serious mental disorder, and the involvement of Bosa, the AMO attached to Mulago Mental Hospital, in the

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[187] Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1956* (Entebbe: Government Printer, Uganda, 1957), p. 49.
[188] MMU, JUD 4(1) (Lunacy), letter from District Medical Officer, Toro to DC Toro, 30 June 1949; G.I. Tewfik, 'Problems of Mental Illness in Uganda', *Mental Disorders and Mental Health in Africa South of the Sahara: CCTA/CSA-WFMH-WHO Meeting of Specialists on Mental Health* (Bukavu: CSA, 1958), p. 63.

disturbances that erupted across Buganda in 1949, remind us that psychiatry was often a complicated process of negotiation between multiple actors.

Samwiri Wamala

Wamala became Katikiro in 1941 in the wake of the *Nnamasole* affair and against a background of increasing political, economic, and social tension in Buganda.[189] In the years following the Second World War, farmers complained of poor wages, diminished by post-war inflation, colonial cotton regulations, and exploitative middlemen.[190] Bataka protesters such as Jemusi Miti and Ssemakula Mulumba also developed critiques of Buganda's hierarchy and colonial power,[191] constructing, as Carol Summers has argued, 'a new sort of citizenship grounded in local concerns over land, graves, and inheritance.[192] According to David Apter, Wamala was 'the first Katikiro to reckon with public opinion', harnessing widespread fear and distrust of missionaries and administrators in his attempt to achieve political reform.[193] His attempt to prevent the Uganda Government from forcing the Lukiiko (Ganda parliament) to pass legislation that would allow the Kabaka (King) to acquire land for public use, for example, not only saw Wamala advising the Resident that the Bill would be exceedingly unpopular, but also directing

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[189] The *Nnamasole* affair grew from the proposed re-marriage of the Queen Mother of the Buganda Kingdom. Frederick Mulindwa, 'The *Bataka* Agitation and Resistance in Colonial Uganda', *Muwazo* 10(3) (2011), pp. 12-24 at pp. 17-8.
[190] Jonathon L. Earle, 'Reading Revolution in Late Colonial Buganda', *Journal of Eastern African Studies* 6(3) (2012), pp. 507-26 at pp. 507-8.
[191] During the 1940s, the term Bataka came to refer to those who wished to redefine British and Ganda policies and roles. Historically, it had other meanings, notably as a term denoting hereditary clan leaders. Apter, *The Political Kingdom in Uganda*, p. 141, fn. 9; Mulindwa, 'The Bataka Agitation', p. 13; Carol Summers, 'Grandfathers, Grandsons, Morality, and Radical Politics in Late Colonial Buganda', *International Journal of African Historical Studies* 38(5) (2005), pp. 427-47 at pp. 429-33.
[192] Summers, 'Grandfathers', p. 427. For a fuller treatment of political dissent in 1940s Buganda, see especially Apter, *The Political Kingdom in Uganda*; Earle, 'Reading Revolution'; Holly Hanson, *Landed Obligation: The Practice of Power in Buganda* (Portsmouth, NH: Heinemann, 2003); Carol Summers, "Subterranean Evil' and 'Tumultuous Riot' in Buganda: Authority and Alienation at King's College, Budo, 1942', *Journal of African History* 47(1) (2006), pp. 93-113.
[193] Apter, *The Political Kingdom in Uganda*, p. 226.

public outcry towards his political rivals.[194] While he was by no means the most outspoken of the Baganda activists of the 1940s, his prominent position in the Lukiiko and his criticisms of the colonial government's acquisition of land at Mulago (for Mulago Hospital) and Makerere (for Makerere College) placed him at the centre of British attention and medical concern.[195]

The decision to summon Wamala to a formal medical board was taken in the face of these strained relations between the Buganda and Protectorate governments. Yet it does not appear to have been without medical justification. In May-June 1944 Wamala had consulted two AMOs—Erifazi Mukibi-Mwanjale and Samuel B.K. Mukasa, Wamala's son-in-law—about a number of physical and mental complaints.[196] By 1944 Mukibi-Mwanjale, a member of the Lugave (pangolin) clan, which comprised Wamala's main political support base, was a well-established surgeon at Mulago Hospital.[197] According to Mukibi-Mwanjale some months later, Wamala had exhibited signs of overwork, and had improved following a period of 'rest, suggestion, reassurance talks about his hidden fears, [and] regulation of his diet with extra vitamins'. He also admitted, however, to giving Wamala a course of tryparsamide, a treatment used in cases of neurosyphilis.[198]

It was the possibility of neurosyphilis that the medical board was most interested in when it met at Mulago Hospital at the end of October 1944. Formally organised by the Resident of Buganda, and supposedly without the knowledge of the

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[194] Ibid., pp. 226-7.
[195] Ibid., p. 227.
[196] RHO, Mss.Brit.Emp.S.22 G.552 (Anti-Slavery Society Papers: Uganda), 'Copy of the Medical Board report', 30 October 1944.
[197] Iliffe, *East African Doctors*, p. 88.
[198] Juliet D. Hurn, 'The History of General Paralysis of the Insane in Britain, 1830 to 1950' (unpublished PhD thesis, University of London, 1998), pp. 242-3.

Lukiiko,[199] the medical board consisted of Trowell, A.W. Williams (Physician and later Medical Superintendent of Mulago Hospital), and a Muganda AMO, Sebastiane B. Kyewalyanga. Members of the Buganda government were not obliged to undergo routine medical examinations, but they could be summoned to attend a medical board if suspicion of serious ill-health arose. In an example that suggests that even medical missionaries were willing to intrude in local politics, Albert Cook stressed that he considered it his 'duty' not just as a physician but as a British subject to inform the colonial government that his patient, Katikiro Apollo Kagwa, was suffering from 'alarmingly high blood pressure', something that Kagwa later claimed had been a deliberate attempt to get him removed from office.[200] In Wamala's case it is unclear if Mukibi-Mwanjale or Mukasa had passed on their concerns, or if the information had reached the government officials through other channels. Mukibi-Mwanjale was certainly (and unsurprisingly) keen to disassociate himself from the findings of the medical board when they were reported at the beginning of November. His medical testimony, he claimed, had been misinterpreted, and 'so framed as to indicate to any reader that my patient had no other symptoms but mental, and no other treatment but tryparsamide'.[201]

If Mukibi-Mwanjale was unhappy with the board's findings, Kyewalyanga, the board's only AMO, also found himself in an uncomfortable position. The board had failed to find conclusive evidence that Wamala was suffering from neurosyphilis: he had refused a lumbar puncture, something 'essential in the diagnosis of neuro-

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[199] RHO, Mss.Brit.Emp.S.22 G.552 (Uganda), note by K.B. Maindi, Acting President General, the Uganda Motor Drivers Association Trade Union, attached to a copy of a letter from F.R. Bell, for the Resident, Buganda, to Owekitibwa S.S.Wamala, 24 October 1944.
[200] ACMM (Mengo Hospital Correspondence), letter from A.R. Cook, Mengo Hospital, to Mr. Jarvis, 26 April 1926.
[201] RHO, Mss.Brit.Emp.S.22 G.552 (Uganda), letter from S. Mukibi Mwanjale, Mulago Hospital, to H.C. Trowell, copy to the Kabaka, and the Director of Medical Services, Entebbe, 9 November 1944.

syphilis', and the board had found 'little outside information concerning the mental symptoms from those in close contact with the patient', without which it was near 'impossible to give a decision concerning t e [sic.] presence of mental disease'.[202] Following a brief physical examination, Trowell and Williams were ready to conclude that it was highly likely that Wamala was suffering from neurosyphilis. Kyewalyanga, on the other hand, was more cautious. On his request, the diagnosis of neurosyphilis was removed from the board's findings, and the final statement reworded to conclude that there was 'a serious mental disorder and that the presence of neuro-syphilis cannot be excluded'. Given this finding, the board recommended that Wamala be removed from office for a period of twelve months.[203]

In this instance, psychiatry was no unproblematic, conspiratorial 'tool of empire' for either the European or the African MOs; even if Wamala's actions had given the British grounds to distrust him, all of the medical officers involved agreed that Wamala was suffering from (or had suffered from) mental ill-health, however defined. Indeed, in a note attached to the bottom of the medical board's report, Trowell and Williams urged Mukibi-Mwanjale and Mukasa to continue the treatment for neurosyphilis, 'as in our opinion the disease is probably there'.[204] Where the medical officers diverged, was in their view of what function the medical board could serve; the AMOs, unsurprisingly, were particularly sensitive to the political implications attached to a diagnosis of degenerative venereal disease.[205] Indeed, the whole episode was characterised by political and professional tensions—between Mukibi-Mwanjale and the medical board; between Wamala and the medical board; and between Kyewalyanga and his European colleagues.

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[202] Ibid., 'Copy of Medical Board report', 30 October 1944.
[203] Ibid.
[204] Ibid.
[205] See Tuck, 'Syphilis, Sexuality, & Social Control'.

These tensions were indicative of the wider socio-economic and political discontent that was to prompt widespread disturbances in 1945 and 1949. The strikes and riots of January 1945 were primarily a result of wage grievances following the hardships of the Second World War, and saw workers from nearly every government institution walk out and demand higher wages.[206] At Mulago Hospital, large numbers of subordinate staff joined the strike, and on the second day strikers entered the wards with sticks in an attempt to force the remaining African staff to leave.[207] In the weeks following the strikes, the education system came under attack from those who felt that the strike demonstrated how easily hospital workers 'could just chuck up their jobs and cause suffering to their own people'.[208]

While African medical practitioners were not exempt from scrutiny, there is little evidence to suggest that they left their positions on the wards. According to E. Wilson, Physician at Mulago Hospital, Mukibi-Mwanjale 'stood and appealed to the strikers not to drive away those who were caring for their own people - we had several badly injured rioters on that ward'.[209] Indicating something of the position of the mental hospital in the mind of the public, one 'Onlooker' even jumped to the defence of the staff at Mulago Hospital by pointing out how: 'the Strike was confined to the menial staff, cooks, dhobies, sweepers, and the majority of the attendants in the Mental Section of the Hospital. None of the ward nursing staff or African doctors was absent from work, and all carried out their duties in circumstances of great difficulty despite intimidating threats'.[210]

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[206] Iliffe, *East African Doctors*, p. 89; Carol Summers, 'Radical Rudeness: Ugandan Social Critiques in the 1940s', *Journal of Social History* 39(3) (2006), pp. 741-70 at pp. 750-1.
[207] Iliffe, *East African Doctors*, p. 89.
[208] 'Comment on the Strike', *Uganda Herald,* 21 February 1945, p. 10.
[209] E. Wilson, as cited in Iliffe, *East African Doctors*, p. 89.
[210] '"Onlooker" on the Strike', *Uganda Herald,* 7 March 1945, p. 4.

In an attempt to analyse the disturbances, the colonial government focused on the political, rather than the economic causes, stressing 'the factional ambitions of a limited number of politicians in Buganda'.[211] Wamala, unsurprisingly, came under the spotlight, the strikes having been used by Wamala's supporters to secure his archrival's dismissal in case he was promoted to Katikiro in Wamala's absence.[212] Forced to resign at the end of February, Wamala was promptly deported to Hoima along with four others suspected of inciting trouble.[213] The severity with which the colonial administration pursued Wamala was not lost on at least one observer, who questioned how the British could deport a man found to be mentally unwell to a place of 'ill treatment'.[214] Deportation, it appears, was a much more straightforward and uncomplicated way of dealing with suspected troublemakers than formal certification for mental illness.

Stephen Bayo Bosa

If the relationship between psychiatry and colonial rule was made problematic by the involvement of AMOs in medical examinations, it was further complicated by the suspicion that fell on staff at Mulago Hospital following the 1945 disturbances.[215] Mukibi-Mwanjale, for example, was accused of harbouring sympathies towards the activists, and was subsequently transferred to the remote station of Moyo, where, according to Iliffe, 'he could not practise surgery, was kept under surveillance,

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[211] Gardner Thompson, 'Colonialism in Crisis: The Uganda Disturbances of 1945', *African Affairs* 91 (1992), pp. 605-24 at p. 605.
[212] Iliffe, *East African Doctors*, p. 89.
[213] HC Deb 7 March 1945 vol 408 c2014 (Uganda (Deportation Order)); 'Katikiro Tenders Resignation', *Uganda Herald,* 28 February 1945, p. 5; 'Om. S. S. Wamala Arrested and Deported', *Uganda Herald,* 7 March 1945, p. 1.
[214] Wamala was not the only deportee linked to 'ill treatment'. According to Carol Summers, intelligence reports on Festo Kibuka Musoke 'suggested that by the time he came out of detention after the 1945 strike, he seemed "mentally unbalanced". Summers, 'Radical Rudeness', fn. 8.
[215] Iliffe, *East African Doctors*, pp. 89-90.

suffered a mental breakdown, retired, and never recovered'.[216] Bosa, the AMO at Mulago Mental Hospital, was also reported as being 'anti-European' in confidential reports submitted to the colonial administration, and his progress closely monitored until well into the 1950s.

Particular attention was paid to Bosa during the summer of 1949, when he was arrested in connection with further disturbances that had spread across Buganda in April 1949. Bosa had provided a medical certificate to a man calling himself Yusufu Musoke, showing that he had been in hospital suffering from dysentery for the duration of the disturbances.[217] As Bosa noted:

> One morning early in June while I was working in the Out-Patients' Department, a young man came to me with an old Medical Form 5 which was wrinkled and partially torn. He told me he had been treated in this hospital between the dates shown on the Medical Form 5, but that his Medical Certificate had been washed in his trouser pocket by accident, and was now illegible and therefore not acceptable by his employer who threatened to cut his pay. He asked me if I could kindly re-write it for him. I did the same, copying down the same Hospital Number and date from the old dilapidated Medical Form 5, which at the time I thought was genuine and therefore I did not think of checking up the number in the Register.
>
> Two or three days later the same man came back to me asking that he would like that Medical Certificate signed. I then wrote a small chit on Medical Form 5 certifying that the man had been treated as per Medical Form 5 No. . . . . and I signed this chit.
>
> Apparently this man knew me very well although I did not know him at the time.
>
> From that time I forgot everything about the affair until I was approached by a Police Officer on 13th August, and I was only then made to understand that that man had come to me with a false certificate, and under a false name; and that he had subsequently attempted to use my signed Medical Certificate to cover another

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[216] Ibid.
[217] UMOHA, C90/ACR (Bosa), letter from R.S.F. Hennessey to Mr S.B. Bosa, 6 September 1949.

person under charge of a criminal offence.[218]

Bosa was arrested on charges of false certification and suspended from duty. The evidence was hardly in his favour: the certificate Bosa had provided had been used as an alibi by a man accused of setting fire to the house of a county chief,[219] and the man who had approached Bosa for the medical certificate, whose real name was Petero Nsubuga, was an employee of the mental hospital.[220] In his interview with the police, Bosa admitted wrongly certifying sickness, but claimed that it was due to negligence on his part rather than any conspiracy to subvert the course of justice.[221] Bosa was acquitted, but faced a disciplinary interview with Henry S. de Boer, DMS, before he was allowed to return to work. Recounting his version of events to de Boer, Bosa observed that his case was only serious because of its 'political connections'—he could see '[n]o other reason except general need for accuracy'.[222] It seems likely that this was the case, particularly as the political sympathies of AMOs from across Mulago Hospital again came under scrutiny in the months following the disturbances.[223] However much responsibility had been devolved to AMOs, they were still firmly located within the rigid structures of a paternalist colonial state, and were by no means exempt from scrutiny during political troubles.

Bosa was found guilty of negligence and narrowly avoided losing his job, but was allowed to remain at Mulago Mental Hospital, most likely because de Boer was aware of their need for someone who was able and willing to work with the mentally

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[218] Ibid., letter from S.B. Bosa, Assistant Medical Officer, Mulago, to Director of Medical Services, 5 September 1949.
[219] Ibid., letter from Senior Superintendent of Police, Kampala to Medical Superintendent, Mulago, 31 August 1949.
[220] Ibid., H.S. de Boer, 'Interview: A.M.O. S.B. Bosa, 6 September 1949'.
[221] Ibid., f. 5, letter from A.W. Williams, Medical Superintendent, Mulago, to Director of Medical Services, 15 August 1949.
[222] Ibid., H.S. de Boer, 'Interview: A.M.O. S.B. Bosa, 6 September 1949'.
[223] Iliffe, *East African Doctors*, pp. 90-1.

ill. What the case reinforces, however, is that African medical practitioners acted both within and outside the confines of their assigned positions; if Bosa had been aware that his certificate might be used as an alibi, it would further bring the agendas of African medical practitioners into question.

African physicians were not mere agents of state; but during the 1940s at least, neither did they actively use psychiatry to challenge it. On the one hand these practitioners were required to work within the structures and guidelines set out by the Colonial Medical Service; on the other, their beliefs and actions were shaped by local socio-economic and political circumstances. As Ryan Johnson and Amna Khalid have argued, '[i]ntermediaries and subordinates straddled two cultures', rendering the categories of collaborator and resistor obsolete.[224]

(in)Visible patients, or, the limits of psychiatric knowledge, 1949-1962

During the 1940s, African medical practitioners such as Bosa, Mukibi-Mwanjale, and Kyewalyanga were incorporated—willingly and unwillingly—into formal structures of psychiatry and confinement in Uganda. At the same time, concerns started to be raised by European medical practitioners about the long-term suitability of Mulago Mental Hospital for the treatment of the mentally ill: not only was overcrowding a serious concern, but the available space on Mulago hill did not allow for cultivation or expansion, two aspects that were deemed to be central to the recovery of in-patients.[225] As Mitchell noted, the compounds were 'far too small from the point of view of Mental treatment, and the welfare of the patients, as the

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[224] Khalid and Johnson, 'Introduction', p. 19.
[225] RHO, Mss.Afr.s.1589 (Baty Papers), 'Correspondence', 'Copy of the Recommendations of the Mental Hospital Enquiry Committee', 11 February 1942. On land issues at Mulago Hospital more generally, see A.W. Southall and P.C.W. Gutkind, *Townsmen in the Making: Kampala and Its Suburbs* (Kampala: East African Institute of Social Research, 1957), pp. 95-6, 113; Williams, 'The History of Mulago Hospital'.

patients have insufficient space to move about, and it results in excessive interference and quarrelling among the patients. The present railings are inadequate, the patients are continually escaping by climbing over the fence'.[226]

Concern over space was not limited to the mental hospital. Indeed, since it opened as a general hospital in 1923, Mulago Hospital had seen the ad hoc addition of specialist buildings and departments, of which the mental hospital was only one more competitor for space.[227] Such was the pressure on land at Mulago by the mid-1940s, that the Colonial Development Plan of 1946 advised that a new mental hospital be built elsewhere, still within easy reach of Kampala, but with enough land 'to ensure that the inmates have privacy, and can be usefully employed in work that will help in their cure. An area of 1,000 acres is recommended'.[228] The site selected for this new hospital was at Butabika, seven miles from Kampala, and with ample space for outside recreation (Image 5).[229]

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[226] RHO, Mss.Afr.s.1589 (Baty Papers), 'Correspondence', ff. 26-30, letter from Mental Hospital, Mulago, to Director of Medical Services, Entebbe, 31 October 1946, para. 2.
[227] Williams, 'The History of Mulago Hospital'.
[228] RHO, Mss.Afr.s.1589 (Baty Papers), 'Correspondence', ff. 17-8, 'Extract from Report and Recommendation on the Post-War Development of the Medical Services', p. 1.
[229] Wood, 'A Half Century of Growth', p. 119.



Image 5: Butabika Hospital ward exterior, c. 1970
Credit: James Wood

In contrast to discussions over the site for Mulago Mental Hospital, the colonial government did not consult with mission doctors in Kampala on the choice of the new site at Butabika. By the early 1940s, the influence that CMS mission doctors had previously enjoyed was on the wane, and changes in government legislation on patient fees and charges prompted the first of several financial crises at Mengo Hospital.[230]

When Butabika Hospital opened in 1955, it was still in the process of construction, and it would not be until the mid-1960s that all patients were transferred.[231] While it was ultimately intended that with the establishment of

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[230] See, for example, correspondence in UNA, C2086 (CMS Hospital Mengo). In 1939, the Colonial Medical Service set out their views on the future of Mengo Hospital. With the addition of 300 new beds at Mulago Hospital planned for 1940, it was anticipated that 'the need for Mengo Hospital as a general hospital would…pass away'. ACMM (Mengo Hospital Correspondence), letter from the Bishop's House, Kampala, to the Chief Secretary, 18 April 1939.

[231] Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1955* (Entebbe: Government Printer, Uganda, 1956), p. 43; Uganda Protectorate, *Ministry of Health, Uganda, Annual Report for the Year from 1st July 1960 to 30th June 1961* (Entebbe: Government Printer, Uganda, 1961), p. 26; Wood, 'A Half Century of Growth', p. 199.

Butabika Hospital, Mulago Mental Hospital would be closed, the appointment of a Specialist Alienist, Young, in 1949, ensured that psychiatry remained within the concerns of the intellectual community at Mulago Hospital.[232] In addition to running Mulago Mental Hospital, Young's duties included the training of Bosa and any other interested AMO in psychiatry, as well as lecturing on mental illness at Makerere Medical School. With his previous experience as Assistant Superintendent at Bracebridge Mental Hospital, Lincoln, and as Assistant Medical Superintendent of the Lunatic Asylum, Barbados, Young's appointment marked a more general awareness that if health services and medical education were to develop in the long term, European specialists were necessary.[233]

Young's arrival in Uganda prompted a broadening of medical interest in Mulago Mental Hospital from explorations of neurosyphilis to more general in-patient population characteristics. From 1949, the admissions rate had started to rise dramatically, and would continue to do so throughout the 1950s. By 1956, the number of admissions was 652, nearly double that of 1951, when 350 patients had been admitted.[234] The rise in numbers was not limited to Uganda: mental hospitals in Kenya and Tanganyika also saw an sharp increase in the number of admissions that was not always followed by a rise in the number of discharges (Table 1).[235]

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[232] Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1958* (Entebbe: Government Printer, Uganda, 1959), p. 42.
[233] 'G C Young', *British Medical Journal,* 4 December 1976, p. 1392; Colonial Office, *Colonial Office List 1948* (London: His Majesty's Stationary Office, 1948), p. 295. The development of psychiatric education was one of the recommendations of the Post-War Development Plan. H.S. de Boer, *Report and Recommendations on the Post-War Development of the Medical Services in Uganda* (Entebbe: Government Printer, Uganda, 1944), p. 47.
[234] Tewfik, 'Psychoses in Africa', pp. 127-8.
[235] Beuschel, 'Shutting Africans Away', p. 211-30; Tewfik, 'Psychoses in Africa', p. 128.

Table 1: Admissions to mental hospitals in Kenya, Uganda, and Tanganyika, 1942-56
Source: G.I. Tewfik, 'Problems of Mental Illness in Uganda', *Mental Disorders and Mental Health in Africa South of the Sahara: CCTA/CSA-WFMH-WHO Meeting of Specialists on Mental Health* (Bukavu: CSA, 1958), p. 64.

	Kenya	*Uganda*	*Tanganyika*
1942	206	157	54
1943	236	145	79
1944	267	146	61
1945	257	169	110
1946	228	152	116
1947	265	195	119
1948	371	159	184
1949	295	218	196
1950	401	295	212
1951	502	331	214
1952	519	334	200
1953	536	376	235
1954	547	401	306
1955	527	500	321
1956	--	652	--

As the pressure on accommodation became increasingly acute, the rise in admissions prompted fresh concern, in Uganda as elsewhere, about the types of patients being admitted, and when and why patients might be discharged. The psychiatrists who pursued this type of research would eventually use their data to question a number of long-held assumptions about psychiatry and 'the African mind'.

Challenging 'colonial psychiatry'

From 1951 to 1955, Young collated information on ethnicity and place of residence for all in-patients at Mulago Mental Hospital. One of his key findings was the predominance of Baganda from Mengo District, the area in which the hospital was situated, as well as Banyaruanda immigrant labourers living in Kampala. In 1951, Young noted, Baganda and Banyaruanda patients comprised approximately thirty and eleven per cent respectively of all in-patients.[236] He suggested that proximity to the mental hospital appeared to encourage admission,[237] but in elaborating on this comment, Young drew on the work of Carothers, stressing that '[t]here are well-founded reasons for believing that the incidence of insanity in Africans living in their natural environment is low. Higher rates of insanity are found in Africans living away from their former tribal areas, and this section of the community is likely to increase in the future'.[238] Carothers' views on the 'psychotic immunity' of Africans living in their 'natural environment' were well-known, and given Young's limited experience in Africa, it is unsurprising that he would draw on the theories of an established 'expert'.

When Young revisited his statistics a few years later, however, he presented an alternative explanation. Noting that while the highest ratio of civil patients to population came from the county within which the hospital was situated (30 per 100,000), Young added that there was a 'strikingly low rate (2 per 100,000) for Busoga District, which contains the second largest town in Uganda [Jinja], and has

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[236] Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1951* (Entebbe: Government Printer, Uganda, 1952), p. 59.
[237] Ibid.
[238] Ibid., p. 60.

for many years had important concentrations of estates and industrial labour'.[239] This time Young did not feel it necessary or useful to rely on Carothers, instead concluding that his findings did not 'support the suggestion that urban or industrial conditions predispose to mental ill-health among Africans'.[240] In so doing, Young was questioning a number of widely held assumptions about the effects of detribalisation on the African mind.

Crucial to Young's revision of ideas was his time and experience as Specialist Alienist, as well as the intellectual community at Mulago Hospital, which offered a space in which to discuss ideas about African psychopathology. Following Young's appointment in 1949, psychiatry became a subject for Mulago Hospital Staff Clinical Meetings, at which both European and African MOs were in attendance. Within a year of his arrival Young spoke at one of these meetings on a number of in-patient cases, including dementia paralytica and schizophrenia. Of particular interest to his colleagues was a case of a young boy who had suffered a mental breakdown after six weeks at a new school. The discussion that followed raised the question of the relationship between mental breakdown and education, a subject that provoked a number of divergent views. In the report on the meeting, published in the *EAMJ*, it was recorded that:

> Dr. Hutton had noticed that a certain course of instruction was particularly lethal in this respect, and questioned whether this was due to the content of the course or the make-up of the candidates who were attracted to it. Dr. Trowell remembered that in England the outfall of medical students owing to mental illness was considerable. Dr. Williams thought the strain on Africans was less an intellectual one than a difficulty in adjusting their traditional ways of thought to

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[239] Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1953* (Entebbe: Government Printer, Uganda, 1954), p. 39.
[240] Ibid., pp. 39-40.

newly-acquired views on family and social life.[241]

As noted earlier in this chapter, the question of the educability of Africans had interested psychiatrists, anthropologists, and administrators in Africa since the 1920s, drawing from and contributing to the literature on detribalisation.[242] While in the 1930s, these authors had been concerned primarily with measuring the intelligence of Africans, interest had shifted by the 1950s to why educators appeared to be seeing so many cases of breakdown among students, and how mental instability might be linked to a 'clash of cultures'. These ideas about educability would continue to shape psychiatry until well into the 1960s, feeding into Raymond Prince's 'brain-fag' concept, which will be examined in Chapter IV.[243]

The questioning of detribalisation and its effects was to become even more prominent under Gerald I. Tewfik, who succeeded Young as Specialist Alienist in 1956. In a Mulago Hospital Clinical Staff Meeting in 1958, Tewfik noted that much of the psychiatric literature on Africa was often 'inadequately supported' and 'if true, would suggest that the African may have a failure of mental development which could be permanent'.[244] Referring specifically to Carothers' *The African Mind in Health and Disease* as exemplifying the worst aspects of this literature, Tewfik stressed that:

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[241] 'Proceedings of a Mulago Staff Clinical Meeting, 22nd. July, 1950: Psychiatric Cases', *East African Medical Journal* 27(9) (1950), pp. 371-2 at p. 371.
[242] G.F.A. Baer, 'The Educability of the Bantu', *History of Education Journal* 4(2) (1953), pp. 73-77; M.L. Fick, *The Educability of the South African Native* (Pretoria: South African Council for Educational and Social Research, 1939); McCulloch, *Colonial Psychiatry*, pp. 118-20; Paul Rich, 'Race, Science, and the Legitimization of White Supremacy in South Africa, 1902-1940', *The International Journal of African Historical Studies* 23(4) (1990), pp. 665-86; H.S. Scott, 'A Note on the Educable Capacity of the African', *East African Medical Journal* 9(4) (1932), pp. 99-110.
[243] Raymond Prince, 'The "Brain Fag" Syndrome in Nigerian Students', *Journal of Mental Science* 106 (1960), pp. 559-70 at p. 559.
[244] G.I. Tewfik, 'Mulago Hospital Clinical Staff Meeting April 26, 1958: The African Mind Fact or Myth?', *East African Medical Journal* 35(8) (1958), pp. 512-3 at p. 512.

> Criticisms of one race by another have been shown to be nearly always fallacious. Man is a very poor judge of his fellows. Assessments that are made are usually based on seeking a resemblance to oneself and derogatory judgments are made on people of a different facial architecture, colour, race and social position. This serves to ensure self-prestige and allows differential treatment to be practised without disturbance of the conscience.[245]

Likening the psychiatric literature to racial prejudice towards Jews in Europe, Tewfik added that 'African behaviour can only be understood in the light of its culture; comparison with other nations cannot be relevant until a normal has been defined'.[246]

The discussion demonstrated both the extent to which psychiatric knowledge was open to debate by European and African physicians who had little direct responsibility for the mentally ill, as well as the ways in which older theories of biological determinism still held sway. Some were quick to defend the work of older physicians and pathologists such as Vint, whose work was described as being 'done under very difficult conditions and his facts…turned into fiction by others'.[247] Others were more cautious, suggesting that the fields of inquiry were valid, but due to the 'emotional significance attached to the terms African and European' authors had to remain careful of their language.[248] John Kibukamusoke, a surgeon and AMO at Mulago Hospital, was reported as finally adding that:

> Africa was a recently discovered area and differences in behaviour were thus more obvious. He [Kibukamusoke] felt that some forms of behaviour were misconstrued or over-emphasized due to lack of appreciation of the cultural background of the people. There were different concepts of right and wrong and an approach from a

[245] Ibid.
[246] Ibid.
[247] Ibid., p. 513.
[248] Ibid.

> European viewpoint might lead to interpreting differences as due to structural rather than cultural differences.[249]

The questioning of the assumptions guiding theories on detribalisation and mental instability was not unique to Uganda. By the early 1950s, a number of psychiatrists and anthropologists, located primarily in West Africa, were also beginning to unpick some of the more racist theories of colonial psychiatry.[250] In an article on psychosis among the Yoruba, for example, T.A. Lambo, a Nigerian-born and western-trained psychiatrist, described the work of a number of ethnopsychiatrists, including Carothers, as being:

> At their worst…glorified pseudo scientific novels or anecdotes with a subtle racial bias; at their best…they are abridged encyclopedias [sic.] of misleading information and ingenious systems of working hypotheses, useful for the guidance of research, but containing so many obvious gaps and inconsistencies, giving rise to so many unanswerable questions, that they can no longer be seriously presented as valid observations of scientific merit.[251]

Young and Tewfik contributed to this body of criticism, and along with a number of other physicians at Mulago Hospital aimed specifically at distancing themselves from research that had come from Kenya over the last thirty years. In so doing, however, they failed to contribute their own explanations for the particular characteristics of the patients admitted to Mulago Mental and Butabika Hospitals. Indeed, neither Young nor Tewfik attempted to explain why men outnumbered women in Uganda's

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[249] Ibid.
[250] Heaton, 'Stark Roving Mad', pp. 92-3.
[251] T.A. Lambo, 'The Role of Cultural Factors in Paranoid Psychosis among the Yoruba Tribe', *Journal of Mental Science* 101(423) (1955), pp. 239-66 at p. 241.

mental hospitals, nor why depression was seen only in female patients.[252] This, they attributed to the difficulties of understanding their patients and lack of data from beyond the asylum walls, which they were either unable or unwilling to collect.[253]

In-patients and physical therapies



Image 6: Butabika Hospital ward interior, c. 1970
Credit: James Wood

Instead of pursuing research on psychiatric epidemiology in Uganda, Young and Tewfik concentrated on the effects of psychiatric treatments on patients already under their care. Young introduced prefrontal leucotomy and Largactil to Mulago Mental Hospital, and recorded his remarks on their effects and 'worth'.[254] In the early

[252] Tewfik, 'Psychoses in Africa', p. 133.
[253] Tewfik, 'Problems of Mental Illness', p. 66; Uganda Protectorate, *Annual Report of the Medical Department, 1951*, p. 60.
[254] Uganda Protectorate, *Annual Report of the Medical Department, 1953*, p. 40; Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1954* (Entebbe: Government Printer, Uganda, 1955), p. 54. Leucotomy, otherwise known as pre-frontal lobotomy, was devised in the 1930s as a treatment for schizophrenia. It is still used (in a modified way) in some

twenty-first century, prefrontal leucotomy, like other psychosurgeries, has come to represent 'our most visible icon for everything that is dangerous and bad about uncontrolled medical science, about the havoc that can ensure when evil (or perhaps simply misguided) individuals masquerade as competent scientists or doctors'.[255] Yet, as Jack Pressman has argued, psychosurgery occupied a central place within mainstream psychiatry in the 1950s and 1960s, offering real hope to patients, and its efficacy demonstrated by solid, if ultimately flawed, medical evidence.[256] While Young did not publish his investigations into the uses of leucotomy, he argued that as a treatment it had proved useful in 'the most depraved and hopeless cases'.[257] The remaining evidence tells us little about the types of patients who underwent the leucotomy procedure, and if it was used primarily as a sedative, as Gail Beuschel has suggested for Kenya.[258] Young nevertheless presented the treatment as a sign of Uganda's advancement in mental health care, and the hope it could bring to mental patients.

Like Young, Tewfik was also interested primarily in understanding the effects of the latest psychiatric treatments on patients. In 1957, he recorded how the two patients who had undergone leucotomies were 'greatly improved. One male patient who had been a most difficult patient improved markedly and was discharged to the care of his people within two months of operation. The other is also considerably

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neurosurgical centres as a treatment for depression and obsessional illness. J.S. Pippard, 'Leucotomy: A Qualified Defence of 'Then'', *QJM: An International Journal of Medicine* 94(8) (2001), p. 451.

[255] Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (San Francisco: University of California, 1998), p. 3. Tiffany Jones has described attacks on the methods of psychiatrists used by South Africa in the 1960s. Tiffany Fawn Jones, *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa* (Abingdon, Oxon: Routledge, 2012), ch. 7.

[256] Pressman, *Last Resort*, p. 3.

[257] Uganda Protectorate, *Annual Report of the Medical Department, 1954*, p. 36.

[258] Beuschel, 'Shutting Africans Away', p. 272.

improved and will be discharged in the near future'.[259] While Tewfik made few further comments on the subject, it is interesting that he felt that male patients would make suitable candidates for the procedure, particularly as elsewhere, notably in Southern Rhodesia, those selected for leucotomy were usually female.[260]

Of greater interest to Tewfik, however, was ECT, which he applied widely and frequently. In 1957, for example, ECT was given to 588 of the 662 patients under treatment at Mulago Mental and Butabika Hospitals.[261] While by the mid-1950s the use of short acting muscle relaxants had become common practice in the United Kingdom, reducing the number of fractures associated with the procedure, no such 'improved techniques' were available in Uganda.[262] Despite this, Tewfik noted that he had been struck 'by the absence of fractures of the long bones occurring as a complication of electro-convulsive therapy'.[263] This, Tewfik highlighted, had implications both for the application of ECT and understandings of the ability of Africans in Central Africa to withstand physical strain on the hip and shoulder region.[264]

By focusing on physical therapies and the characteristics of in-patients, Young and Tewfik created an insular body of psychiatric knowledge. They felt uncomfortable speculating on mental illness outside of the mental hospital and declined to comment on social issues. This contrasts with the work of psychiatrists

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[259] Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1957* (Entebbe: Government Printer, Uganda, 1958), p. 46.
[260] Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley & Los Angeles: University of California Press, 1997), ch. 7; Jackson, *Surfacing Up*, p. 177; Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (New York: Penguin Books, 1985), p. 205.
[261] Tewfik, 'Problems of Mental Illness', p. 68.
[262] J.P. Kelly, 'Fractures Complicating Electro-Convulsive Therapy and Chronic Epilepsy', *Journal of Bone and Joint Surgery* 36B(1) (1954), pp. 70-9; G.I. Tewfik, 'Low Incidence of Fractures among Africans Following Electro-Convulsive Therapy', *West African Medical Journal* IX(1) (1960), pp. 26-8 at p. 27.
[263] Tewfik, 'Low Incidence of Fractures', p. 26.
[264] Ibid., p. 28.

elsewhere in Africa, where practitioners such as Carothers drew explicit connections between detribalisation and political instability.[265] In Uganda, it would not be until the post-colonial period that psychiatrists would start to look beyond the asylum walls.

Conclusion

By the time an Australian expatriate psychiatrist, T.W. Murray, was appointed in 1960, the direction of psychiatry had changed dramatically. An ambitious scheme to develop psychiatry as a specialism for Africans was being discussed by Makerere University College and the Uganda Government, Bosa was in the United Kingdom working towards his DPM at the Maudsley Hospital, and the first formal attempt to extend the reach of psychiatry had been made with the opening of a psychiatric ward at Soroti Hospital.[266] These changes, which will be examined in Chapter IV, stemmed directly from the geographical and intellectual relationship that grew between the mental hospital, Mulago Hospital, and the medical school, and were reinforced by discussions that involved both European and African MOs.

The decision to build a mental hospital at Mulago was premised on the desire of missionary and government physicians to provide greater medical supervision to patients. The new 'place' for psychiatry at Mulago ensured, albeit unintentionally, that psychiatry was not isolated from the nascent intellectual community at the medical school. In practice, this meant that concern about institutional and intellectual psychiatry was no longer limited to a handful of colonial administrators—those working at Mulago Hospital, too, became involved in its development. Had a

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[265] For example: J.C. Carothers, *The Psychology of Mau Mau* (Nairobi: Government Printer, 1955); Carothers, 'A Study of Mental Derangement in Africans'.
[266] These developments will be explored in Chapters IV, V, and VI.

new site for the mental hospital been selected at Luzira, next to the Protectorate Prison, psychiatry might have taken a very different path.

In many ways this chapter has presented a one-sided history—the remaining sources tell us almost nothing about the patients or their experiences of confinement. While the voices of families and the mentally ill outside the walls of the asylum have left traces that will be explored in the subsequent two chapters, there were no patient records to be considered here.[267] This should not imply that the mentally ill did not shape treatment or 'resist' the routines of the asylum—there is much historical evidence elsewhere to suggest that they did.[268] Rather, the absence of patient voices in administrative correspondence and published research reflects the impersonal language through which administrators and physicians engaged in psychiatry, and the absence of any attempt to extend psychiatry beyond the asylum walls.

By the end of the colonial period, the role of the mental hospital in Uganda, as it was elsewhere, remained limited: constrained by location, finances, and the interests of individual physicians and psychiatrists, psychiatry lacked the geographical reach and therapeutic power to be effective. Yet psychiatry in Uganda was premised on and shaped by much more than a singular intention to define and subdue deviant populations. It grew up alongside, and was influenced by, medical missionaries in Kampala, the growth of an intellectual community at Mulago, calls for medical education for Africans, and the increasingly problematic relationship between psychiatry and colonial rule. The chapters that follow take these themes as both historical background and as starting points.

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[267] The records of Mulago Mental Hospital appear to have been lost or destroyed in the years following its closure in 1964.
[268] See, for example: Melissa Graboyes, 'Chappati Complaints and Biriani Cravings: The Aesthetics of Food in Colonial Zanzibari Institutions', *Journal of Eastern African Studies* 5(2) (2011), pp. 313-28; Mills, *Madness, Cannabis, and Colonialism*.

Chapter II:

'The Blame is on the Parents': Families and the Experience of Mental Health Care in Uganda, 1894-62

In an interview conducted in Mpigi District in October 2011, Peteralina Nabuto, a traditional healer, argued for the importance of families in the treatment of mental illness. Having started as a birth attendant in the 1950s, she came to specialise in the 1960s in treating *ekigalanga*, a condition brought on by possession by the ghosts of ancestors (*mizimu*), and characterised by stomach pains.[269] Her first case of mental illness was in a young girl living nearby ('mental cases were always from around') whom she had seen acting strangely.[270] Nabuto went to the girl's parents to share her suspicions about their daughter's state of mind and they agreed that she should try to treat her. 'Like with all mental illness', Nabuto asserted, 'the cause is spiritual and you have to appease and fulfil the ancestors' demands…[so]…we made an offering of a bark cloth, knife and basket to the ancestors'. Key to her success, Nabuto stressed, was the role of the parents, not just in taking part in the treatment, but in acting quickly to prevent the condition from becoming permanent. 'So when one gets a severe madness', Nabuto explained, 'the blame is on the parents for failure

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[269] Interview with Peteralina Nabuto (MPG-04), Buyijja, Masaka District, 19 October 2011. On *mizimu*, see especially Orley, *Culture and Mental Illness*, pp. 18-9; J.C. Ssekamwa, 'Witchcraft in Buganda Today', *Transition* 30 (1967), pp. 30-9 at pp. 31-2; Zeller, 'The Establishment of Western Medicine', pp. 34-6. On *ekigalanga*, see John L. Cox, 'Childbirth as a Life Event: Sociocultural Aspects of Postnatal Depression', *Acta Psychiatrica Scandinavica* 78(S344) (1988), pp. 75-83 at p. 79; Orley, *Culture and Mental Illness*, pp. 27-8.

[270] Interview MPG-04. According to Orley, the most usual complaint among female patients suffering from *ekigalamba* was stomach pains. Orley, *Culture and Mental Illness*, p. 27.

to fulfil ancestral demands early'.[271] Butabika Hospital, both when it first opened, as well as today, was for Nabuto a place for patients who were beyond hope—for those whose families had failed them.

This chapter focuses on the experiences of families who negotiated different types of mental health care in colonial Uganda. It does not argue, as the title and opening paragraph might suggest, that parents were to 'blame' for mental ill-health. Rather, it takes the notion that families were responsible for seeking mental health care as the starting point for a discussion about the burden of caring for a mentally ill relative and the decisions families made about treatment. Recent historical literature on asylums in Europe and the colonial world has demonstrated the importance of families in providing extra-institutional care and in determining if and when to seek confinement.[272] The role of families in Uganda was little different: the ways in which the mentally ill were treated very often depended on the willingness of families to tolerate their behaviour and to seek external assistance, when necessary.

In the previous chapter it was argued that the establishment of a mental hospital on Mulago hill brought psychiatry within the concerns of the nascent intellectual community at Kampala. While this was significant for the long-term trajectory of the discipline of psychiatry in Uganda—the full implications of which will be examined in Chapters IV, V, and VI—it was of limited importance for those families who endured the pressures and fears of mental ill-health on an everyday basis. The colonial mental hospital, as this chapter demonstrates, was a peripheral agent in mental health care. Families continued to care for the mentally ill in their own ways and to make decisions about treatment that were unrelated to government

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[271] Interview MPG-04.
[272] See, for example, Coleborne, *'Madness' in the Family*; David Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine* 10(1) (1997), pp. 137-55.

policy. Those families who did engage with the mental hospital did so largely on their own terms, and with their own expectations and priorities in mind.

The chapter starts by looking at the burden of mental illness, exploring the reasons why some families felt they needed to turn to confinement, and their experiences of the mental hospital once a relative had been admitted. In so doing, the chapter draws on letters found in district archives in Kabale, Fort Portal, and Soroti. These letters were written by county and sub-county chiefs on behalf of families who were seeking protection against the violent outbursts of a mentally ill relative, who wished to enquire about a patient confined in the mental hospital, or who sought the discharge of a patient they felt would be better cared for at home.[273] While the correspondence between families and the mental hospital was mediated through a series of chiefs and district administrators, the descriptions contained within the letters attest both to the difficulties facing those who provided care for the mentally ill and to the ability of families to influence the processes of confinement and discharge.

The chapter then turns to a number of other ways families attempted to deal with mental ill-health, looking at traditional medicine, mission hospitals, and tonics and remedies in turn. In so doing, it argues that families were not passive actors in mental health care. They turned to, and interacted with, a range of different methods of healing.

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[273] Examples can be found in KDA, JUD 1/3 I (British Court (Lunacy)); MMU, JUD 4(1) (Lunacy); SDA, JUD 1/2 (Lunatics).

Families and mental health care

The burden of mental ill-health

One of the most difficult circumstances facing families was the financial responsibility that caring for the mentally ill could bring. While Uganda's Penal Code defined circumstances in which insanity could be used as a defence in criminal trials,[274] relatives could still be pressured by their local communities into providing compensation for actions taken by the mentally ill. 'The ghost of anyone who had been wrongfully accused and had committed suicide', according to John Roscoe in a study of the Banyoro, 'was very dangerous….If she hanged herself on a tree, the body was buried just clear of the roots, the tree was cut down and its roots were dug up; the whole was then burned to ashes and the relatives had to pay ample compensation to the chief on whose land the deed had been done'.[275] Among the Lango, moreover, the mentally ill were not killed in vengeance for murders they committed, but relatives could be obliged to pay blood money.[276]

During the 1940s at least, the records of the Principal Court of Buganda suggest that the mentally ill and their relatives were offered some form of financial protection in the native court system, which administered justice in non-capital criminal and civil cases involving Africans.[277] In an appeal case heard in 1941, the

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[274] H.F. Morris and James S. Read, *Uganda: The Development of Its Laws and Constitution* (London: Stevens & Sons, 1966), pp. 296-7. On insanity and the law in colonial and early post-colonial Uganda see Justice Fuad, 'Insanity and the Law' (unpublished Law Development Centre paper, copy in possession of author, 1970); Alan Milner, 'M'naghten and the Witch-Doctor: Psychiatry and Crime in Africa', *University of Pennsylvania Law Review* 114(8) (1966), pp. 1134-69; J.F. Wood, 'The Law and Treatment of the Mentally Ill Offender' (unpublished lecture, copy in possession of author, 1970).
[275] John Roscoe, *The Bakitara or Banyoro: The First Part of the Report of the Mackie Ethnological Expedition to Central Africa* (Cambridge: Cambridge University Press, 1923), p. 42.
[276] J. H. Driberg, *The Lango: A Nilotic Tribe of Uganda* (London: T. Fisher Unwin Ltd., 1923), p. 210, fn. 1.
[277] The existence and jurisdiction of pre-colonial courts in the kingdoms of Buganda, Ankole, and Toro were recognised by the Uganda Protectorate by the Agreements of 1900 and 1901. Elsewhere, native courts, modelled on the Ganda system, were set up in most districts under the 1905 Native

judges noted how the family members of a man accused of bestiality had agreed to compensate the owner of the goat concerned with three new goats. When they failed to do so, the goat owner had pursued the issued through Buddu County Court. In examining the case, the judges ruled that not only was there 'no medical evidence to prove that the goat was raped', but that in agreeing to the compensation, the family members had only 'wanted to protect their mentally ill brother'. The agreement was subsequently found to be invalid.[278] In another case, heard in the Principal Court in 1943, the judges ordered that the Chief of Kabula County refund ten shillings paid by the relatives of Amiri K. as punishment for his refusal to work. The appellant, the court ruled, was suffering from 'mental problems', and therefore exempt from communal labour requirements.[279]

While it is questionable how many families were able to seek redress through the native court system, the existence of such cases, in Buganda at least, demonstrates how caring for a mentally ill relative could become a very real burden.[280] It may have been a fear of such financial and legal responsibility, for example, that prompted Paskali, of Toro District, to implore the District Commissioner (DC) in 1954 to 'help and send his brother to Mulago Hospital Kampala where he can be looked after'. Paskali stressed that he was poor, had no

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Courts Ordinance. The Principal Court of Buganda was the highest native court in Buganda, being overseen by members of the Ganda Lukiko. On the history and development of native courts in Uganda, see H.F. Morris, 'Jurisdiction of the Buganda Courts and the Scope of Customary Law in Uganda', *Journal of African Law* 9(3) (1965), pp. 154-61; H.F. Morris, 'Two Early Surveys of Native Courts in Uganda', *Journal of African Law* 11(3) (1967), pp. 159-74; Morris and Read, *Uganda*, pp. 39-43; Michael William Tuck and John Allen Rowe, 'Phoenix from the Ashes: Rediscovery of the Lost Lukiiko Archives', *History in Africa* 32 (2005), pp. 403-14.

[278] SCMA (Records of the Principal Court of Buganda), Criminal Appeal Case No. 273/41.

[279] Ibid., Criminal Appeal Case No. 105/43.

[280] Kathryn Barrett-Gaines and Lynn Khadiagala have claimed that the records of district courts are a 'largely undiscovered treasure trove for researchers', particularly in Kabale, Iganga, Mbale, and Jinja. Kathryn Barrett-Gaines and Lynn Khadiagala, 'Finding What You Need in Uganda's Archives', *History in Africa* 27 (2000), pp. 455-70 at pp. 462-4. Due to time, language, and financial constraints (these records were usually written local languages), it proved impossible to expand the search of court records beyond those of the Principal Court of Buganda.

other family of his own, and was 'unable to look after the mad man'. As the chief who forwarded his request noted:

> the mad man is doing damage to the property of other people.
>
> He previously killed 4 cattle, 3 goats, one dog and burn [sic.] a house and now he is taking away the property of other people by force. He can kill people. His brother is poor and asks for help to retain the mad man in jail to stop him damaging the property of other people.[281]

Paskali's account hinted at fear of legal action as much as it stressed the burden on himself, his family, and local community. In requesting assistance, moreover, Paskali made no distinction between confinement in Mulago Hospital and in a jail. Not only did he associate the activities of his brother with those of criminal lunatics—who despite the existence of Mulago Mental Hospital were still frequently kept in jails for up to a year—but he was desperate to be relieved of responsibility for future crimes in any way possible.[282]

The financial and personal threat associated with caring for a mentally ill relative was also apparent in a letter by Daudi Mujungi, an ex-chief, who detailed the actions of his mentally ill son in a letter to the DC Toro:

> He returned to my home and he was living in my house because he had dismissed his wife and spoilt his house and all his belongings he [sic.] did these things on account of madness. When he returned he was not well- he started to beat people severely and the following show his bad acts :-
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> 1. He has beaten all my wives and children and their heads are full of

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[281] MMU, JUD 4(1) (Lunacy), f. 26, letter from Ishingoma, Sabawali for Mwayoka, Mwenge, to DC Toro, 21 September 1954.
[282] Uganda Protectorate, *Annual Report on the Treatment of Offenders for the Year Ended 31st December, 1954* (Entebbe: Government Printer, Uganda, 1955), pp. 13-4.

sores caused by his beatings.

2. He wants to burn houses of neighbours.

3. He does not like me he wants to harm me.

4. My people have ran [sic.] away from my house

5. He slashed 3 heads of cattle.

I ask the Government through you Sir so that this dangerous mad person may be kept by the Government and he may be taken from my house as he has proved to be a dangerous person. One day he will kill a man and the Government will blame me and that is why I ask the assistance from the Government to remove this dangerous person. My suggestins [sic.] are that he should be kept in prison or in Mulago mental hospital but not to be at my house where all people have ran [sic.] away for fear of him I shall be very grateful for your assistance in this dangerous time Sir'.[283]

Being an ex-chief, it is likely that Daudi would have known about the distinction between a mental hospital and a jail as made by the colonial administration.[284] Like Paskali, however, he drew an association between prisons and mental hospitals—Mulago Mental Hospital was not necessarily a place for treatment, but it was certainly one of confinement, where families might be offered some form of relief.

The extent to which families were aware of the purpose of government institutions for the mentally ill is unclear. Luganda newspapers such as *Gambuze* and *Matalisi*, which emerged during the Bataka controversies of the 1920s, carried articles from the 1930s on criminal trials where the insanity defence was used, as

[283] MMU, JUD 4(1) (Lunacy), f. 127, letter from Daudi Mujungu, Bwamba, to DC Toro, 15 June 1960.

[284] Dixon Paul Baruva, a member of the Busoga Lukiko in the 1950s, recalled going on an official tour of Butabika Mental Hospital on its opening in 1955. Interview with Dixon Paul Baruva (BAR-01), Ranynama, Kisozi Sub-County, Kamuli District, 20 July 2011. Kham Kirk Karekaho Karyegyesa, previously veterinary officer and member of the Legislative Council, also noted that chiefs in the Rukungiri area were aware of a range of health issues, which included mental illness. Interview with Kham Kirk Karekaho Karyegyesa (KAR-01), Kabunga, Rukungiri District, 7 July 2011.

well as informative pieces on the mental hospital.[285] In 1932, for example, *Matalisi*, owned by the *Uganda Herald*, which was in turn part of His Majesty's Syndicate, noted that '[a] hospital is going to be built at Mulago, and it will be especially for mental illness. It is believed that the Government will bring learned foreigners to work there'.[286] The message was almost certainly designed as a statement of the superiority of European medical facilities, but provided little practical advice for the families of the mentally ill. A similar article in *Gambuze*, an independent newspaper that was considered by the authorities to be 'quite moderate in its outlook',[287] reminded readers in 1933 that the Uganda Government was building a hospital for mad people (*eddwaliro ly'abalalu*) on Mulago hill 'so the staff of Mulago can look after it'. 'Now for all those with madness', the article added, 'this is an announcement so you do not move anywhere else, this will be where the mentally ill will be taken for treatment'.[288] While *Gambuze* was not always supportive of government policy, it appears that in this case, as Michael Tuck has noted about articles on venereal diseases, the newspaper's editor, Yafesi Tabula, was content to engage in 'the propaganda work of European doctors'.[289]

Articles related to mental ill-health also appeared in English language newspapers, such as in 1955, when the Specialist Alienist G.C. Young informed readers of the *Uganda Argus* that there were:

> several factors working against the recovery of the mentally sick in

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[285] See, for example, 'Ebiffa Mu Kampala', *Ddoboozi lya Buganda,* 10 October 1950, pp. 2-3.
[286] 'Edwaliro Ly'abalalu', *Matalisi,* 7 December 1932.
[287] RHO, Mss.Afr.s.1814 Box 14 FP 27 (Frederick Pedler Papers), f. 75, 'Discussion No. 170'.
[288] 'Eddwaliro Ly'abalalu', *Gambuze,* 6 January 1933, p. 2.
[289] Tuck, 'Syphilis, Sexuality, & Social Control', p. 182. During the late 1920s *Gambuze* criticised the colonial government for their forced labour policies and plans to promote Swahili. James F. Scotton, 'The First African Press in East Africa: Protest and Nationalism in Uganda in the 1920s', *International Journal of African Historical Studies* 6(2) (1973), pp. 211-28 at pp. 222-3.

> Uganda. First was "the laudable one of wanting to look after the mentally sick in the family circle as long as possible." Second was "the common belief that mental disease is due to witchcraft and time and money are wasted in countering this by further witchcraft."[290]

Young linked these factors to a 'widely held' belief of the mental hospital being a place of permanent confinement. This belief, 'built on superstition', held 'that to allow a relative to enter a mental hospital was as good as signing his death warrant'.[291]

Even in cases where relatives were aware of the existence of the mental hospital, it is clear from correspondence that they frequently lacked knowledge about the processes of committal. By 1949, this involved written statements from those close to the suspected lunatic, the reports of two medical practitioners, and a report from a local chief.[292] The 'correct' procedure caused some confusion for A.N. Birakwate, who attempted to get his father, a former Saza Head Clerk of Kinkizi, committed to a mental hospital in 1960. Having written to the District Magistrate, Kigezi, describing how his father 'has now become so dangerous to the community that he has chased my mother, his wife, out of the home', he then contacted the DC Kigezi, to 'obtain necessary forms and detention order [sic.]'.[293] As a teacher, he felt unable to travel to Kabale to make arrangements in person, and hoped the forms could be sent to him for completion and then forwarded with the patient. The testimony provided by Birakwate was deemed to be 'quite useless' by the DC. Detention forms, as the DC noted, were not issued 'at request', but instead followed

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[290] '£90,000 Hospital Wing at Butabika Opened', *Uganda Argus,* 11 June 1955, p. 5.
[291] Ibid.
[292] MMU, JUD 4(1) (Lunacy), letter from District Medical Officer Toro to DC Toro, 30 June 1949.
[293] KDA, JUD 1/3 I (Lunacy), f. 247, letter from A.N. Birakwate to DC Kigezi, 29 October 1960.

from a referral by the Saza Chief Kinkizi, the Police Station, Kabale, and the reports of medical practitioners.[294]

In requesting the removal of relatives, families were active agents in mental health care in ways that were recognised by the colonial government. Indeed, even if these formal requests for certification were unsuccessful, medical officers and administrators were aware that they relied upon families to provide extra-institutional care. Due to limited accommodation at the mental hospital, MOs were urged throughout the colonial period to recommend only the most 'urgent' or violent patients for admission.[295] All other cases, as a circular memorandum from DMSS J. Hope Reford stressed in 1926, 'should be handed to their relatives'.[296] As late as 1958, moreover, Tewfik highlighted the limited resources of medical officers with responsibility for the mentally ill, emphasising that the 'problem of caring for the mentally sick in a community depends much more on the tolerance of that community than on the incidence of psychosis'.[297]

While mental ill-health was a burden for families who had responsibility for a mentally ill relative, it would be misleading to overstate the extent to which families came to rely on the colonial government for relief. Just as there were those who actively sought the committal of relatives, there were also cases where the removal of lunatics was not accepted, or permitted, by family members. In one case in 1939, for

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[294] Ibid.; ibid., f. 248, letter from DC Kigezi to A.N. Birakwate, 3 November 1960. Cases of suspected lunatics could be quite frustrating for district administrators, who were unable to act until the proper procedure had been followed. MMU, 471(118) Loc Govt (Lunatics & Vagrants), f. 46, letter from DC Toro to Katikiro of Toro, 26 July 1938.

[295] KDA (Circulars), p. 1, circular memorandum from Chief Secretary entitled 'Mulago Mental Hospital, 25 March 1936; MMU, MED 1079(295) (Lunatics), f. 1, circular memorandum from J. Hope Reford to all Medical Officers, 8 December 1926; SDA, JUD 1/2 (Lunatics), f. 22, letter from J.S. Champion, Ministry of Health and Medical Headquarters, Entebbe, to M. Rogers, DC Teso, 31 March 1960; ACMM (Medical Department Circular Memos), circular memorandum entitled 'Admissions to Mental Hospitals', 20 November 1957.

[296] MMU, MED 1079(295) (Lunatics), f. 1, circular memorandum from J. Hope Reford to all Medical Officers, 8 December 1926.

[297] Tewfik, 'Problems of Mental Illness', p. 62.

example, a chief complained that he had sent a police officer to detain a suspected lunatic following reports from a European that a lunatic was roaming on his property. When the police officer arrived, 'he found his relatives had already taken him away and they had chained him to a piece of wood. For that he could not possibly bring him and they are still guarding him'.[298] In another case in 1954, a chief in Toro District described how he wanted to detain a man who was 'a menace to the villagers in his area. He has already attacked a man with a panga and the man is in Kyenjojo Hospital'. His relatives, on the other hand, 'wish to take him home and guard him'. Uncertain on the correct way to proceed, he asked the police for advice, and sent one of the relatives to explain their case further.[299] In thwarting attempts at police and government action—just as with requests for confinement—the families of the mentally ill asserted their agency in the processes of confinement as well as their own roles as caregivers.

Getting lost

The reluctance of some families to have their relatives committed to the mental hospital stemmed from a variety of reasons. A belief that mental illness was best treated by 'African' medicines was one, as we shall see later in this chapter. But it may also have stemmed from the alienating experience of confinement for both patients and families. In correspondence that suggests that Young's comment that confinement was likened to a 'death warrant' had some basis in reality, admission to the mental hospital could be followed by years of silence.[300] In 1952, for example, the brother of a man who had been admitted to Mulago Mental Hospital in 1944

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[298] MMU, 471(118) Loc Govt (Lunatics), f. 48, letter from Sabawali to DC Toro, 14 April 1939.
Ibid., f. 47, letter from DC Toro to Owig. Sabawali, 11 April 1939.
[299] MMU, JUD 4(1) (Lunacy), f. 22, letter from Omugwi w/Emisango, Toro, to O.C. Police, Toro, 13 September 1954.
[300] '£90,000 Hospital Wing at Butabika Opened'.

approached the DC Toro to make enquiries into his whereabouts.[301] Having forwarded the enquiry to the Superintendent of Mulago Mental Hospital, the DC Toro was subsequently informed that the patient had died of neurosyphilis six years previously, and was buried at Kololo, Kampala.[302] There was no policy of repatriating bodies, and from the 1930s, those who died at Mulago Mental Hospital were also subject to post-mortem examinations.[303]

Not only was the distance and cost of transportation to Kampala prohibitive for most relatives, but also communication was less than ideal. Letters sent to DCs by families in the months and years following admission attest to the desperation felt by many families, who sent repeated enquiries about their relatives, often too far away to visit. In 1954, the parents of Kamugalwira B. contacted the DC Kigezi to ask for news of their son. He had been admitted to Mulago Mental Hospital in 1953, and they had not heard of him since. The Medical Superintendent, Young, replied promptly, but in language that may have been difficult for the boy's parents to understand. As Young noted, '[h]is physical health is satisfactory but mentally he is sullen, suspicious retarded [sic.] and without much insight'.[304] In a similar case, the father of Festo M. approached his local chief to report how his son had run mad the previous year had been brought to Ndorwa Jail. According to the chief, Festo's father reported to him that while in jail 'his illness increased and he was sent to Mulago Hospital (where mad people are kept). And from then he has never heard of his son'.[305] The chief duly wrote to the DC Kigezi to request that he enquire about the

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[301] MMU, JUD 4(1) (Lunacy), f. 11, letter from DC Toro to Superintendent, Mental Hospital, Mulago, 4 December 1952.
[302] Ibid., f. 12, copy of letter from Medical Superintendent, Mulago, to DC Toro, 2 August 1946.
[303] Post-mortem examinations were conducted for research purposes. See, for example Billington, 'Neurosyphilis in Natives of East Africa'.
[304] KDA, JUD 1/3 I (Lunacy), f. 29, letter from G. Campbell Young to DC Kigezi, 4 January 1954.
[305] Ibid., f. 4, letter from Yeremiya Bigombe, for Saza Chief Ndorwa, to DC Kigezi, 10 May 1954.

whereabouts of this man. Following a letter to Mulago Hospital, Young contacted the DC Kigezi, noting that he could confirm that the patient was still alive, but his behaviour 'is unreliable and his detention is still necessary'.[306]

The communication problems stemmed primarily from a lack of personnel and resources—Young had no time to update the relatives of his patients with regular reports on their progress—but it was also linked to the unreliability of the information available to administrators, medical officers, and the Superintendent of the Mental Hospital. In a case that may not have been uncommon, a police officer in Soroti described his frustration at encountering a suspected lunatic at his local station, who looked lost, perhaps being a 'a Muganda or Musoga by tribe'. 'When I try to ask her name', he noted, 'she does not tell me, she said she was not given a name since she was born'.[307]

The problems caused by this lack of information could be devastating for both patients and families. Indeed, in July 1930, the DC Toro wrote to the Superintendent, Hoima Lunatic Asylum, to enquire about Zozimu R., who had not been heard of by relatives since being sent to the asylum from Kampala in May.[308] No patient with that name could be found in the Asylum Registers, however. '[I]f admitted', the Assistant Superintendent noted briefly, 'he may have been described under another name'.[309] No further information about Zozimu could be traced in the correspondence—as far as the administration was concerned, he was lost.

As this section has demonstrated, the experience of confinement could be an alienating one, and it is therefore unsurprising that families were often reluctant to let

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[306] Ibid., f. 7, letter from G. Campbell Young to DC Kigezi, 19 May 1954.
[307] SDA, JUD 1/2 (Lunatics).
[308] MMU, MED 1079(295) (Lunatics), f. 98, letter from DC Toro to Superintendent, Lunatic Asylum, Hoima, 11 July 1930; ibid., f. 97, note from Mutuba II Burahya to DC Toro, 8 July 1930.
[309] Ibid., f. 99, letter from Assistant Superintendent, Mental Hospital, to DC Toro, 18 July 1930.

their relatives be taken away. Indeed, with a number of alternative forms of mental health care existing simultaneously in Uganda, the mental hospital appears to have been the last resort for otherwise desperate families. It is to these other healing traditions that this chapter now turns.

Traditional medicine

Traditional medicine, encompassing herbs, rituals, and divination, remained the most important therapeutic system throughout the colonial period, operating within local ideas about sickness and disease.[310] While there is considerable evidence pointing to the efficacy of the therapies available in local medical systems for mental illness, references to traditional medicine and insanity occur most frequently in the colonial written record when treatment failed. On a medical report certifying a patient as mentally ill in 1924, for example, it was noted that when the patient had first suffered from the condition four years ago, 'his father treated him with his own medicines'.[311] Rather than just being an example of the failure of other treatment methods, however, this case reaffirms a point made earlier in this chapter about the mental hospital being a last resort. Choosing a particular treatment method, as John Ssekamwa noted about the Baganda, was 'just a matter of trying different medicines until one is effective'.[312]

In Uganda, as elsewhere in colonial Africa, the British created a system that distinguished 'native medical practitioners' from 'witch-doctors', but failed to

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[310] John Orley, 'Indigenous Concepts of Disease and Their Interaction with Scientific Medicine', in E.E. Sabben-Clare, D.J. Bradley, and K. Kirkwood (eds), *Health in Tropical Africa During the Colonial Period: Based on the Proceedings of a Symposium Held at New College, Oxford, 21-23 March 1977* (Oxford: Clarendon Press, 1980); Zeller, 'The Establishment of Western Medicine'.
[311] As cited in Zeller, 'The Establishment of Western Medicine', p. 360.
[312] Orley, *Culture and Mental Illness*, p. 59.

adequately define either term under law.[313] Thus while the 1912 Criminal Law (Witchcraft) Ordinance declared that anyone who 'holds himself out as a witch-doctor or witch-finder or pretends to exercise or use any kind of supernatural power, witchcraft, sorcery or enchantment shall be guilty of an offence and shall be liable to imprisonment for a period not exceeding five years or to fine, or to both',[314] the 1913 Medical Registration Ordinance stressed that nothing in the Ordinance 'shall be construed so as to prohibit or prevent the practice of systems of therapeutics according to native, Indian or other Asiatic method by persons recognised by the community to which they belong'.[315] Despite this ambiguity, traditional healers were largely tolerated by colonial administrators who instead directed their attention towards highlighting the 'witchcraft' activities of those they deemed to be political threats.[316]

While the colonial administration saw 'witchcraft' as both a sign and cause of African madness,[317] understandings of mental illness by different ethnic groups were much more complex. Following two years of fieldwork with communities in Kyaddondo and Kyaggwe counties in central Uganda, John Orley described the rich language developed by the Baganda for recognising and understanding different

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[313] Jacob Tropp, 'Tough Pills to Swallow: Struggles over African Medical Practices among Healers, Patients, and the Colonial State in the Transkei', unpublished conference paper presented at the African Studies Association 54th Annual Meeting, Washington DC, 17 November 2011; Vaughan, 'Idioms of Madness', pp. 233-8.
[314] No. 6 of 1912, 'The Criminal Law (Witchcraft) Ordinance, 1912', *The Uganda Official Gazette* (Entebbe, 1912), 30 April 1912.
[315] 'An Ordinance Relating to Medical Registration, 1913', *The Uganda Official Gazette* (Entebbe, 1913), 1 July 1913.
[316] Interview with Zaire Coast Byaga (MPG-03), Buyijja, Masaka District, 19 October 2011; Interview MPG-04; Interview with Heria Nakirijja (MPG-02), Buyijja, Masaka District, 19 October 2011; Interview with Wilson Senkezi (MPG-01), Buyijja, Masaka District, 19 October 2011. Examples of cases brought against those declared to be practising witchcraft can be found in TNA, CO 536/95, 331 (Deportation of Ninabatwa to Mengo, Buganda Province); TNA, CO 536/91, 299 (Deportation of Woman Named Mawangale). The relationship between 'witchcraft' and political rule will be considered in Chapter V.
[317] Mahone, 'Psychiatry in the East African Colonies'; Julie Parle, 'Witchcraft or Madness? The *Amandiki* of Zululand, 1897-1914', *Journal of Southern African Studies* 29(1) (2003), pp. 105-32; Vaughan, 'Idioms of Madness', pp. 233-8.

mental conditions. The Baganda defined two broad types of insanity: *eddalu*, or violent madness, in which one was said to fall mad; and a milder form of *eddalu*, known as *eddalu ly'akazoole*, which the Baganda recognised as being easier to treat. In both types of insanity the refusal to eat food was a common symptom.[318] Beyond these two categories, Orley noted that there were a number of terms that could come under the heading of mental illness, if only due to the similarities of the symptoms to western psychiatric conditions. These included *obusiru*, or foolishness, both congenital and acquired, and *akawango*, a persistent headache on the top of the head, associated with stress and anxiety.[319]

For the Baganda, mental illness, being particularly difficult to treat, was considered to be a Ganda illness, and distinguished from those brought with the arrival of Arabs and Europeans in the nineteenth century. Ganda illnesses were 'strong' and usually 'sent by another', being caused either by another person or a spirit acting on its own.[320] As with the Baganda, the Sebei also conceived of 'African' and 'European' diseases, suitable for treatment by traditional and western medicine respectively.[321] Madness (*pununotet at Met* and *Kubunmet motit*), defined most frequently as 'when person throws himself about in a frenzy', was an 'African' condition, arising from three main causes: '(a) caused by having killed a person (b) caused by charms of bonik (wizards) (c) caused by curse of worrgoyik (prophets)'.[322] Giving an example of the surprise that could result from the treatment of 'native'

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[318] Orley, *Culture and Mental Illness*, pp. 4-5.
[319] Ibid., pp. 6, 11.
[320] Ibid., p. 15.
[321] J.M. Wetherby, 'Sebei Conceptions of Health and Disease', unpublished conference paper presented at the East African Institute of Social Research Symposium on Attitudes to Health and Disease among some East African Tribes, Kampala, December 1959, p. 72.
[322] Ibid., pp. 71-2.

illnesses by western methods, Philip Hutton, Physician at Mulago Hospital, described how:

> [o]ne of the views held by local Africans was that there were two kinds of illnesses:- Those which could be cured by injections and those which were only amenable to 'native medicine' i.e. the practise of witch doctors….On one occasion having 'cured' a case of hysterical blindness with suggestion assisted by pentothal I was constantly being stopped and congratulated by members of staff for having cured an 'African' disease with an injection.[323]

While understandings of mental illness as an 'African' condition did not exclude families from seeking relief from western medicine, it may explain why families waited until other methods had failed before turning to either mission or government hospitals or the mental hospital.[324] J.M. Wetherby listed eight broad groups of disease among the Sebei, including diseases caused by the spirits of ancestors (*borrtapoyiik*), diseases caused by charms or spells of wizards (*borrtappanet*), and diseases caused from 'above', such as by a rainbow (*borrtapparak*). According to Wetherby, this categorisation directly affected the search for a cure:

> If a person or child falls ill, the usual procedure – if certain signs do not indicate a particular cause of illness – is to try to cure it with "home-made" remedies. Goats are considered a good source of medicines – no-one will ever beat a goat….Failing home cures they will consult a doctor, i.e. a person knowledgeable about herb medicines, etc. This person (male or female) is called kyepsagitiandet.
>
> They will even try European medicine besides African medicine, but if disorder persists they begin to say "it is not a disease", "brrio kuborr" and they look for other causes.

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[323] RHO, Mss.Afr.s.1872(84) (Philip William Hutton Papers), pp. 30-1.
[324] Interview with Vincent Wankiiri (WAN-01), Kampala, Uganda, 29 August 2011.

> The next step is to consult the diviner, kyepsogoyandet; Christians will try to avoid doing this but if illness persists they often turn to the diviner.
>
> They may suspect foul play on the part of a wizard or hatred on the part of individuals who have acquired the services of a wizard.[325]

Once a person exhibited behaviour that was deemed to be unusual or unacceptable, families had a number of options for care or treatment, and they were pragmatic enough to use them.[326] The use of restraint appears to have been widespread, particularly with men, whose madness was deemed to make them abnormally strong.[327] 'When a man lost his reason', as Roscoe noted on the Baganda, 'and he became dangerous to the community, his relations put him in the stocks and kept him under restraint. They were afraid to do more than restrain him, so they gave him food and shelter, but left him so confined that he did not live long. They were afraid, however, to take active steps to end his life'.[328] In western Uganda, too, one Munyankole elder described a woman who had run mad when he was young. 'She would beat people', he recalled, 'was always naked. They always tied her hands and dressed her up'. Her family, he added, cared for her and fed her, so she lived this way for over ten years until eventually she died.[329] Another man noted that in cases of madness in the Galiliya area (Lake Kyoga), families 'carved out a tree trunk and

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[325] Wetherby, 'Sebei Conceptions', pp. 72-3.
[326] Steven Feierman, 'Change in African Therapeutic Systems', *Social Science & Medicine* 13B (1979), pp. 227-84.
[327] Driberg, *The Lango*, p. 210, fn. 1; Orley, *Culture and Mental Illness*, pp. 31-2; John Roscoe, *The Baganda: Their Customs and Beliefs* (London: Macmillan and Co., Limited, 1911), pp. 22-3; Roscoe, *The Bakitara or Banyoro*, p. 290. A number of my interviewees also made this point.
[328] Roscoe, *The Baganda*, pp. 22-3.
[329] Interview with Munyankole male, approximately 87 years old (RUK-02), Butinde Village, Kebisoni Sub-County, Rukungiri District, 5 July 2011.

inserted in the leg' of the mad person. This tree was called *enkomyo*, meaning literally 'to stop / halt'.[330]

Beyond restraint, herbalists were often 'the first line of defence', living only short distances from patient's homes.[331] While the training of herbalists and other healers was frequently kept secret, anthropologists have pointed to the existence of large bodies of knowledge about medicinal plants and roots among different ethnic groups. When three women 'went mad' near Rukungiri in the late 1950s, one Munyankole recounted how people in his village looked 'for medicinal herbs especially *omwesamuryo* [lit. the one that makes you sneeze] and *olubuya*' and then proceeded to tie them 'to their nose/nostrils'. This, he added, 'would calm them down'.[332] According to Wetherby, the Sebei deemed medicines derived from the *kalelonik* tree to be useful in treating madness, broadly defined.[333] Diane Zeller, moreover, described how among the Baganda:

> There were…two methods known for curing madness (eddalu). (1) The roots of a certain plant, lumaama, were ground and mixed with ebinyirikisi by'emitulumba gya gonja (the inner part of the banana stem). While this cooked without water, the patient inhaled the fumes and was rubbed on the head with the mixture. (2) Dried seeds of bigingiribitya (a kind of plant) were ground and mixed with natural butter. This mixture was inserted into cuts made on the patient's head. The patient was then placed in the sunshine so the medicine would melt and be incorporated into his body.[334]

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[330] Interview with Muganda male, approximately 92 years old (KAY-03), Kawuku, Kayunga District, , 3 June 2011.
[331] Interview WAN-01.
[332] Interview with Munyankole male, approximately 71 years old (RUK-06), Butinde Village, Kebisoni Sub-County, Rukungiri District, 5 July 2011.
[333] Wetherby, 'Sebei Conceptions', p. 77.
[334] Zeller, 'The Establishment of Western Medicine', p. 403.

Perhaps unsurprisingly, given the extent of the variety in methods for dealing with mental illness, there were healers who specialised in treating certain types of conditions. Heria Nakirijja, for example, is a Muganda traditional birth attendant and herbalist who has specialised in treating different types of headaches since the 1960s. Early on in her practice she started to distinguish between a persistent headache that affected one half of the body, *omutezi*,[335] and those that were linked to mental illness. She would attempt to relieve the symptoms, 'but the actual mental illness I do not treat'.[336] According to Orley, the mental illness that needed to be distinguished from *omutezi* was usually *akawango*, which he described as a 'persistent headache on top of the head, usually lasting for months or years', and 'almost certainly associated with stress and anxiety'.[337] Nakirijja would send such patients away.[338]

If these methods of treatment failed, the patient's family could also seek the help of a healer who would arrange for a ceremony where the aim was to listen to the demands of the spirit and to then appease it. Traditional doctors in Buganda (*abasawo abaganda*) were frequently believed to be possessed by the *balubaale* (hero gods), and in attempting to find the cause of illness the *balubaale* would be called, welcomed, and celebrated. The patient's family were expected to attend this ceremony, and to contribute financially.[339] Families were also required to play central roles in healing methods practised by Iteso healers. 'When a woman suffers from any form of mental derangement', Lawrance noted in 1957, 'her relatives summon a witch-doctor and under his or her directions build a 'devil hut'. The witch-doctor

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[335] J.F. Bennett defined *omutezi* as a migraine, usually affecting one side of the head. Orley, *Culture and Mental Illness*, p. 63, note 13.
[336] Interview MPG-02.
[337] Orley, *Culture and Mental Illness*, p. 11.
[338] Interview MPG-02.
[339] Orley, *Culture and Mental Illness*, pp. 20-4. On the different spirits in Buganda see especially Neil Kodesh, 'Networks of Knowledge: Clanship and Collective Well-Being in Buganda', *Journal of African History* 49(2) (2008).

then goes to work'.[340] Among the Banyankole, too, according to Roscoe, when a woman became 'mentally deranged when pregnant':

> A hut was built at a little distance from the woman's home and she was taken to live there. Her mother-in-law stayed with her and hoarded her and tended her with special care, for it was feared that the ghost would injure the family in some way should they neglect the mother. The child, when born, was called the child of the ghost, and particular care was taken of it lest the ghost should not be satisfied with its progress and should afflict the family.[341]

In all of these methods, family members were incorporated into the healing process in ways that were neglected by the mental hospital. While they did not necessarily relieve families of responsibility, they nevertheless provided explanations and treatments that they could comprehend. If and when these methods failed, families could and did then turn to western medicine.

Medical missions

Mission hospitals were not always enthusiastic about providing care for the mentally ill. Patients that were difficult to manage were frequently turned away in the admissions room, or discharged after only a few days stay in a hospital. In 1903, Monika was admitted to Mengo Hospital suffering from fever. After three days she '[d]eveloped maniacal symptoms', throwing her head back. She was immediately given potassium bromide, a drug used widely in asylums in the United Kingdom and

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[340] J.C.D. Lawrance, *The Iteso: Fifty Years of Change in a Nilo-Hamitic Tribe of Uganda* (London: Oxford University Press, 1957), pp. 184-5.
[341] John Roscoe, *The Banyankole: The Second Part of the Report of the Mackie Ethnological Expedition to Central Africa* (Cambridge: Cambridge University Press, 1923), pp. 117-8.

India to sedate patients, but discharged the following day 'on account of noise'.[342] While Monika may have been given instructions to attend the hospital dispensary as an out-patient, there is no sign in the case files that any further treatment was provided—her behaviour was too disruptive for the physicians, whose demanding case loads prevented them from attending to difficult patients.[343] Katebereze, a 'lovely lad' of approximately twenty years, was diagnosed with dementia by A.H. Macdonald in 1921, after he had '[b]een in semicomatose [sic.] condition for 10 days'. While this caused few problems on admission, after twelve days Macdonald complained that he had been spitting, was 'half in bed + half out', incontinent, and generally 'difficult to manage'. After a further five days of this behaviour, the hospital authorities decided Katebereze was too dirty to be kept in the ward, transferred him to Charity Ward, where he stayed for a further week.[344] Falanzia L., too, was admitted in 1922, having been brought in on a stretcher. According to Albert Cook, she had 'been wandering about in a demented state', and was driven off by people 'who beat her'. She proved a difficult patient to treat, however, and in one particularly blunt entry it was noted that she had passed water on the bed. After five days, in which she had received potassium bromide three times a day, Falanzia was discharged unimproved, not being 'a suitable case for hospt [sic.]'.[345]

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[342] *The Prescribers Pharmacopœia: A Synopsis of the More Recent Remedies, Official and Unofficial, with a Therapeutic Index* (Bombay: Kemp & Co., Ltd., 1896); Andrews *et al.*, *History of Bethlem*, p. 522; David Healy, *The Creation of Psychopharmacology* (Cambridge, MA & London: Harvard University Press, 2002); Anne Shepherd and David Wright, 'Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint', *Medical History* 42(6) (2002), pp. 175-96 at p. 176.

[343] Such was the volume of work, Albert Cook noted in 1919, including correspondence from 'all over both Protectorates, sometimes entailing 20 letters a day, all the Administrative work of a large Hospital, keeping in touch with Govt Officials, looking after Affiliated Dispensaries, needful Indents, as well as the purely Professional side of the work', that he felt exhausted and in desperate need of a secretary. UoBSC, CMS G3 A7/O 1919 (Uganda Mission Outgoing Correspondence), f. 35, letter from Albert Cook to Dr Lankester, 18 February 1919.

[344] ACMM (Sir Albert Cook Records: Mengo Hospital Case Notes), 1921, Volume 6a, Case No. 1879.

[345] Ibid., 1922, Volume 1, Case No. 266.

Despite the potential difficulties posed by the mentally ill, mission hospitals, as general hospitals, provided limited care to those seeking relief from mental ill-health. Over the period 1897 to 1950, the case notes and admission registers of the CMS Mengo Hospital, on the outskirts of Kampala, indicate that at least 558 patients—366 Africans, 89 Europeans, and 103 Asians—were admitted and diagnosed with some form of mental ill-health, including hysteria, neurasthenia, dementia, schizophrenia, and psychoneurosis.[346] At the CMS Toro Hospital, Fort Portal, too, at least 101 patients—97 Africans, 1 European, and 3 Asians—were admitted over the period 1909 to 1941, and given largely vague diagnoses of 'mental' or 'nervous condition'.[347]

Missionaries were well placed to come into contact with the mentally ill, both at medical stations and outposts, and through their non-medical activities, which included preaching and itinerating.[348] Leya N. was one such patient who was brought in to Mengo Hospital by a non-medical missionary, Miss Corby, who had been teaching at the CMS Gayaza village. According to Miss Corby, Leya had been '[q]uite well until tea-time to-day', when she complained of a fever, headache, and started crying'. 'Then at about 8 pm', the account continued, Leya 'rushed about, hitting people, groaning, + screaming'. Diagnosed with malaria and hysteria, Leya was treated with quinine and potassium bromide and discharged 'improved' four days later.[349]

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[346] MHRR (Mengo Hospital Records, 1944-50); ACMM (Mengo Hospital Case Notes).
[347] KHR (Toro Hospital Admission Registers).
[348] On mission activity in Uganda see: Thomas Herbert Cope, 'Missionaries of the Church Missionary Society as Travellers in East Africa 1844-1914' (unpublished PhD thesis, University of Aberdeen, 1989); Hansen, *Mission, Church and State*; Summers, 'Intimate Colonialism'; Vongsathorn, "Things That Matter".
[349] ACMM (Mengo Hospital Case Notes), 1941, Volume 3, Case No. 966.

Jamali L. was similarly directed to Mengo Hospital in 1937, having '[b]een on "Mission" at Gayaza' before developing 'visions + talking "nonsense"'.[350] Diagnosed by a mission doctor with 'religious mania', her admission came at a time of increasing tension between the Church of Uganda and early *Balokole* ('the Saved People') Revival whose 'outpouring of the Spirit' was welcomed in theory but difficult to manage in practice.[351] A number of the early East African Revivalists were certainly regarded as verging on hysterical in their fervour and during personal testimonies, both by the established Church and traditional leaders.[352] Among the more uncomfortable elements of conversion testimonies was the recounting of highly sexualised acts, and the very open nature in which the revivalists talked about sin. J.E. Church, a medical missionary in Rwanda who played a key role in the East African Revival, recalled how on a visit to Kampala one 'very agitated missionary' declared that a fellow founding revivalist had 'gone mad', for he was 'going about everywhere talking to people about their sins'.[353] This particular revivalist was admitted to Mengo Hospital for a month at the end of 1943, having been '"weak" for some 12 months'. Perhaps unsurprisingly, it was soon suggested that there was a psychogenic basis for the revivalist's illness. He was diagnosed with psychasthenia, a condition in which obsessions and phobias were said to predominate.[354]

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[350] Ibid., 1937, Volume 6, Case No. 1377.
[351] Kevin Ward, '"Obedient Rebels": The Relationship between the Early "Balokole" and the Church of Uganda: The Mukono Crisis of 1941', *Journal of Religion in Africa* 19(3) (1989), pp. 194-227.
[352] Derek R. Peterson, 'Revivalism and Dissent in Colonial East Africa', in Kevin Ward and Emma Wild-Wood (eds), *The East African Revival: History and Legacies* (Kampala: Fountain Publishers, 2010); Derek R. Peterson, 'Wordy Women: Gender Trouble and the Oral Politics of the East African Revival in Northern Gikuyuland', *Journal of African History* 42(3) (2001), pp. 469-89; Ward, '"Obedient Rebels"'.
[353] HMC, JEC 8/5a (J.E.C. Church Papers), '"Nsibambi: the prophet" or "How are you getting on?"', p. 14.
[354] ACMM (Mengo Hospital Case Notes), 1944, Volume 1, Case No. 2036. On psychasthenia, see Barbara Sicherman, 'The Uses of a Diagnosis: Doctors, Patients, and Neurasthenia', *Journal of the History of Medicine and Allied Sciences* 32 (1977), pp. 33-54 at p. 36.

While patients were referred to mission hospitals from across Uganda, most came from the locality, being brought in by friends, relatives, and employers. Mengo Hospital had a particularly close relationship with the Buganda Government, whose Kabaka (King) and Katikiro (Prime Minister) were both attended to by medical missionary Albert Cook. In addition to supporting the hospital through donations of labour, land, and building materials, the Buganda Government actively encouraged the Baganda to visit the hospital for all types of ill-health, including mental illness. In 1923, for example, the Muwanika (Treasurer), sent in Evene S. after he had started singing hymns persistently, walking at night, and acting 'generally insane'. The admitting doctor found Evene to be suffering from '[m]ild lunacy', but otherwise 'perfectly conscious', and sent him back to work with a letter on the same day.[355] While distance and encouragement from the Buganda Government may have been key factors in a decision to bring a patient to Mengo Hospital, in most cases the patient records are too brief to give any clear indication of the reasons why a mission hospital was chosen. What is clear, however, is that missionary medicine was not always the first response to signs of mental ill-health. In 1924, Kama B. was brought to Mengo Hospital by friends, having been 'very talkative + noisy' for several days. According to Albert Cook, she exhibited 'the usual symptoms of a hysterical attack'. This, he concluded, was being exacerbated by the behaviour of her friends, who 'had thrust a strip of wood between her teeth'.[356] In another case, it was noted that Kibiringe, a Muganda student at Makerere University College, who had been '[m]entally unstable' since failing his exams, had a bad family history—'[m]other

[355] ACMM (Mengo Hospital Case Notes), 1923, Volume 1, Case No. 339.
[356] Ibid., 1924, Volume 1, Case No. 220.

insane'—and '[h]as now been manic for about fortnight at home tied by legs + ankles in room by himself'.[357]

Regardless of the reasons for visiting a mission hospital, the families of the patients admitted for treatment tended to be highly sceptical of the treatment received, particularly when there were few signs of improvement. Moreover, while there is no mention in the case notes of religious or spiritual treatment being employed in these cases, the families of the mentally ill may have been uneasy with the requirement to attend ward services and receive visits from missionaries.[358] Nakoli M. was admitted to Mengo Hospital in 1929, having been found walking around Kampala by the police. Nakoli was diagnosed with acute mania and given multiple doses of potassium bromide on a daily basis. After a month there was still no improvement in his condition and he was '[t]aken away against wish of the Doctor'. Nakoli maintained that he had been 'given poison mixed in water by a native', and it was perhaps a remedy for this poison that his relatives wished to find elsewhere.[359] Isaya K. was brought at night by friends who stressed that he had 'had no sleep for three days. Throws things about, digs holes in the garden. Behaviour frightens his friends'. Despite the initial faith in the hospital by Isaya's friends, however, after six days, his relatives arrived and took him away. No explanation was noted for this decision, but it may have indicated their desire to try another type of healer.[360] More detail is evident in the case notes for Erina W. who was admitted following a history of violence, hysteria, insomnia, and 'talking nonsense'. Towards the end of her twenty-day stay at the hospital, Erina took a dislike to her husband and

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[357] Ibid., 1949, unmarked volume, Case No. 818.
[358] KDA (Medical General, 1921-5), letter from L.E.S. Sharp to DC Kabale, 28 April 1921.
[359] ACMM (Mengo Hospital Case Notes), 1929, Volume 5, Case No. 1375.
[360] Ibid., 1931, Volume 1, Case No. 299.

the head hospital girl. Shortly after, and perhaps suspecting that the hospital staff were turning Erina against him, her husband removed her from the hospital.[361]

Mission hospitals were not institutions of confinement; rather, they attempted treatment on a short-term basis, and allowed friends and relatives to retain control over their patients. Mission doctors at Mengo and Toro Hospitals could certify patients and refer them to the mental hospital, but this was a rare occurrence, and appears to have depended on the ability of families to take over care on discharge. In 1931, Mukagi was admitted to Mengo Hospital having been '[f]ound wandering about naked has evidently been beaten large bruise + swelling on arm + leg No bones broken Slightly mental'. The admitting doctor, Margaret Cook, dressed his bruises and gave him some potassium bromide to calm him down. With no family apparently available, the hospital staff noted that Mukagi was to be transferred to prison, and he was '[l]eft at Police Station'.[362] In 1941 Isiraeri S., a Muganda of approximately 15 years, was '[b]rought in by the school master of Mengo School as he was behaving strangely in school + had no sense to learn his lessons'. The condition, which Ernest Hunter diagnosed as acute mania, had only come on that morning, and as Isiraeri lay curled on the floor of the admissions room, Hunter noted that he was '[v]ery talkative'. Isiraeri was prescribed potassium bromide, paraldehyde, and morphia, and no further notes were made on his behaviour in the hospital. After two days, however, the decision was made to transfer Isiraeri to Mulago Mental Hospital.[363] A few months later Zalika N. who was diagnosed with acute toxic mania following malaria, had become progressively more unmanageable during her stay. After a week, she was recorded as being '[r]estless, noisy, getting out of bed', and the

[361] Ibid., 1935, Volume 2, Case No. 620.
[362] Ibid., 1931, Volume 4, Case No. 1001.
[363] Ibid., 1941, Volume 3, Case No. 1159.

following day was transferred to Mulago Mental Hospital. Having treated the malaria with quinine, and with no family available, her mental state was too problematic for the mission doctors to discharge her unaccompanied.[364]

Mission hospitals did not replace traditional medicine, which remained strong until well into the post-colonial period.[365] Rather, mission hospitals provided an alternative option for relief in an increasingly varied medical marketplace. They offered a new type of treatment for mental ill-health that was not always accepted or understood, but allowed families to retain control over the patients.

Tonics and remedies

Anne Digby has argued that in South Africa '[m]issionaries played a significant early role in fostering the growth of rural medical consumerism amongst the coloured and African population because, in a shared ground between missions and colonial society, there was 'explicit association of Christianity, commerce and civilisation''.[366] Digby's assertion could also be applied to Uganda, where, as elsewhere in Africa, medical missionaries were the primary providers of western medicine and education before the 1930s, and made charges for treatment based on the perceived wealth and race of the patient.[367]

According to the missionaries themselves, the demand for tonics and remedies among the African population led to requests that were both frustrating and

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[364] Ibid., 1941, Volume 5, Case No. 1629.
[365] Zeller, 'The Establishment of Western Medicine', ch. vii.
[366] Anne Digby, 'Self-Medication and the Trade in Medicine within a Multi-Ethnic Context: A Case Study of South Africa from the Mid-Nineteenth to Mid-Twentieth Centuries', *Social History of Medicine* 18(3) (2005), pp. 439-57 at pp. 441-2.
[367] The variety in charges can be seen clearly in the cases notes at ACMM. On the role of medical missions in providing medical care in Africa see especially Michael Jennings, "Healing of Bodies, Salvation of Souls': Missionary Medicine in Colonial Tanganyika, 1870s-1939', *Journal of Religion in Africa* 38(1) (2008), pp. 27-56; Jennings, "A Matter of Vital Importance"; Vaughan, *Curing Their Ills*, p. 56. Michael Tuck's PhD thesis on syphilis in colonial Uganda contains an interesting discussion on charges for syphilis injections. Tuck, 'Syphilis, Sexuality, & Social Control', pp. 218-26.

bizarre. In one such case at Ng'ora Dispensary in 1934, Miss D.A. Brewster described how the following remarks were typical of patient-missionary encounters:

> "No, not that sort, I want the pink."
>
> "Please fill the bottle. I have come a long distance."
>
> "I do not want medicine to drink for my throat, but some to rub on the outside, and give me some for my child, he has a sore inside his stomach."[368]

Moreover, such was the desire of early missionaries to use medicine to impress those who would not otherwise by swayed by evangelism, that missionaries frequently turned to placebos. Albert Cook, for example, handed out water dyed purple with potassium permanganate, and allowed patients to breathe from bottles filled with solutions of liquid ammonia. 'The latter', as Zeller has argued, 'made the people stagger off with tear-filled eyes convinced of the powers of Western medicine'.[369]

Outside of accounts by missionaries, however, there is little evidence that points to the ways families came to use the increasing number of tonics and remedies available in Uganda, not just from mission and government dispensaries, but in shops and markets. Indeed, by the 1950s, the travelling salesman on a bicycle or car could be found all over Uganda.[370] Even in the smallest of townships in northern Uganda, as John Stonehouse noted, the stock of Indian shops was 'remarkably good….a

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[368] D.A. Brewster, 'More News from Ng'ora', *The Mission Hospital* no. 38 (1934), p. 99.
[369] Zeller, 'The Establishment of Western Medicine', p. 322.
[370] Interview with Godfrey Asiimwe (ASI-01), Makerere University, Uganda, 21 October 2011; Interview with Mwambutsya Ndebesa (NDE-01), Makerere University, Uganda, 21 October 2011; John Stonehouse, *The Prohibited Immigrant* (London: The Bodley Head, 1960), p. 77.

profusion of cloth, shirts, patent medicines, tea, condensed milk, bottles of boiled sweets—and, of course, Pepsi-Cola'.[371]

While for most of the colonial period, the cost of imported patent medicines meant they were only accessible to the European population,[372] by the early 1950s, a variety of low cost medicines were being advertised to the African population by Indian and African salesmen.[373] Deemed to be simple medical substances, they were exempt from the Drugs and Poisons Ordinance, and no license was required to sell them.[374]

Taking advantage of the growth of the Luganda newspapers *Gambuze* and *Matalisi*, Indian trading companies targeted potential consumers in adverts claiming to treat almost any illness.[375] 'Lumala', which was marked at Shs. 2/- by Hassam Harji, Namirembe Market, was advertised as a cure for no less than thirty-six different conditions, including headache, ringworm, laziness, bodily weakness, jiggers, and madness (*akalogojo*).[376] This type of madness, according to Orley, was a mild form, 'in which the person speaks strangely and apparently fails to understand well what is happening around him'.[377] The advert gave no details about how 'Lumala' might cure *akalogojo*, but instead stressed Hassam Harji's expertise in

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[371] Stonehouse, *The Prohibited Immigrant*, p. 64.
[372] In 1934, while tonics tended to cost a few shillings, wages for unskilled labourers ranged from Shs. 4/- to Shs. 20/- a month, in addition to a daily food ration, and from Shs. 16/- to Shs. 150/- a month for semi-skilled and skilled labour. Europeans employed in commerce or on plantations, by contrast, received an average of £200 or £750 per annum. Uganda Government, *Annual Report on the Social and Economic Progress of the People of the Uganda Protectorate for 1934* (1935), p. 48.
[373] P.C.W. Gutkind, *The Royal Capital of Buganda: A Study of Internal Conflict and External Ambiguity* (Hague: Mouton, 1963), p. 234; Harold Inghams, *Uganda: A Crisis of Nationhood* (London: Her Majesty's Stationary Office, 1960), p. 175; J.R. Weisz, 'East African Medical Attitudes', *Social Science & Medicine* 6 (1972), pp. 323-33 at p. 326.
[374] No. 10 of 1931, 'An Ordinance Relating to Drugs and Poisons', *The Uganda Official Gazette* (Entebbe, 1931),
[375] On the early history of Luganda newspapers see Dhiru B. Patel, 'The Evolution of Modern Mass Media in Uganda', *Proceedings of the Seventh Symposium, the East African Academy, September 1969 on 'Communications in East Africa'* (Kampala, Uganda: Makerere University Printery, 1969); Scotton, 'The First African Press'.
[376] 'Omulamu Yafuna Ebingi', *Gambuze,* 26 January 1951.
[377] Orley, *Culture and Mental Illness*, p. 5.

understanding illness of any kind—no customers would be allowed to buy any medicine that would not help them.[378]

Julie Parle has demonstrated how African herbalists and healers in Natal and Zululand 'expanded their commercial activities in the years immediately before the First World War, deploying the language of biomedicine as well as incorporating some of the symbolic and practical tools of 'Western' medicine and pharmacology'.[379] While there is only minimal evidence that suggests that traditional healers in Uganda entered the commercial marketplace,[380] Luganda newspapers indicate that African and Indian traders actively drew on both western and local ideas about health and disease in attempting to sell their products. Muwanga & Bros was run by a retired African Medical Assistant, and stocked 'patent foods' alongside a range of other 'medicines' and 'drugs' in its Kampala store.[381] In adverts in *Gambuze*, Muwanga & Bros stressed the role of the *balubaale* in causing disease, emphasising that only its staff were capable of knowing the medicines that could treat the illnesses of 'black people' (*Abaddugavu*).[382] 'Before buying medicine from anywhere', the advert advised: 'first check that the seller understands medicine and the illness [*endwadde*] that the medicine cures. Many have lost their shillings by just buying medicines. There are many sellers who know little about the blackman's [*Muddugavu*] ailment'.[383]

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[378] 'Lumala', *Matalisi,* 17 January 1947; 'Omulamu Yafuna Ebingi'.
[379] Parle, *States of Mind*, p. 194.
[380] For example, a report on Katwe market, the largest market in Kampala in the 1950s, noted that in addition to foodstuffs—in particular *matoke*—the market was home to 'two stalls permanently occupied by regular traders, selling skins and native medicines'. A.B. Mukwaya, 'The Marketing of Staple Foods in Kampala, Uganda', in Paul Bohannan and George Dalton (eds), *Markets in Africa* (Evanston, Illinois: Northwestern University Press, 1962), p. 655-6.
[381] *Saben's Commercial Directory and Handbook of Uganda* (Kampala: Saben's Directories, 1955), p. 124.
[382] 'Muwanga & Bros', *Gambuze,* 7 December 1951.
[383] Ibid.

Meanwhile, adverts for Jomestri, imported from India by the Bombay Trading Company, drew on language about mental ill-health that was common in European and American adverts for health tonics and 'pick-me ups' until well into the 1950s (Image 7).[384]



Image 7: Advert for Jomestri, 1951
Credit: *Gambuze*, 26 January 1951

'If you are tired of life', the advert declared, 'having sleepless nights, loss of appetite, unsettled stomach: as soon as you use JOMESTRI, you will be cured immediately'.[385] This language of physical and mental weakness was juxtaposed against the promise of a cure for *ekigalanga*, which, as we saw at the beginning of this chapter, was a condition brought on by possession by the ghosts of ancestors.[386] *Ekigalanga*, which traditional healer Peteralina Nabuto stressed required attention to the demands of spirits and input from family members, was presented here as being cured instantly by Jomestri. Such was the ease with which Jomestri worked, the advert added, was that 'it's like pushing someone who is squatting'.[387]

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[384] Ali Haggett, *Desperate Housewives: Neuroses and the Domestic Environment, 1945-1970* (London: Pickering and Chatto, 2012).
[385] 'Omulamu Yafuna Ebingi'.
[386] Interview MPG-04.
[387] 'Abakyala Lino Mulyeyune', *Gambuze,* 26 January 1951, p. 3.

The existence of these adverts raises questions that, due to lack of evidence, it is impossible to explore fully in this thesis. Notably, were these tonics and remedies an effective option for relief, or were they, as has been claimed about their European counterparts, just exploiting the desperation of individuals and families seeking relief from mental ill-health?

Conclusion

This chapter has explored the experiences of families as they negotiated different types of mental health care in colonial Uganda. In the absence of knowledge of, or confidence in the mental hospital, families responded to the idea of 'confinement' by the state in different ways. For some, the mental hospital was simply a place for mad people, to be used when the financial responsibility became too great, or the patient too violent. For others, admission to a mental hospital was an alienating experience for both patient and family—a place where communication was limited and alternative therapies could no longer be accessed.

The colonial mental hospital was a peripheral agent in a country where families usually took responsibility for the mentally ill. Indigenous medical systems, while not actively encouraged by the colonial government, remained important to families across Uganda, providing therapies that were not only easily accessible, but drew on local concepts of disease and misfortune. With the arrival of Europeans, mission hospitals and patent medicines also entered the medical marketplace, providing alternatives to the long-term care provided by the state. While families could be highly suspicious of these forms of therapy, they nevertheless indicate that the mental hospital was only one aspect of a much wider network of options for dealing with mental ill-health in the past.

While this chapter has explored families and their engagement with different types of mental health care in broad terms, the next chapter narrows the area of focus onto one specific type of mental health care—the mission hospital—and to a single diagnosis—neurasthenia.

Chapter III:

Neurasthenia at Mengo Hospital: A Case Study in Psychiatry and a Diagnosis, 1906-1950

One of the key features of psychiatry in colonial Africa was the way in which understandings of mental illness intersected with assumptions about racial difference. The African and European 'mind' was considered to be biologically and culturally distinct, with mental illness, by extension, differing in both cause and appearance.[388] Neurasthenia, a condition of nervous and mental exhaustion, was one such illness that took on extended racial connotations when it was transported from America and Europe into the colonial context.[389] Variously labelled as 'neurasthenia in the tropics' or 'tropical neurasthenia', the condition was associated almost exclusively with the mental and physical breakdown of white colonisers.[390] It reinforced ideas of racial difference already presumed by colonial rule, positing white 'nerves' against a more dangerous and unpredictable black 'madness'.[391]

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[388] Sadowsky, *Imperial Bedlam*, p. 21. The idea of difference has been highlighted in many scholars, including Deacon, 'Madness, Race and Moral Treatment'; Ernst, 'Idioms of Madness'; Jackson, *Surfacing Up*; McCulloch, *Colonial Psychiatry*; Sally Swartz, 'The Black Insane in the Cape, 1891-1920', *Journal of Southern African Studies* 21(3) (1995), pp. 399-415; Vaughan, *Curing Their Ills*.
[389] Anna Crozier, 'What Was Tropical About Tropical Neurasthenia? The Utility of the Diagnosis in the Management of British East Africa', *Journal of the History of Medicine and Allied Sciences* 64(4) (2009), pp. 518-48.
[390] See, for example, James Purves-Stewart, *The Diagnosis of Nervous Diseases*, 4th edn (London, 1916), p. 380; Hugh S. Stannus, 'Tropical Neurasthenia', *Transactions of the Royal Society of Tropical Medicine and Hygiene* 20(5) (1927), pp. 327-343.
[391] Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham, NC: Duke University Press, 2006), p. 141; Crozier, 'What Was Tropical', p. 533; Mahone, 'The Psychology of the Tropics'.

This chapter uses a case study approach to examine the complexity and contradictory nature of diagnoses like neurasthenia in colonial Africa. Drawing on the case notes of European and African patients diagnosed with neurasthenia at the CMS Mengo Hospital, it argues that in practice, and outside of the colonial asylum in particular, the doctoring of mental ill-health was more nuanced than histories of psychiatry and empire might imply. In so doing, it aims to place patients and their relationships with doctors at the forefront of investigation.

Neurasthenia provides the ideal subject for a case study of this kind because as a medical construct it has been shown to be revealing of wider colonial anxieties.[392] Using medical journals, memoirs, and administrative records, historians have linked the diagnosis with ideas about acclimatisation, masculinity, and degeneration, arguing that neurasthenia not only provided a socially acceptable explanation for European and American dysfunction, but a means of regulating the behaviour of colonisers in the tropics. Such was the use of the diagnosis for 'policing the colonizers', Anna Crozier has argued, that medical officers in British East Africa continued to publish on neurasthenia and its relationship to acclimatisation until well into the 1930s, despite calls from medical authorities in Europe to abandon the diagnosis.[393]

This chapter introduces patient case notes from Mengo Hospital into the historiography of tropical neurasthenia. At Mengo Hospital, the tales of pain and suffering recorded by the doctors remind us that there is more to the history of tropical neurasthenia than colonial anxieties and socio-political control. This was a diagnosis that was negotiated in hospital examination rooms as much as in medical

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[392] Anderson, *Colonial Pathologies*; Crozier, 'What Was Tropical'; Dane Kennedy, *Islands of White: Settler Society and Culture in Kenya and Southern Rhodesia, 1890-1939* (Durham, NC: Duke University Press, 1987); Mahone, 'The Psychology of the Tropics'.
[393] Crozier, 'What Was Tropical', p. 545.

journals and government medical boards. Significantly, it was also a diagnosis that was not always reserved exclusively for white colonisers—at Mengo Hospital from the early 1900s, neurasthenia was diagnosed in African patients too.

The chapter starts by tracing the relationship between neurasthenia and race in the medical literature in order to provide a broad context for the sections that follow. The chapter then turns to diagnoses of neurasthenia in Europeans and Africans at Mengo Hospital over the period 1897-1950.[394] Of the 558 patients who were admitted with a form of mental ill-health during this period, at least 42 Europeans and 57 Africans were diagnosed with neurasthenia and treated as in-patients for periods of between two days and two months. An analysis of the case notes for these patients not only provides an opportunity to examine a diagnosis across racial groupings, but to explore the ways in which ideas about mental ill-health, race, and 'difference' were understood and deployed in a mission hospital context.

Neurasthenia and race

In exploring the relationship between race and tropical neurasthenia in the medical literature, it should be remembered that racial understandings of nervousness were not unique to the colonial context.[395] As neurasthenia became associated with concepts of degeneration in America from the late 1890s, the appearance of neurasthenia in black Americans was increasingly noted.[396] Neurasthenia, it was said, was particularly common in 'half-breeds', being brought on by the 'struggle of the

[394] This is the period for which medical records are available for research at the Albert Cook Memorial Library and Mengo Hospital Records Room.
[395] Campbell, *Race and Empire*; Crozier, 'What Was Tropical', p. 529.
[396] Brad Campbell, 'The Making of 'American': Race and Nation in Neurasthenic Discourse', *History of Psychiatry* 18(2) (2007), pp. 157-78.

best specimens of an inferior race to attain the plane of a superior [one]'.[397] These sentiments were repeated and reinforced later in the colonial context as attention shifted in the 1920s from an almost exclusive focus on the nervous strains of white colonisers to the psychological stability of indigenous peoples living under colonial rule.[398] Until the 1930s, however, comments on the occurrence of neurasthenia in 'natives'—by which authors meant those who were neither white nor American or European—appeared only as after-thoughts in articles focusing on the health of white colonisers. Preoccupied with the dangers of climate, the cost of invaliding, and the long-term sustainability of colonialism, the medical literature debated and refined understandings of neurasthenia in Americans and Europeans alone.

As early as 1906, W.W. King claimed that while neurasthenia did occur in Puerto Ricans, it was far more common in those coming from 'colder countries'. As such, it was 'a very interesting question to American physicians, in view of the close relations recently established between the United States and Porto Rico [sic.], Cuba, [and] the Philippines'.[399] While King continued to discuss the ways in which lifestyle, climate, and hygiene might bring on the condition in white colonisers, he had acknowledged the occurrence of neurasthenia in Puerto Ricans. This, he qualified, was usually 'encountered associated with hysteria—hystero-neurasthenia'. An ill-defined medical construct that was avoided by most medical authorities, King did not add much by using the term hystero-neurasthenia. But his emphasis on how neurasthenia presented differently in Puerto Ricans is suggestive considering the

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[397] Charles W. Burr, 'Neurasthenia. The Traumatic Neuroses and Psychoses', in William Osler and Thomas McCrae (eds), *Modern Medicine: Its Theory and Practice* (Philadelphia & New York: Lea & Febiger, 1910), p. 725.
[398] This shift has been described more generally in Mahone, 'The Psychology of the Tropics'; Vaughan, *Curing Their Ills*.
[399] W.W. King, 'Tropical Neurasthenia', *Journal of the American Medical Association* XLVI(20) (1906), pp. 1518-9 at p. 1518.

importance his medical contemporaries placed on the role of the nervous system in the development of functional disease.[400] If Americans and Puerto Ricans were biologically different, mental illness, by extension, would also differ in both cause and appearance.

Such was the belief in biological difference between different races, particularly before the 1920s, that a number of medical commentators questioned whether natives could even suffer from neurasthenia. Drawing on the original conceptions of the condition as formulated in America and Europe, medical officers stressed how neurasthenia was a disease of modernity and 'civilisation'—the burden of 'nerves' was one shared only by the superior, colonising races.[401] Charles F. Harford, of the CMS, reinforced this point in a discussion on the potential role of electricity in causing neurasthenia among Europeans in India. He asserted that he had heard on good opinion that the Japanese did not suffer from 'Japan head', a term used by the CMS to describe nervous troubles. For Harford, this was a sign that 'electrical influences' in the tropics affected European but not Japanese nervous systems.[402]

Even as ideas of biological difference gave way to cultural difference during the 1920s, some observers continued to stress how nervous conditions affected Americans and Europeans alone. As Sir Robert Armstrong-Jones claimed in 1928, 'when dealing with an unsophisticated and incomplete civilization the psychasthenic or neurasthenic was not found'.[403]

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[400] Tracey Loughran, 'Hysteria and Neurasthenia in Pre-1914 British Medical Discourse and in Histories of Shell-Shock', *History of Psychiatry* 19(1) (2008), pp. 25-46 at p. 37.
[401] For an extensive discussion on a range of aspects of neurasthenia, see especially the essays in Marijke Gijswijt-Hofstra and Roy Porter (eds), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam & New York: Editions Rodopi B. V., 2001).
[402] Sir R. Havelock Charles, 'Neurasthenia, and Its Bearing on the Decay of Northern Peoples in India', *Transactions of the Royal Society of Tropical Medicine and Hygiene* 7 (1913), pp. 2-31 at p. 24.
[403] 'Neuroses in the Tropics', *British Medical Journal,* 17 March 1928, pp. 448-9 at p. 449.

Mirroring a more general shift in interest towards the health of the colonised, the 1920s saw an increase in comments about neurasthenia in different races. These comments also tended to focus less on whether natives could suffer from the condition, and more on the reasons why it might occur at all. W.E. Musgrave, of the Philippines General Hospital, declared that:

> Race is a striking feature among the predisposing causes. In natives it is usually more prevalent among those who are trying to adopt Western methods of energy, application and efficiency and who are unprepared by breeding, training or environment to do so. This is strikingly illustrated in the Philippine Islands where twenty years of constant effort to establish Occidental methods have led to a decided increase of the disorder among the younger generation of more progressive Filipinos.[404]

Neurasthenia was not only an inevitable result of contact with 'civilisation', but also a useful explanation for the perceived failures of the colonised.

Similar sentiments appeared in the British medical literature. In one of the first sustained discussions of neurasthenia in 'coloured individuals', recorded at a meeting of the Royal Society of Tropical Medicine in 1927, H.M. Hanschell noted that he knew of cases of West Indians becoming neurasthenic in London. He recalled how '[w]hen these cases came to the Seamen's Hospital in the Albert Dock they invariably complained of physical illness—which thorough examination failed to confirm. On obtaining their confidence, an essential, though often a long business, one found anxiety and mental conflict; and back [sic.] of it all a desire to return to the West Indies'.[405] Following Hanschell, Hugh S. Stannus confirmed that he had also

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[404] W.E. Musgrave, 'Tropical Neurasthenia, Tropical Hysteria and Some Special Tropical Hysteria-Like Neuropsychoses', *Archives of Neurology & Psychiatry* 5(4) (1921), pp. 398-407 at p. 339.
[405] Stannus, 'Tropical Neurasthenia', p. 340.

seen neurasthenic symptoms in Africans. Using a language reminiscent of debates in Britain on the degeneration of the working classes, Stannus added that:

> I, too, have seen neurasthenic symptoms in such people in this country, but also in natives in their own countries—not while living their normal lives in their villages, but when partly educated and subjected to conditions to which they were not adapted—just as one sees neurasthenia common to-day among a partly educated class whose immediate forbears were uneducated.[406]

These ideas had roots in both race and class-based understandings of neurasthenia as it had developed in its original American and European contexts. But they were also reinforced by wider shifts in thinking about race in science and anthropology.[407] As attention shifted from biological to cultural difference and Freudian understandings of the psyche rose in prominence, 'primitive' races were said to suffer from an internal conflict resulting from being trapped between two worlds.[408] As noted in Chapter I, such thinking was most prominent in Africa between the 1930s and 1950s, as psychiatrists, anthropologists, and psychologists stressed the role played by education and urbanisation in 'deculturising' the African and prompting mental illness.[409]

While the ethnopsychiatric literature on deculturisation focused primarily on the more unpredictable and disturbing forms of mental illness, such as mass hysteria, it was rarely linked to conditions that in their original European contexts were

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[406] Ibid., p. 343.
[407] On these shifts see especially Graham Richards, *'Race', Racism and Psychology: Towards a Reflexive History* (London & New York: Routledge, 2012); Nancy Stepan, *The Idea of Race in Science, 1800-1960* (London: Macmillan, 1982).
[408] Ranjana Khanna, *Dark Continents: Colonialism and Psychoanalysis* (Durham, NC: Duke University Press, 2001).
[409] J.C. Carothers, 'A Study of Mental Derangement in Africans, and an Attempt to Explain Its Peculiarities, More Especially in Relation to the African Attitude to Life', *Journal of Mental Science* 93 (1947), pp. 548-97; Vaughan, *Curing Their Ills*, ch. 5.

considered to affect only the 'civilised' races.[410] Discussions of neurasthenia in natives was by contrast limited primarily to non-specialists, something that goes some way in explaining why they came into contact with people exhibiting neurasthenic symptoms at all. Certainly, neurasthenia was a condition that was not found in the colonial asylum, just as it was not found in asylums in Europe or America. It was the general clinic or urban workplace where these 'neurasthenics' were encountered—places where they were not disruptive and posed no danger to family or community. The CMS Mengo Hospital, to which this chapter now turns, was one such setting.

Neurasthenia at Mengo Hospital

If there was some question in the medical literature as to whether Africans could suffer from neurasthenia, particularly before the 1920s, this was certainly not the case at Mengo Hospital. Between 1906 and 1950, fifty-seven Africans were diagnosed with the condition and treated as in-patients. The first recorded case occurred in 1906, a time when the medical literature still focused almost exclusively on the appearance of the condition in white Europeans and Americans. Over the next fourteen years, a further five Africans—male and female—were diagnosed with the condition. While these numbers are small, they are comparable both to the number of Europeans diagnosed with the condition and to the figures released by the colonial government showing the number of European officers invalided each year due to neurasthenia (Table 2). Over the years 1911-15, for example, two Africans and ten Europeans were diagnosed with neurasthenia at Mengo Hospital, while one European official was invalided from Uganda.

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[410] Mahone, 'The Psychology of Rebellion'.

Table 2: Cases of neurasthenia at Mengo Hospital shown against the invaliding of European Officials due to neurasthenia, 1906-1950
Sources: Mengo Hospital Case Notes, Albert Cook Library, Makerere University; Mengo Hospital Case Notes, Mengo Hospital Records Room, Kampala; Uganda Protectorate Annual Medical Reports 1911-1950

Years	Mengo Hospital Records		Uganda Protectorate Reports
	African cases of neurasthenia	*European cases of neurasthenia*	*Invaliding of European officials due to neurasthenia*
1906-1910	2	[No records]	1
1911-1915	2	10	1
1916-1920	2	11	9
1921-1925	3	3	5
1926-1930	6	6	2
1931-1935	15	7	1
1936-1940	20	3	2
1941-1945	2	0	[No records]
1946-1950	5	2	0
Total	57	42	21

Of course, the total number of Europeans living in Uganda during this time was significantly smaller than the number of Africans. The estimated population for 1918, for example, showed 570 Europeans (313 males and 257 females) and 3,357,080 Africans.[411] Moreover, when the number of Africans diagnosed with neurasthenia is placed against the total number of in-patients admitted each year to Mengo Hospital, the diagnosis appears to be even less significant. In 1908, for example, when Mengo Hospital had 120 beds and had seen 1408 in-patients over the year, there was only one diagnosis of neurasthenia (in an African male).[412]

[411] Colonial Office, *Colonial Office List 1919* (London: His Majesty's Stationary Office, 1919), p. 411.
[412] UoBSC, CMS M/F 1 (Medical Mission Accounts and Statistical Returns), 2, CMS Medical Mission Auxiliary, 'Account of Receipts & Expenditure for the Year Ending December 31st 1908'; ACMM (Mengo Hospital Case Notes), 1908, Volume 1, Case No. 173. During this year there was one other case of mental ill-health among the African in-patients—hysteria in a female patient. Ibid., 1908, Volume 5, Case No. 759.

Nevertheless, the presence of the diagnosis in the patient case notes indicates that from early on in Mengo Hospital's history, and contrary to much of the medical literature on the subject, the doctors not only believed that Africans could suffer from neurasthenia, but that they could recognise it, and treat it in a mission hospital.

As indicated in Table 2, the number of Africans diagnosed with neurasthenia at Mengo Hospital started to rise after 1920, mirroring the acknowledgement in the medical literature that the condition could occur in any race. The number of cases peaked at Mengo Hospital in 1931-40, when at least thirty-five neurasthenic patients were admitted. The phenomenon was short lived, however—the diagnosis waned during the 1940s, dying out completely after 1950.

Diagnoses of neurasthenia in the European patients followed a quite different trajectory, with the highest number of cases occurring between 1911 and 1920. While there are no surviving case notes for Europeans diagnosed with neurasthenia before 1911, it is clear from other documents that at least three CMS missionaries were invalided from Uganda with neurasthenia in the 1900s. All of these missionaries would have been required to see Albert or Jack Cook for a medical certificate before their departure.[413] If they had been formally admitted to the hospital, their records have likely been destroyed or misplaced—before the opening of a private European ward in 1910, and the subsequent acquisition of European admission registers and casebooks, notes on the Europeans treated at Mengo Hospital were frequently left loose.[414] The total number of European patients admitted for any condition also rose

[413] UoBSC, CMS M/M 7 (Health of Missionaries Working in Uganda and Elgon Missions), 'Missionaries Invalided Home Uganda + Elgon Missions' (nd.).
[414] A few remaining case notes can be found scattered among the files of correspondence in ACMM (Mengo Hospital Correspondence).

steeply with the opening of the European ward, from 37 in 1910, to 78 in 1911, to 110 in 1912.[415]

Significantly, for a condition that in the early medical literature was associated almost exclusively with the breakdown of white colonisers, neurasthenia was the most common diagnosis of mental ill-health for both African and European patients in the 1930s. Between 1931 and 1940, of the 101 African patients admitted with some form of mental health problem, 35 cases of neurasthenia were diagnosed.[416] During the same period, of the 12 European patients admitted suffering from mental ill-health, 10 cases of neurasthenia were diagnosed. As such, the prevalence of the diagnosis raises questions about understandings of neurasthenia at Mengo Hospital, particularly in the 1930s: was neurasthenia considered to present differently in European and African patients? Was there a shift from somatic to psychological understandings of the condition? And did the doctors at Mengo Hospital look more to British or 'colonial' understandings of neurasthenia?

It should be noted here that in all cases at Mengo Hospital the diagnosis was that of 'neurasthenia', rather than 'tropical neurasthenia'. This is not surprising considering that the terms 'neurasthenia' and 'tropical neurasthenia' were used interchangeably in the medical literature. As Crozier has pointed out, the differences between neurasthenia and its tropical variant were mostly 'in emphasis rather than kind', with particular weight placed on the sun as a causative factor.[417] That the doctors at Mengo Hospital used the term 'neurasthenia' could thus have been an

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[415] 'Uganda Mission: Mengo', *Mercy and Truth* no. 211 (1914), pp. 199-201 at p. 200.
[416] With 23 African patients admitted, hysteria was the second most common diagnosis of mental ill-health at Mengo Hospital during this time.
[417] Crozier, 'What Was Tropical', p. 532.

admission that the 'tropical' in tropical neurasthenia tended to refer more to a sense of locality than 'to characterize any special type of neurasthenia'.[418]

Neurasthenia had always been a 'protean' condition, and as Freudian theories on the soma and psyche rose in prominence in Europe, environment was increasingly discounted as a predisposing factor for nervous breakdown.[419] Anderson has argued that with these shifts the 'tropical' in tropical neurasthenia lost its relevance: 'Not simply a potentially avoidable physiological failing of the white race in an alien land, neurasthenia became…a sign of wilful individual disaffection with modern life, evidence of deep-seated mental conflict, of the family drama'.[420] In contrast, Crozier has demonstrated how in British East Africa, ideas about neurasthenia as related to topography persisted in published medical literature until well into the 1930s.[421] The case notes at Mengo Hospital suggest that in general medical practice in East Africa, too, the neurasthenia diagnosis persisted as a label for mental and physical breakdown. How the doctors and patients understood and applied the condition at Mengo Hospital is the subject of the following two sections.

European patients

The process of examination for the European patients at Mengo Hospital showed a strong emphasis on the search for somatic signs of illness. As it was in George M. Beard's original outline of the condition, the diagnosis of neurasthenia was one reached as much by process of exclusion as through the imposition of pre-

[418] King, 'Tropical Neurasthenia', p. 518; Glenn T. Trewartha, 'Recent Thought on the Problem of White Acclimatization in the Wet Tropics', *Geographical Review* 16(3) (1926), pp. 467-78.
[419] Sicherman, 'The Uses of a Diagnosis', p. 33.
[420] Anderson, *Colonial Pathologies*, p. 147.
[421] Crozier, 'What Was Tropical'.

conceived notions and ideas.[422] The most common symptom was pain that on examination could not be linked to any organic cause. Jeanne B.'s pains had prompted her to ask Albert Cook in 1930 'whether she had appendicitis', yet upon examination this and a range of other physical explanations for her pain were ruled out.[423] Edith D. had been suffering from headaches, giddiness, and nausea for some time, and in the week before her admission had also developed shooting pains in her leg. Her examination involved checks on her cardiovascular system, throat, abdomen, teeth, and urine, which turned up nothing abnormal except for excessive urination.[424] In a similar case, Dorothy F. was also put through a thorough physical examination after she stated that she had been troubled by irregular pains ever since she had 'sat on the luggage carrier of a motorcycle' in England two years before.[425]

In the case notes, the search for physical signs are interspersed with notes on the patient's place of residence and time spent in East Africa, suggesting that climate was considered to play a role in predisposing an individual to the condition. Guy R. had suffered from 'restlessness, shakiness + severe pain in the back of the neck' for three weeks when he arrived at Mengo Hospital. He had a long history of travel across East Africa, which by the time of his admission in 1933 stretched over 10 years. Guy had recently spent time in the sun, and while he reassured his doctor that he had worn a sun helmet, it was noted that the pain 'may have been due to the effect of exposure to the sun'.[426] In another case in 1935, the doctors at Mengo Hospital felt

[422] Sicherman, 'The Uses of a Diagnosis', pp. 40-1.
[423] ACMM (Mengo Hospital Case Notes), 1930, Volume 1 (Annie-Walker), Case No. 139.
[424] Ibid., 1927, Volume 1A (Annie-Walker), Case No. 55.
[425] Ibid., 1921, Volume 1A (Annie-Walker), Case No. 157.
[426] Ibid., 1932-3, Volume 6 (Annie-Walker), Case No. 26.

it noteworthy that Sarah O., who had experienced weight loss and periodic pain for over a year, was always away on safari.[427]

As highlighted earlier in this chapter, Crozier has argued that Colonial Medical Officers in British East Africa 'noticeably lagged behind the changing psychiatric fashions of the 1920s and 1930s, frequently still publishing on acclimatization and theories of neurasthenic breakdown relating to place', something she in part attributes to a preference for older doctors.[428] The doctors at Mengo Hospital, too, continued to link climate with the mental and physical states of their patients until well into the 1930s. Crozier's argument, however, draws too fine a line between the climatic and psychological aspects of the condition—the divide between neurological and psychological interpretations of illness was rarely clear-cut, and general practitioners in Britain and America continued to use neurasthenia as a convenient label for mental and physical breakdown. As Mathew Thomson has noted for Britain:

> With its amorphous character, neurasthenia proved adaptable to the changing climate of opinion. The idea that mental and somatic factors both played a part had after all always been implicitly if not explicitly accepted. Moreover, acknowledging that mental worry might precipitate bodily ills left such ills no less real for this; and it left the possibility that the same was true in reverse.[429]

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[427] Ibid., 1935, Volume 1B (Annie-Walker), Case No. 4.
[428] Crozier, 'What Was Tropical', p. 537.
[429] Mathew Thomson, 'Neurasthenia in Britain: An Overview', in Marijke Gijswijt-Hofstra and Roy Porter (eds), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam & New York: Editions Rodopi B. V., 2001), p. 83. On the divide between neurological and psychological interpretations of neurasthenia, see especially Campbell, 'The Making of 'American''; Tom Lutz, 'Varieties of Medical Experience: Doctors and Patients, Psyche and Soma in America', in Marijke Gijswijt-Hofstra and Roy Porter (eds), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam & New York: Editions Rodopi B. V., 2001).

At Mengo Hospital, while the emphasis on the soma and climate persisted throughout the period, it was rarely divorced from the more psychological aspects of the condition, particularly from the 1920s. Vera H., a female patient diagnosed with neurasthenia in 1932 had been in Uganda for two years when she presented herself at Mengo Hospital. As with the other patients, Vera was examined for physical signs of illness, and her length of time spent in Uganda noted. At the same time, however, her problem was presented as in part psychological, in so far as her doctor, Robert Stones, noted that she '[d]oes not like [the] country [and] wishes to return to England'.[430] For E. L. too, it is unclear whether the doctor placed more weight on his travels around East Africa without quinine or an '[e]motional shock', which had 'brought back trouble with [right] ear…pain, giddiness, nausea and nervousness'.[431]

More problematic is the case of Marie G., a Belgian Protestant missionary who was in certain respects the archetypal tropical neurasthenia patient: she had been 'rescued' from her station in Rwanda by CMS missionaries, having been alone at the station for five years.[432] Her isolation may have played a key role in her diagnosis, and that she was sent back to Belgium highlights a related assumption about tropical neurasthenia—that the symptoms would disappear if the patient changed their location or returned to Europe.[433]

The variety found in the case notes suggests that in practice, understandings of neurasthenia cannot be divided easily into the climatic and the psychological. Not only was this distinction frequently blurred in the medical literature, but the doctors also brought their own understandings and priorities to the examination room.

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[430] ACMM (Mengo Hospital Case Notes), 1932, Volume 1A (Annie-Walker, Case No. 64.
[431] Ibid., 1939, Volume 1A (Annie-Walker), Case No. 6.
[432] Ibid., 1936-8, Volume 10 (Annie-Walker), Case No. 73. An interesting debate on whether missionaries were susceptible to neurasthenia can be found in Stannus, 'Tropical Neurasthenia'.
[433] Anderson, *Colonial Pathologies*, p. 144.

Judgements about the 'nerves' and character of missionaries, for example, played an important role in missionary recruitment and in the annual medical examinations of missionaries in the field, something frequently conducted by the doctors at Mengo Hospital.[434] Moreover, in a medical certificate produced for the Old East African Trading Company in 1929, Cook described Richard M. as suffering from 'morbid depression, kleptomania, insomnia and a dread of impending mental trouble'. These symptoms, Cook stated, suggested that a diagnosis of neurasthenia was suitable, and as such Richard was 'in my opinion quite unfit for continued residence in the Tropics'.[435]

Such cases appear to have been exceptional, however. There are no references in the case notes to behaviour that might have been in need of 'policing', such as the tendency to drink, steal, or engage in inappropriate relationships.[436] Instead, the patients nearly always arrived at the hospital because they themselves felt they were ill, and were discharged back to their homes or workplaces after brief admission periods. It is therefore more appropriate to consider the ways in which the doctors at Mengo Hospital were responding to the reality of the examination room than to see neurasthenia solely as an intellectual construct, serving a socio-political role. Working under the pressure of needing to complete as many consultations as possible and with limited options for referral, these doctors also had to contend with the expectations and assumptions of their patients.

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[434] See Georgina Endfield, 'Through Marsh and Mountain: Tropical Acclimatization, Health and Disease and the CMS Mission to Uganda, 1875–1920', *Journal of Eastern African Studies* 4(1) (2010), pp. 61-90. The language of 'nerves' was eventually replaced in missionary recruitment with the language of the 'neuroses'. The importance of 'mental balance' was stressed in the *Report of C.M.S. Commission (1945) on the Health of Missionaries* (London: Church Missionary Society, 1946).
[435] ACMM (Mengo Hospital Correspondence), 'Medical certificate', 11 March 1929, enclosed in a letter from Stephen Schnapp, The Old East African Trading Company, Kampala, 12 March 1929.
[436] Sicherman has argued that by diagnosing neurasthenia physicians 'were interpreting behavioral symptoms that some found morally reprehensible (an inability to work for no apparent cause, compulsive or phobic behavior, bizarre thoughts) as signs of illness rather than wilfulness'. Sicherman, 'The Uses of a Diagnosis', p. 53.

One such assumption was that Mengo Hospital was among the best for Europeans in East Africa. This was partly due to the facilities available at the European-only Annie Walker Ward, but also due to the reputation of Mengo Hospital's founder, Albert Cook.[437] Hundreds of letters from Europeans seeking advice, diagnoses, and medication survive in the archives of Mengo Hospital, now located in the Albert Cook Library at Mulago Hospital. They bear testament both to Cook's notoriety and to the personal suffering of those seeking relief from mental and physical dysfunction. In one letter from a European living in Kisumu, Kenya, the author complained of a wide range of symptoms, including 'ringing in the ear', 'lassitude or lack of energy', 'loss of appetite', 'inclination for vomiting' and 'night emissions'. Drawing attention to his long search for a diagnosis that he could accept, the author reminded Cook how:

> I have undergone the treatment of four physicians each of them has treated my case differently, i.e. one said I was suffering from hearth-weakness [sic.] + nervousness, the other dyspepsia, the third chest disease, the fourth piles, etc, and this has been done on me since October last, now, as a desperate man, I have come in search of you, the only famous + celebrated Doctor in the country for first resource and decision, and to whom I have thought to be the only man who will put me right...[438]

The case notes indicate how some patients had endured years of mental and physical problems prior to their admission to Mengo Hospital. Florence C. had suffered from pain in her pelvis, back, and upper thighs for five years by the time she presented herself at Mengo Hospital in 1912. She had already consulted a number of

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[437] Such was the popularity of Albert Cook that on his retirement in 1934 mission authorities feared that his withdrawal into private practice would necessitate the closure of Mengo Hospital altogether. UoBSC, CMS G3 A7/O 1934 (Uganda Mission Outgoing Correspondence), f. 40, letter from Bishop of Uganda to Rev H.D. Hooper, London, 13 March 1934.

[438] ACMM (Mengo Hospital Correspondence), Letter from J.P.M. to Albert Cook, 17 April 1914.

other doctors, including Dr. Johnstone of Penrith, who had 'removed a polypus [and] operated for haemorrhoids', and Dr. Playfair, who 'per contra said it was "all imagination"', and had prescribed his famous 'rest-cure'.[439] Similarly, Alice S. had a 'neurasthenic history' of 'vague pains' and 'fears' that stretched back years. On arrival at Mengo Hospital in 1935 she told the admitting doctor, A.T. Schofield, that she had already seen other physicians and been subject to numerous X-rays, all supposedly to little effect.[440] Whether or not the recounting of these histories of suffering played a role in the diagnosis—they probably did—they show something of the experience of these patients in their search for relief. They were not only searching for treatments that would relieve their suffering, but a diagnosis that would validate their complaints.[441]

As in Britain and elsewhere in the colonies, neurasthenia provided an explanation for a vast range of ailments that 'successfully satisfied the needs of doctors and patients within the medical marketplace'.[442] At Mengo Hospital, the idea that 'nerves' could cause mental and physical breakdown would have been familiar to most of the European patients, particularly as popular literature and advice on 'nerves' and environment continued to circulate until well into the 1930s.[443] An advertisement for Phyllosan Tablets in the *Uganda Herald* in 1935, declared that:

> Climatic peculiarities in Tropical Africa slow up all vital processes and bodily functions readily succumb to a sense of exhaustion

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[439] ACMM (Mengo Hospital Case Notes), 1912, Volume 5, Case No. 1447. On the history of the 'rest cure' see especially Hilary Marland, "Uterine Mischief': W.S. Playfair and His Neurasthenic Patients', in Marijke Gijswijt-Hofstra and Roy Porter (eds), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam & New York: Editions Rodopi B. V., 2011).
[440] ACMM (Mengo Hospital Case Notes), 1935, Volume 1B (Annie-Walker), Case No. 59.
[441] On the importance of a diagnosis, see especially F.G. Gosling and Joyce M. Ray, 'The Right to Be Sick: American Physicians and Nervous Patients, 1885-1910', *Journal of Social History* 20(2) (1986), pp. 251-67; Sicherman, 'The Uses of a Diagnosis'.
[442] Thomson, 'Neurasthenia in Britain', p. 79.
[443] Lutz, 'Varieties of Medical Experience', p. 59; Thomson, 'Neurasthenia in Britain', p. 83.

> accentuated at times by undue strain or mental and physical fatigue. The tendency towards premature ageing and similar complications becomes rapid, which unless arrested in its early stages sets up anaemia, heart weakness and nervous debility.[444]

As late as 1946, the Health Instructions for Missionaries Overseas similarly stressed the dangers of climate, if alongside more psychological strains. It reminded readers how '[a]lteration of environment and strains in one's work and personal relationships are very frequent causes of nervous exhaustion. More missionaries are invalided under this heading than from more definite diseases'.[445]

At Mengo Hospital, not only did the patients recount years of nervous troubles, but drew on this language of nerves to describe how they were feeling. Mrs H. told her admitting doctor that she had been 'feeling run down [and] 'nervy' recently', although it is likely that her longer history of being 'mentally afflicted after [the] birth of [her] child in 1926' was also important.[446] Likewise, W. A., weakened by influenza and fever, complained of feeling 'all-to-pieces [and] physically run down'.[447] In the context of the hospital examination room, it is therefore unsurprising that the doctors at Mengo Hospital held on to a diagnosis that would be accepted and understood by their patients. Even if they were aware that neurasthenia had fallen out of fashion as a diagnosis, it could still serve a function.

African patients

While the Europeans may have expected 'nerves' to be the cause of their complaints, this was not necessarily the case for the African patients. Remarks on the

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[444] 'Nature's Remedy', *Uganda Herald,* 13 March 1935, p. 11.
[445] UoBSC, CMS M/M 9 (Compilation Volume of Health Instructions for Missionaries), *Health Instructions for Missionaries Overseas* (London, 1946), p. 3.
[446] ACMM (Mengo Hospital Case Notes), 1928, Volume 1A (Annie-Walker), Case No. 62.
[447] Ibid., 1920, Volume 2 (Annie-Walker), Case No. 164.

mental state of the patient were always written from the perspective of the admitting doctor—a patient would 'look nervous' or be 'of a nervous disposition'. While this could just indicate that the language of 'nerves' was one shared by Europeans alone, it could also demonstrate some of the cultural difficulties faced by both doctor and patient in the examination room. Indeed, as Orley noted in his study of mental illness among the Baganda: 'Patients often present a series of complaints about aches and pains which in many cases reflects the difficulty that the patient has in expressing himself (and possibly his desire to express his illness in what he thinks are terms acceptable to western medicine)'.[448] G. Allen German similarly highlighted the preference for the language of the body in his study of depression in 1972. He noted that it was only those patients who had been most exposed to western culture through the school system who 'used terms like 'depression' spontaneously', and who 'admitted to being sad or unhappy when questioned directly'.[449]

Certainly, while the European patients talked of feeling tired, overworked, or run down, the African patients drew on physical language alone to complain of vague pains, insomnia, heart palpitations and giddiness. Yaeri N. had suffered from a number of pains before she presented herself at Mengo Hospital in 1918. The admitting doctor noted that '[f]or sometime [she] has had considerable vaginal discharge [and] burning pain on micturition [urination]', as well as pain in her abdomen, head, and temples.[450] Yet on physical examination, no organic cause could be found for her complaints. Likewise, the doctor could find nothing physically wrong with Mikaeri L., who in 1908 was reported to have been 'taken ill 10 days ago with dryness of throat [being] unable to swallow his saliva. 2 days later he suffered

[448] Orley, *Culture and Mental Illness*, p. 50.
[449] G. Allen German, 'Aspects of Clinical Psychiatry in Sub-Saharan Africa', *British Journal of Psychiatry* 121 (1972), pp. 461-79 at p. 470.
[450] ACMM (Mengo Hospital Case Notes), 1918, Volume 2, Case No. 683.

from headache and giddiness [and] fever pains all over [his] body. He has had these symptoms everyday until now'.[451]

The case notes demonstrate that neurasthenia was a condition that the doctors at Mengo Hospital felt they could recognise and treat in their African patients. Moreover, the symptoms presented and the emphasis on the search for somatic signs of illness highlights the similarities rather than the differences in the examination of African and European patients. Where there was a difference was in the relative occurrence of the condition before the 1930s: while neurasthenia was the most common diagnosis of mental ill-health in Europeans during the 1910s and 1920s, the African patients were far more likely to be diagnosed with hysteria. These cases of hysteria were usually clearly distinguished from neurasthenia—the doctors emphasised the presence of 'hysterical outbursts', the feeling of a ball in the throat, spontaneous movements, jerks and fits. A few cases, however, were remarkably similar. Mai N. had been suffering from pain in her abdomen for two weeks when she presented herself at Mengo Hospital in 1908. A physical examination conducted by Cook found that her abdomen was slightly distended, but otherwise no abnormal signs of illness could be found.[452]

There was no gendered aspect to either the hysteria or neurasthenia diagnosis at Mengo Hospital before the 1930s—both diagnoses were spread evenly between the male and female patients. Yet comments on the patient's occupation, education and schooling suggest that the doctors might have brought their own expectations to the examination room. The first recorded case of neurasthenia was in Daudi M., a male Muganda chief who arrived at the hospital in 1906 and complained that he had been

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[451] Ibid., 1908, Volume 1, Case No. 173.
[452] Ibid., 1908, Volume 5, Case No. 759.

feeling unwell for many months. According to Cook, Daudi looked depressed, and following a physical examination, Cook noted that he was not anaemic, his tongue was 'slightly coated', and he contracted 'his abdominal muscles in a curious way'. The only clue as to why Daudi was diagnosed with neurasthenia comes in his position as a chief. Staying in the chief's ward would have elicited higher patient fees, perhaps making Cook more amenable to his admission.[453] But it could also have indicated the ways in which neurasthenia was associated with class. Just as neurasthenia was said to be an affliction of the 'superior' races, it was also one that was believed to affect those of higher mental ability within a particular race.[454] As such, the diagnosis of neurasthenia in Daudi could be seen as a recognition that Cook felt his position as a chief set him apart from other Africans at the hospital.

There are no clues as to why the other eleven cases were diagnosed with neurasthenia before the 1930s, however. In these cases the doctors made only brief notes on the symptoms presented by the patients and the tests performed during the examinations. If there was any aspect of the diagnosis that was based on class, race, or gender, it was not made explicit in the case notes. From 1931, however, the doctors increasingly made notes on the mental ability and educational progress of the male neurasthenic patients. These comments did not dominate the case notes, and at times it is difficult to distinguish between notes taken for general information and notes that the doctors felt indicated a form of pathology, but their presence is significant as indicators of the preconceptions held by the doctors at Mengo Hospital during that time.

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[453] UoBSC, CMS M/F 1 (Medical Mission Accounts).
[454] Havelock Charles, 'Neurasthenia', p. 3. On mental ability and race, see especially Stephen Jay Gould, *The Mismeasure of Man* (New York: Norton, 1981); Stepan, *The Idea of Race in Science*.

Five of the fifteen male patients between 1931 and 1940 were said to be attending school at the time of their admission.[455] Erokano D. had been ill with fever for three weeks before his symptoms worsened to the extent that he was taken to Mengo Hospital. The day before his admission he had 'started to vomit…did not know what he was doing', 'talked nonsense', and 'acted strangely'. His doctor listed previous illnesses, including fever and cough, but also pointed to the strains of school life. He had reportedly been 'working hard at school', and while '[r]ather dull mentally at present', looked 'intelligent [and] answers questions'. Significantly, he was ordered to 'rest at home' and '[n]ot to go to school' for at least two weeks, when he should return to the hospital for further inspection.[456] In a similar case, Charles N. was sixteen years old when he was admitted to Mengo Hospital. He had come from King's College Budo, a CMS school that was widely noted as Uganda's top training ground for future leaders.[457] Charles had suffered from a fit and had vomited that morning, having been unwell for a long time. Neurasthenia was not the first thing the admitting doctor, Schofield, had considered. Likely because of the fit, Schofield noted down that there was no previous history of epilepsy in the patient or in his family, and after a physical examination, '[n]o evidence of epilepsy' was seen. Further examination found nothing abnormal in his stool, blood, or urine, and after a

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[455] There are no comments on the education or schooling of the female patients during the 1930s. While this might have reflected ideas of gender difference, it more likely reflects unequal opportunities for female education at that time. On the education of women in Uganda, see Grace Bantebya Kyomuhendo and Marjorie Keniston McIntosh, *Women, Work & Domestic Virtue in Uganda 1900-2003* (Oxford: James Currey, 2006); A.J. Maleche, 'Sociological and Psychological Factors Favouring or Hindering the Education of African Women in Uganda', unpublished conference paper presented at the East African Institute of Social Research Conference, Kampala, June 1961; Aisha K. Nakawooya, 'A History of Muslim Women Education in Uganda: A Case Study Based on Kampala District 1900-1995' (unpublished MA dissertation, Makerere University, 2003).
[456] ACMM (Mengo Hospital Case Notes), 1937, Volume 7, Case No. 1588.
[457] On the role of King's College Budo in the development of political movements in Uganda, see especially J.C. Ssekamwa, *History and Development of Education in Uganda* (Kampala: Fountain Publishers, 2000); Summers, "Subterranean Evil' and 'Tumultuous Riot' in Buganda'; Carol Summers, 'Young Buganda and Old Boys: Youth, Generational Transition, and Ideas of Leadership in Buganda, 1920-1949', *Africa Today* 51(3) (2005), pp. 109-28.

week in the hospital he was sent for an examination with the head doctor, R.Y. Stones, before returning to Budo.[458] A student at Mukono College, a religious training school, had also been sent to Mengo Hospital after he had suffered from 'pain in [his] back' for two weeks. Having been examined at a government dispensary and at Mengo Hospital on a previous visit, he was no better. The admitting doctor, Stones, noted that he still complained of 'increasing pain in back [and] central renal region' and that 'his urine has been red for 1 month'. Following his admission, the patient continued to complain of 'pain in chest', for which none of the doctors could find any organic cause.[459]

These references to education and school life fit neatly with the ethnopsychiatric literature on detribalisation and mental breakdown that appeared elsewhere in Africa during the 1930s.[460] As we saw in Chapter I, missionary and government doctors in Uganda were well aware of these theories, both from their reading of the *EAMJ* and from their engagement with a wider intellectual community in East Africa. As such, the association between education and neurasthenia in a small number of the African patients at Mengo Hospital suggests that the diagnosis could have been imbued with ideas about racial difference. Indeed, the mental and physical breakdown of Africans who were unable to cope with a 'civilised' environment contrasts with those Europeans who were deemed to be physically and psychologically unprepared for the 'tropical' environment.

While the European patients may have understood some of the social and medical implications of neurasthenia, it is unclear how the African patients viewed the diagnosis. Certainly, if the doctors explained that neurasthenia would not 'spoil

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[458] ACMM (Mengo Hospital Case Notes), 1937, Volume 5, Case No. 1036.
[459] Ibid., 1939, Volume 6, Case No. 1580a.
[460] On this literature, see especially McCulloch, *Colonial Psychiatry*; Vaughan, *Curing Their Ills*, ch. 5.

the brain' it would have gone some way towards relieving the anxiety of the Baganda patients.[461] Conditions like neurasthenia had no direct equivalents in Luganda, the language of the dominant patient group at Mengo Hospital. Only *akawango* came close to the signs and symptoms of neurasthenia, being a 'persistent headache on top of the head, usually lasting for months or years' that due to its association with the brain frequently brought on depression and anxiety.[462]

Without the social uses of the diagnosis that were so important for validating the physical and mental complaints of many of the European patients, it is difficult to ascertain what purpose, if any, the diagnosis served for the African patients. Certainly, it would be wrong to dismiss their complaints, just as it would be to suggest that these Africans were failing to cope with 'civilisation'. As such, these cases need to be seen as attempts of general medical practitioners to make sense of a wide range of vague and unidentifiable symptoms. As with the European patients, these attempts were not disconnected from ideas about race, gender, and class, but were above all shaped by the needs and expectations of the examination room.

Conclusion

Barbara Sicherman has argued that neurasthenia 'emphasized what physicians could do for their patients rather than their impotence'.[463] In the context of a mission hospital, where options for specialist treatment were limited and the doctors were keen to influence minds and souls, this assessment certainly fits. Regardless of race, gender, or class, the neurasthenic patients all received similar treatments, including bed rest, nutritious food, tonics, bromides, purgatives, and blisters. These therapies

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[461] Orley, *Culture and Mental Illness*, pp. 52-3.
[462] Ibid., p. 11.
[463] Sicherman, 'The Uses of a Diagnosis', p.39.

had been popular in the treatment of 'nervousness' in Britain since the nineteenth century, and remained so at Mengo Hospital until the 1940s.[464] While all patients at Mengo Hospital had to attend religious services on the wards, there is no evidence in the case notes to suggest that spiritual care made up a formal part of treatment. What is clear is that the doctors at Mengo Hospital had reason to believe they could treat neurasthenia successfully. Of the ninety-eight cases of neurasthenia diagnosed in Europeans and Africans between 1906 and 1950, twenty-four were discharged 'cured', fifty-one 'improved', and five 'relieved'.

This chapter has been concerned with diagnoses of neurasthenia at Mengo Hospital. It started by looking at race in the medical literature, demonstrating that while the majority of articles focused on the health of white colonisers alone, a few also considered where and when 'natives' might succumb to the condition. As the relationship between neurasthenia and race became a subject in its own right in the 1920s, discussions of neurasthenia in African contexts increasingly drew on assumptions about 'the African mind'. While the doctors at Mengo Hospital were similarly influenced by ideas about race and 'civilisation' from the 1930s, a close reading of the case notes suggests that through their search for somatic signs the mission doctors saw more similarities between their patients than they did differences.

Sadowsky has asserted that unlike government officials, CMS missionaries in southwest Nigeria did not 'emphasize any major differences between European and African conceptions of madness….in different historical circumstances and with different interests in mind, different historical actors can emphasize the degree of

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[464] On the use of drugs in asylums and psychiatry in Europe, Andrews *et al.*, *History of Bethlem*, p. 522; Berrios and Porter (eds), *A History of Clinical Psychiatry*; Healy, *The Creation of Psychopharmacology*; Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum'.

relativity differently'.[465] The research presented in this chapter certainly appears to extend this insight to missionaries in Uganda. It is my contention, however, that the similarities seen in the case notes at Mengo Hospital can be explained by focusing on the setting of the hospital examination room, rather than the position of these doctors as missionaries. The suffering of the patients was both a clinical reality and a means for general medical practitioners to rationalise the symptoms they were presented with. As Sicherman has reminded us, '[i]n what is frequently a highly charged atmosphere, the physician's primary task is to identify 'it,' to transform the diffuse symptoms of his patient into a condition that can be rationally understood and treated'.[466]

This chapter has demonstrated that neurasthenia was more than an intellectual construct. It was a condition that was as complicated and problematic when found in the hospital examination room as it was when it was debated in the medical literature. As a case study, the chapter has also pointed to some of the cultural difficulties faced by both doctor and patient in the examination room, notably in the African patient's lack of the shared language of 'nerves'. It is included within this thesis because as such conditions became more visible for physicians in Uganda concerns were raised about the cultural gulf between medical practitioners and their patients. These concerns would, in turn, prompt significant developments in mental health care in Uganda, the implications of which will be examined in the final three chapters.

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[465] Sadowsky, *Imperial Bedlam*, p. 21.
[466] Sicherman, 'The Uses of a Diagnosis', p. 37.

Chapter IV:

Establishing the 'Golden Age' of Psychiatry: Makerere Medical School, 1955-1972

Addressing the Uganda branch of the BMA in 1955, H.C. Trowell, Senior Specialist at Mulago Hospital, described some of the difficulties encountered when treating minor psychological disease. With his African patients, Trowell noted:

> I seldom feel really at home and I feel sorry for my students that they see this travesty of a physician, one who cannot really talk fluently with his patients and even then has almost no understanding of the medley of motives, hopes, fears, reserves and evasions which are encountered in our African patients. I often wish my students could see me practising among my own people, among whom I detect more quickly the anxieties and background of every case.[467]

These linguistic and cultural barriers made the training of African medical practitioners in psychiatric and psychological medicine both challenging and necessary; if western medicine was to be successful, doctors needed to be capable of understanding their patients. In Trowell's opinion, Africans possessed natural cultural 'insight' into their patients' fears and anxieties that could be harnessed through medical training, just as doctors in Europe might come to 'detect' these signs in their own patients.

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[467] Trowell, 'Training Medical Practitioners', p. 257.

During the mid-1950s, long-held concerns over the effects of 'westernisation' and 'detribalisation' on the mental stability of Africans merged with plans for the expansion of medical training at Makerere Medical School, prompting calls to develop psychiatry into a subject that would adequately prepare all African doctors to respond to mental ill-health. While these calls came from across East and Central Africa, it was Uganda, with its long history of training Africans, who took up the challenge. The expatriates who joined the Department of Psychiatry from 1966, together with their African colleagues, attempted to bring the question of mental health care to the forefront of general medical practice, and initiated a 'golden age' for psychiatry in Uganda.

The Uganda Government, by contrast, focused their attention on maintaining a small group of up-country psychiatric units, the underdevelopment of which was indicative of the low-status accorded to psychiatry within the Ministry of Health. As this chapter argues, the decision to establish a Department of Psychiatry at Makerere Medical School came as a relief to the Uganda Government; plagued by financial troubles and a lack of staff, the creation of the new department meant that the development of mental health care was no longer their sole responsibility. Not only did it bolster the staff available for consultancy work, but it created a situation in which care for the mentally ill was shared by university and government psychiatrists. In a special arrangement between the Uganda Government and Makerere University College, all government psychiatrists were honorary lecturers at Makerere Medical School, and all psychiatrists at Makerere Medical School were honorary government consultants. In so doing, the new Department of Psychiatry formalised a role that physicians at Makerere Medical School had taken on for years.

While the first three chapters of this thesis have focused primarily on the colonial period, this chapter considers the years immediately leading up to and following Independence from the British in 1962. By using this time period, the chapter emphasises the long-term importance of the relationship between psychiatry and Makerere Medical School that had grown from the siting of Mulago Mental Hospital on Mulago hill in 1935; when medical practitioners at Makerere Medical School made plans for expansion in the mid-1950s, they did not forget psychiatry.[468] Historiographically, the chapter also moves beyond a tendency to treat Independence as a historical endpoint, instead examining the ways psychiatry continued to develop into the post-colonial period.

The chapter starts by looking at the reasons why the training of Africans in psychiatry came to be regarded as a necessary project for the future. In so doing, it elaborates on ideas about detribalisation and mental instability already examined in Chapters I and III. The chapter then considers the education and status of Uganda's first psychiatrists, Benjamin H. Kagwa and Stephen Bosa, both trained in western institutions, and working in Mulago Mental and Butabika Hospitals in the years leading up to the opening of the Department of Psychiatry. The subsequent sections examine the significance of the new relationship between Makerere University College and the Uganda Government, as well as the new focus on psychiatric teaching and research. In so doing, the chapter highlights the importance of psychiatry at Makerere Medical School to institutional and intellectual psychiatry not just in Uganda, but to a small but growing community of psychiatrists across Africa. The speed at which these changes occurred, as this chapter brings out, was due to the energy and zeal of the individual psychiatrists involved.

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[468] This was examined in Chapter I.

Psychiatry by Africans for Africans

As attention turned to the effects of 'westernisation' during the 1930s and 1940s, the need for knowledge on what was 'normal' and 'abnormal' in the African was increasingly noted. 'We need extensive research on African mental health not in the future but now', claimed Donald Mackay, a mission doctor in Northern Rhodesia: 'We need mental clinics in every township. We need men trained in psychiatry and steeped in African background to stem the tide of threatening maladjustment. We hear much of development—but where is there development so pressing as this'.[469] Mackay urged European doctors already resident in Africa to pursue these topics; for him, Europeans were best placed to understand the need for such research. Other physicians, by contrast, felt that Africans would be better placed to understand what was 'normal'. Responding to Mackay in an editorial in the *East African Medical Journal* (*EAMJ*) in 1948, J.A. Carman, based in Kenya, noted that because of the complex variations in African mentality, 'the right type of African doctor is the only person who can hope to approach the subject in the proper way'.[470] What constituted the 'right type' of African doctor had long been debated in East Africa, and particularly in Kenya, where Europeans feared that African medical assistants would 'get too big for their boots'.[471] While the situation was marginally better in Uganda, by 1949 African MOs still had to contend with considerable restrictions in their pay and professional status, and were expected to remain subservient to European MOs.[472]

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[469] 'D M Mackay', *British Medical Journal,* 12 September 1981, p. 738; Donald Mackay, 'A Background for African Psychiatry', *East African Medical Journal* 25(1) (1948), pp. 2-4 at p. 4.
[470] 'Editorial', *East African Medical Journal* XXV(1) (1948), p. 1. J.A. Carman had edited the *EAMJ* since 1946. 'Resignation of the Editor', *East African Medical Journal* 23(1) (1946), p. 13.
[471] H.C. Trowell, as cited in Iliffe, *East African Doctors*, pp. 45-6.
[472] Ibid., ch. 5.

From the mid-1950s, these calls for further research were reinforced by the growth of transcultural psychiatry, which emerged as a discipline concerned with the presentation and management of mental illness across different cultures.[473] Transcultural psychiatry held particular appeal for psychiatrists in Africa because it allowed them to distance themselves from their discipline's often overtly racist history—while ethnopsychiatry had been concerned with the psychology and behaviour of non-western peoples, transcultural psychiatry highlighted the ways in which 'the vista of the scientific observer extends beyond the scope of one cultural unit on to others'.[474] Psychiatrists, it was noted, 'must know about the cultural backgrounds of his patients and of the intricacies of detribalization in order to understand the motives, mental content and behaviour of his patients'.[475]

The idea that psychiatry might be best practised by Africans found fertile ground in Uganda where, as noted in Chapter I, the technical training of Africans had long been a priority. As W.H. Kauntze, Director of Medical Services (DMS), noted on the training of sanitation officers in 1937:

> A European can never quite look at matters from the African point of view, however conscientiously he may try to do so. His mind is imbued with ideas of sanitation learnt by experience and embodied in English law less than eighty years ago…It is difficult for him to appreciate the fear of spirits which leads the African to build houses without openings which might admit less desirable things than air or light, or the belief in sorcery which makes him deposit his excreta where it is unlikely to be found by his enemy. Hence the prime essential is to build up an enlightened body of Africans who can be

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[473] Jatinder Bains, 'Race, Culture and Psychiatry: A History of Transcultural Psychiatry', *History of Psychiatry* 16 (2005), pp. 139-54 at p. 139; Raymond Prince, 'Origins and Early Mission of Transcultural Psychiatry: Some Personal Recollections', *World Cultural Psychiatry Research Review* (2006), pp. 6-11; E.D. Wittkower, 'Transcultural Psychiatry', in John G. Howells (ed.), *Modern Perspectives in World Psychiatry* (Edinburgh & London: Oliver & Boyd, 1968).
[474] Jock McCulloch, 'The Empire's New Clothes: Ethnopsychiatry in Colonial Africa', *History of the Human Sciences* 6(2) (1993), pp. 35-52 at p. 35; Wittkower, 'Transcultural Psychiatry', p. 697.
[475] Edward L. Margetts, 'The Future for Psychiatry in East Africa', *East African Medical Journal* 37(6) (1960), pp. 448-56 at p. 453.

> taught to appreciate the scientific reasons lying behind sanitary law, and who will have such an intimate knowledge of the African mind that the cogent arguments which can be brought forward in favour of sanitary ideals can be so framed as to find favour in spite of inherited beliefs.[476]

Kauntze was not interested in engaging with African ideas about health or sanitation. Rather, he emphasised the value of Africans who could be trained to spread western ideas among their own people.

African doctors also claimed that they had special knowledge about their patients that could be advantageous in hospital examination rooms and out-patient clinics. Opening an article on African patients, Eria M. Babumba noted that he 'was brought up among his own people and knows what his fellow Africans are likely to think, their old beliefs and superstitions, and their usual fears'.[477] The Makerere Medical Graduates' Association, too, argued that African physicians, by right of birth, had 'more direct communication with our fellow African than any other people….Patients trust us more'.[478] Of course, what these discussions tended to overlook, usually for political reasons, was the vast cultural, social, and linguistic gap that existed between western-trained African medical practitioners and many of their patients. While between 1952 and 1962 the distribution of graduates from the medical school was more evenly divided between Uganda (66), Kenya (43), Tanganyika (27), Zanzibar (3), Pemba (1), and Nyasaland (1), than it had been during the 1920s and 1930s, when Uganda had predominated, those graduating from Makerere were still drawn 'more than proportionately from the more highly educated

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[476] Uganda Protectorate, *Annual Report of the Medical Department, 1937*, p. 6.
[477] Eria M. Babumba, 'An African Patient', *East African Medical Journal* 31(8) (1954), pp. 373-6 at p. 373.
[478] UMOHA, PH/ASC/46 (Box 29) (Makerere Medical Graduates Association), f. 9, 'A discussion between the Hon'ble the Director of Medical Services and the Makerere Medical Graduates Associations' Delegation', 1950.

minority of the population'.[479] The gulf between these African doctors and their patients, as we shall see in Chapters V and VI, was not easily resolved by more training.

Calls for the development of medical education across all subjects accelerated with the official policy of 'Africanisation' and the subsequent expansion of Makerere Medical School.[480] The Africanisation of the Colonial Medical Service was initiated in Uganda in 1952 through the appointment of a standing committee to oversee training and promotion.[481] By the time the medical course received full recognition by the General Medical Council of the United Kingdom (GMC) in 1957, the development of postgraduate training—both at Makerere Medical School and through a scholarship scheme to the United Kingdom—was underway,[482] and a new state of the art teaching hospital at Mulago, funded primarily by the British Government, was under construction.[483]

Concern over the effects of 'westernisation' did not escape the attention of the physicians at Makerere Medical School as they planned for the future. Indeed, when the question of psychiatry was considered in 1959, they gave three main reasons for the urgency of its development as an academic subject in Uganda: the difficulties experienced in recruiting a psychiatrist to replace G.I. Tewfik at Mulago Mental Hospital, who had resigned in 1958, leaving the school without a lecturer in

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[479] J.E. Goldthorpe, *An African Elite: Makerere College Students 1922-1960* (Nairobi: Oxford University Press / East African Institute of Social Research, 1965), p. 46; F.G. Sembeguya, 'The Growth of an Indigenous Medical Profession', *East African Medical Journal* 41(2) (1964), pp. 39-45 at p. 40.
[480] 'Africanisation' in this context refers to policies aimed at increasing the number of Africans in administrative and professional positions.
[481] Iliffe, *East African Doctors*, p. 118.
[482] UMOHA, PH/ASC/46 (Box 29) (Makerere Medical Graduates Association), f. 83, H.J. Croot, 'Post-Graduate Medical Training in Uganda: The Position as at 30th November, 1957', 5 December 1957.
[483] New Mulago Hospital opened in 1962 at a cost of £2,300,000, three-quarters of which was provided by the British Government. Foster, 'Makerere Medical School', p. 678.

psychiatry; evidence from the Student Health Service at Makerere University College on the social and personal stresses facing students; and a conviction that 'because of language difficulties and cultural attitudes psychiatry among Africans will best be practised by Africans'.[484] In looking for advice, Makerere Medical School turned to the Nuffield Foundation, which had sent out a range of visiting consultants to the medical school since the late 1940s.[485] Their application stressed how Makerere had 'a special responsibility to undertake a study of the psychological implications of higher education in East Africa', and that an understanding of the 'conditions in which [the] postgraduate training of African psychiatrists to work in Africa can be undertaken are needed'.[486] Makerere Medical School's application was successful, and a few months later, D.L. Davies, Dean of the Maudsley Hospital, arrived for an eight-week tour.[487]

Davies suggested the creation of a Department of Psychiatry at Makerere Medical School, with a Professorial Chair, to be organised along English lines. There was little comment on how the curriculum could be made relevant to East Africa, however. Instead, Davies drew on the latest educational theories published in *The Lancet*, reports of the Royal College of Physicians, and recommendations of the GMC. The only indication that the reach of psychiatry in Uganda differed from that in the United Kingdom was Davies' reminder that the selection of doctors for

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[484] TNA, BW 90/190 (Makerere University, Mulago Medical School and Hospital), Faculty of Medicine, Makerere College, 'Application to the Nuffield Foundation for the Services of a Visiting Consultant to Advise the College on Provision for Teaching and Research in Psychiatry and the Training of African Psychiatrists', April 1959, pp. 1-2.
[485] A.W. Williams, 'The Next Generation', *East African Medical Journal* 34(10) (1957), pp. 521-8.
[486] TNA, BW 90/190 (Makerere University), 'Application to the Nuffield Foundation', p. 2.
[487] Ibid.

specialist training and the local recruitment of student mental nurses should be done 'with an eye to the language problem'.[488]

Makerere University College received Davies' report with interest, and in 1960, the Principal formed an internal committee to advise on how Davies' recommendations might be implemented.[489] Despite the enthusiasm of the committee to implement Davies' plans, neither Makerere University College nor the Uganda Government felt they could commit to funding a Department of Psychiatry.[490] Not only was medical expansion in general constrained by finances, but psychiatry remained a low priority in a country where government expenditure was directed towards revenue producing activities and general education.[491] Instead, the committee turned to external funding sources, considering the suitability of joint Makerere-Government applications to a range of international bodies, including the Ford Foundation and the United States International Cooperation Administration (ICA).[492] Funding bodies already supported teaching at Makerere Medical School—UNICEF most recently providing for the Foundation Chair of Paediatrics—but in the early 1960s there was still little international interest in the promotion of psychiatric education in Africa,[493] and it would be a further six years before Makerere University College was able to allocate funds for the department.[494]

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[488] RHO, Mss.Afr.s.1872(153C) Part 1 (A.W. Williams Papers), 'Reports, Memoranda, Offprints, etc.: Makerere Medical School, 1944-68', Item 7, D.L. Davies, 'Report on the Teaching of Psychiatry at Makerere College' (unpublished report, Kampala, December 1959), p. 13.
[489] Ibid., Item 8, 'Report of Principal's Psychiatry Committee', December 1960, p. 3.
[490] Ibid., p. 12.
[491] Iliffe, *East African Doctors*, p. 130.
[492] RHO, Mss.Afr.s.1872(153C) Part 1 (Williams Papers), Item 8, 'Report of Principal's Psychiatry Committee', December 1960, p. 16.
[493] Uganda Protectorate, *Annual Report of the Medical Department, 1958*, p. 79. On the types of funding received by Makerere University College during this time see Peter Williams, *Aid in Uganda - Education* (London: Overseas Development Institute, 1966), pp. 87-91.
[494] The WHO was only just starting to take a more general interest in mental health care in Africa. WHOA, M4/86/12 (B) (International Congresses of the World Federation of Mental Health), Maria Pfister, 'Features and Trends in the Mental Health Work of the World Health Organization',

Uganda's first psychiatrists

Benjamin H. Kagwa

Little known to the doctors at Makerere Medical School in the late 1940s and 1950s, Uganda already had a qualified and experienced indigenous-born psychiatrist. Benjamin Kagwa, son of Paulo Bakunga, a former Mukwenda (county chief of Singo), had left Uganda in 1928, travelling first to France and England, before continuing to America in pursuit of higher education.[495] With financial support from his father and the Buganda Kingdom, Kagwa studied at Lincoln, Columbia, and New York University, where he gained an MD in 1940.[496] As he approached his graduation, however, the colonial government in Uganda informed him that they would not recognise his American qualifications. If he decided to return to Uganda, he would be registered as an African Assistant Medical Officer (AAMO), the highest position an African medical practitioner could hope to achieve in Uganda at the time. Any higher position, it was noted, would undermine efforts to promote Uganda's own diploma in medicine.[497] The absurdity of the situation was highlighted by J.E.W. Flood, Director of Colonial Scholars, in December 1939:

> it occurs to me that the Uganda Government is simply being sticky for stickiness' sake. It is a perfectly lunatic situation that a black gentleman wearing a string of beads and a smile can practise "native medicine" if he likes, but poor Kagwa, who is a highly educated gentleman, would not be allowed to practise even with the M.D. of New York University unless he cares to set up as a "native"

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unpublished conference paper presented at the World Federation for Mental Health, 6th International Congress on Mental Health, La Sorbonne, Paris, 5 September 1961, pp. 5-6.

[495] UNA, C1304 (Benjamin Kagwa); Benjamin H. Kagwa, *A Ugandan: Defiant and Triumphant* (Hicksville, New York: Exposition Press, 1978).

[496] TNA, CO 536/207/11 (Kagwa B - Native Student).

[497] Ibid., f. 4, extract from letter from Dr. Kauntze to Dr. O'Brien, 9 March 1940.

practitioner.[498]

Feeling that he could not return to Uganda for this reason, Kagwa went on to complete a residency in neuropsychiatry at the Homer G. Phillips Hospital, St. Louis, a hospital staffed almost entirely by black doctors.[499] Over the next twenty-five years, Kagwa worked at a range of hospitals in Chicago and New York, engaging fully with the intellectual communities he found there.[500] In 1949, for example, Kagwa presented a paper to the Manhattan Central Medical Society entitled 'The Office Approach to the Neuro-psychiatric Patient by the General Practitioner'.[501] At a time when his colleagues in Uganda were still fighting for recognition of their qualifications and status, Kagwa was establishing a reputation for himself as a psychiatric expert.

Kagwa returned to Uganda in August 1963 on the invitation of the newly independent Ministry of Health, feeling, according to his wife, Winifred Kagwa, a 'moral responsibility' to 'contribute to the development of his homeland'.[502] Kagwa remained in Uganda for two years, working as a Consultant Psychiatrist at Butabika Hospital before returning to the United States. During this time, Kagwa examined the prevalence and types of mental illness in East Africa, as well as the implications of an outbreak of 'mass madness' near Mbale in 1963-4. His work, which will be considered separately in the following chapter, included a series of neuropsychiatric

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[498] Ibid., f. 1, letter from J.E.W. Flood to A.J.R. O'Brien, 27 December 1939, pp. 4-5. The Director of Colonial Scholars was in charge of the welfare and supervision of students from the colonies while they were studying in the United Kingdom and at Dublin. HC Deb 19 February 1947 vol 433 c1165 (Colonial Students, United Kingdom).
[499] TNA, CO 536/207/11 (Kagwa B), f. 5, 'Negro Physician from Central Africa', *St. Louis Post-Dispatch*, 27 August 1940; Kagwa, *A Ugandan*, p. 113.
[500] Kagwa, *A Ugandan*, pp. 114-5.
[501] 'Manhattan Central Medical Society--N.Y.C.', *Journal of the National Medical Association* 41(1) (1949), p. 38.
[502] Kagwa, *A Ugandan*, p. 17. On Kagwa's return see also 'Dr. Kagwa Home - for Ever', *Uganda Argus,* 23 August 1963, p. 3.

tests on Bagisu communities suffering from 'mass hysteria', and highlights the extent of the gulf between the new generation of Ugandan psychiatrists and the patients they attempted to treat.[503]

Stephen Bayo Bosa

The difficulties encountered by Kagwa in his pursuit of a medical education lessened as Makerere College and Uganda's Medical Department became more amenable to sending medical graduates to the United Kingdom from 1945.[504] As Iliffe has argued, study abroad was the goal of the most ambitious of East Africa's doctors of the 1950s, remaining the only way to secure specialist qualifications in medicine.[505] Stephen Bosa was no exception in his desire to further his knowledge and achieve a specialist position within the Colonial Medical Service, and made postgraduate study in the United Kingdom a condition of him continuing to work with the mentally ill. If study abroad was not possible, Bosa stressed, 'he wished to be posted away from the Mental Hospital back into some hospital where he could do general medicine'.[506] That his request was granted indicates the extent to which the Medical Department had come to rely on Bosa to fill a position unwanted by most African doctors. Indeed, while African MOs were not usually given a choice about their location, they were able to leave and go into private practice from 1949, something that led to an exodus from government service during the 1950s.[507]

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[503] Benjamin H. Kagwa, 'Observations on the Prevalence and Types of Mental Diseases in East Africa', *East African Medical Journal* 42(11) (1965), pp. 673-82; Benjamin H. Kagwa, 'The Problem of Mass Hysteria in East Africa', *East African Medical Journal* 41(2) (1964), pp. 560-6.
[504] These discussions can be traced in UNA, C2330 1 (Africanisation of Departmental Staff).
[505] Iliffe, *East African Doctors*, pp. 99-100.
[506] UMOHA, C90/ACR (Bosa), f. 37, letter from E.M. Clark, for Director of Medical Services, to the Specialist Alienist, Mental Hospital, Mulago, 7 July 1955.
[507] Iliffe, *East African Doctors*, p. 100.

In December 1955, Bosa travelled on a government scholarship to the Institute of Psychiatry at the Maudsley Hospital, London, to embark on the postgraduate Conjoint Diploma in Psychological Medicine (DPM). By 1955, Bosa already had extensive experience of all forms of treatment used at Mulago Mental Hospital, including ECT, insulin shock therapy, leucotomy, drug abreaction, and antipsychotic drugs.[508] Having had no information about the course or life in London, however, Bosa reported feeling bewildered on arrival. As D.L. Davies, Dean of the Institute of Psychiatry, noted in 1957:

> When I asked him [Bosa] for his general impressions about the work here he said he had been rather confused at the beginning, but this arose mainly out of the fact that he had to attend first and second year lectures at the same time, instead of in consecutive years, and this in turn arose from the fact that his initial grant of leave was twelve months for what was in fact a two year course. He said that there was no prior information available to him in Uganda about what he might expect here, and this contributed to his bewilderment. He expresses himself, now, however, as very happy with the instruction he has had, and he seems confident about his success in the examination.[509]

Despite working hard, Bosa failed to pass Part I of the examinations. While Bosa's scholarship was later extended to cover the full two years of the course, he was at a disadvantage because it had never been made clear to him that what was required was 'wide reading with relatively superficial knowledge, rather than [a] sound grasp of fundamental principles'.[510]

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[508] UMOHA, C90/ACR (Bosa), f. 36, letter from G. Campbell Young to the Director of Medical Services, Entebbe, 1 July 1955; Uganda Protectorate, *Annual Report of the Medical Department, 1953*, p. 40; Uganda Protectorate, *Annual Report of the Medical Department, 1954*, p. 54.
[509] UMOHA, C90/ACR (Bosa), f. 38, letter from D.L. Davies, Dean, Institute of Psychiatry, to L.A. Mathias, Uganda Students Adviser, London, 28 October 1957.
[510] Ibid., f. 45, letter from D.L. Davies, Dean, Institute of Psychiatry, to L.A. Mathias, Uganda Students Adviser, London, nd., likely January 1958.

On his return to Uganda in January 1958, Bosa again took up his duties at Mulago Mental Hospital and the recently opened Butabika Hospital. He continued to impress his superiors with his skill for psychiatric work, and in 1959 was made Acting Superintendent of Mental Hospitals following Tewfik's resignation. Being an African doctor in Uganda was still not without problems, however, despite increased opportunities for promotion in the run-up to Independence.[511] Indeed, while Bosa appears to have been popular and generally respected by the European staff at the mental hospitals, there were a number of 'more awkward officers' who refused to work beneath him.[512]

Bosa returned to London in November 1959 to retake the DPM, which he was awarded in 1961. Emboldened by his promotion to Consultant Psychiatrist on his return, Bosa started to petition the newly Africanized Ministry of Health directly with suggestions for the development of mental health care, including the introduction of a Registered Mental Nurses course, more psychiatric training for MOs, and the expansion of psychiatric wards at up-country hospitals, something that Ministry of Health officials refused to discuss with him.[513] In their official comments, Bosa was breaking the chain of command by coming to them directly—he was to address all his concerns to T.W. Murray, an Australian expatriate who was Superintendent of Mental Hospitals from 1960-4.[514] Yet these officials also appear to have been genuinely annoyed that Bosa had 'committed his ideas to paper before we made a comparable move on our side'.[515] Jealous of their new power as policymakers, they

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[511] Iliffe, *East African Doctors*, ch. 5.
[512] UMOHA, C90/ACR (Bosa), f. 56, 'Stephen B. Bosa, Annual Confidential Report, 1959'.
[513] Ibid., minute 10, nd., c. 1964; ibid., minute 8, by S.M.O. (T), 17 February 1964.
[514] Ibid., minute 11, PS/CMO to D.C.M.O., 4 June 1964.
[515] Ibid., minute 8, by S.M.O. (T), 17 February 1964.

did not want to be seen to be taking advice from a doctor who was not aware of his position in the hierarchy, even if he was Ugandan.

By 1964, Murray and Bosa shared a huge workload, including clinical work at Butabika Hospital and Mulago Hospital Mental Health Clinic, the teaching of undergraduate medical students at Makerere University College, court work, and the management of up-country psychiatric wards in Soroti and Mbarara. When Murray took his overseas leave in September 1964, he was requested to 'step aside' to make way for Bosa to become Superintendent of Mental Hospitals.[516] On Murray's return, Bosa stayed on as Superintendent, and the division of clinical duties between the two were reversed, with Bosa taking on a greater part of the administration. The relationship between the two remained ill-defined, however. Murray was given a new role as 'Adviser', a title he held until his departure in 1966, but this served only to complicate matters: was he to be an adviser to Bosa, or an independent adviser to the Ministry of Health? As Bosa complained:

> This is a new situation which has not existed here before. One cannot say that Dr. Murray and myself are just reversing the relationship that existed before Dr. Murray went on leave in September 1964. Then I was subordinate to him and could not make direct contact with [the] Ministry of Health except u.f.s. Dr. Murray in his capacity as Medical Superintendent.[517]

When an attempt was made to clarify the relationship again the Ministry of Health remained vague in its response:

> You will see from these letters that you are the substantive Medical Superintendent and that Dr. Murray is a Consultant Psychiatrist. He

[516] Ibid., f. 81, letter from I.S. Kadama to S.B. Bosa, 4 June 1964.
[517] Ibid., f. 91, letter from Stephen Bosa to I.S. Kadama, 27 March 1965.

> will carry on with his normal duties and may advise you if you so wish, he may of course sign correspondence on your behalf but any personal letters written to me by Dr. Murray should be sent u.f.s. yourself, if they cover official matters.[518]

It was only with the resignation of Murray in April 1966 that the ambiguity in the hierarchy at Butabika Hospital was resolved. By that point, however, the Uganda Government had already demonstrated that it was no more willing to listen to Bosa's petitions for the improvement of psychiatric services than it had been to Murray or any previous psychiatrist. The neglect of psychiatry by the Ministry of Health prompted a clearly frustrated Bosa to protest in October 1965 that:

> The work-output which is being demanded from the small number of doctors is ridiculously fantastic. I have often put in a warning that there is such a thing as "demanding too much out of too few for too long". The Ministry have entirely refused to awaken to the modern concept that Psychiatry is medicine; - a type of medicine that is difficult, exacting and very time-consuming. They have refused to appreciate that Butabika Hospital is practically the only and total psychiatric service for the whole of Uganda (you can more or less discount the ridiculous so-called psychiatric units in the Eastern and Western Regions; I always regard them as an insult to psychiatry), and that as such, the medical team at Butabika has to put in a terrific amount of hard work to keep pace with the very high admission rate in the already overcrowded Wards. Can any doctor carry on at this rate indefinitely? No Sir. In the long run the efficiency must drop, and that may be followed by disasterous [sic.] consequences. THIS HAS STARTED TO HAPPEN HERE.[519]

Just because an African psychiatrist was in charge of mental health services in Uganda, it did not mean that the financial support required to develop psychiatry was more forthcoming. Exhausted by the administrative workload, Bosa resigned as

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[518] Ibid., f. 92, letter from I.S. Kadama to S. Bosa, 12 April 1965.
[519] Ibid., f. 94, letter from Stephen Bosa to the Permanent Secretary / Chief Medical Officer, Ministry of Health, 16 October 1965.

Superintendent at the end of 1965, but continued to work as a Consultant Psychiatrist at Mulago and Butabika. Instead, J. Bulwanyi, a non-specialist Senior Medical Officer and Superintendent of Fort Portal Hospital, was chosen as the new Superintendent of Mental Hospitals, allowing Bosa to commit himself more fully to his clinical duties.[520]

In continuing to see psychiatry as a low priority, the newly independent government differed little from those elsewhere in sub-Saharan Africa. In Kenya, for example, while six satellite psychiatric units had been created by the mid-1960s, they were staffed primarily by non-specialists and, as the 400-bed unit at Gilgil for chronic male patients demonstrates, were focused more on confinement than rehabilitation.[521] Moreover, in a comment that could be extended to most of sub-Saharan Africa, Richard Keller has pointed out that in the Maghreb, '[d]espite the fading appeal of large institutions as therapeutic tools in the industrialized world…they represented the only real resource for managing mental illness for the Maghreb's emerging nations. Amid political turmoil and precarious economic circumstances, experiments with community psychiatric clinics represented a low priority for post-colonial administrators'.[522]

In Uganda, the indifference of the government towards psychiatry was reinforced by the realisation that Makerere University College were allocating funds for a Department of Psychiatry. 'We are lucky', it was noted in 1964, that 'Makerere has now decided to create a Chair of Psychiatry…[as]…the whole question of

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[520] UMOHA, GCT.8 (Ministers' Tours (Excluding H.E. The President)), f. 66, 'Medical and Health Services in Ankole and Toro', 17 September 1965, Schedule II.
[521] Beuschel, 'Shutting Africans Away', pp. 273-4.
[522] Keller, *Colonial Madness*, p. 196.

psychiatry will be adequately handled'.[523] Indeed, it came as a relief to the Uganda Government when Makerere Medical School appointed G. Allen German to the position. German, together with his expatriate and Ugandan colleagues, immediately took responsibility for mental health care services in Uganda.

The Department of Psychiatry, 1966-72

The Department of Psychiatry at Makerere Medical School opened in March 1966 with the arrival of the Foundation Professor of Psychiatry. Born in Scotland, German had been advised to apply for the position by Sir Aubrey Lewis while working as a Senior Psychiatric Registrar at the Maudsley Hospital.[524] A few weeks after German's arrival, Murray left the country, leaving German and Bosa as the only psychiatrists in Uganda. Looking to fill the government vacancy with someone who would be keen to support his plans for development, German wrote to his brother-in-law, James F. Wood, a Senior Registrar at the Ross Clinic, Aberdeen, inviting him to join him in Uganda. Wood accepted, arriving at Butabika Hospital as a government Consultant Psychiatrist a few months later. From the start of his appointment, German was able to wield considerable influence over appointments like that of Wood, as well as clinical practice at Ward 16 (the mental health ward at Mulago Hospital), Mulago Hospital Mental Health Clinic (an out-patient department that had opened in 1964), and Butabika Hospital.[525] Indeed, while German was technically employed by Makerere University College, on his arrival he became the '*de facto*' head of mental health services in Uganda.

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[523] UMOHA, C90/ACR (Bosa), minute 10, nd., c. 1964; ibid., minute 8, by S.M.O. (T), 17 February 1964.
[524] Personal communication with G. Allen German, 29 January 2012.
[525] Ibid.; Personal communication with J.F. Wood, 7 October 2011.



Image 8: Department of Psychiatry, Makerere Medical School, c. 1970
Credit: James Wood

One of the key features of the new Department of Psychiatry was the cooperation it demanded between university and government. In the original plans for the Department, it was intended that the department and out-patient psychiatric unit at Mulago Hospital 'should be complementary to that of the Butabika hospital….Butabika psychiatrists should be appointed visiting consultants at the Mulago Unit, and the professor and lecturer at Butabika Hospital'.[526] This was deemed necessary because of the inadequacy of existing provision for mental patients in Uganda. According to Davies, while Butabika Hospital:

> Representing as it does a considerable and commendable advance on the existing hospital, it is nevertheless designed rather on conservative and custodial lines, contributed to no doubt by the fact that the criminal lunatics (who were removed right away from civil patients at Bethlem to Broadmoor as long ago as 1854) will continue to be

[526] RHO, Mss.Afr.s.1872(153C) Part 1 (Williams Papers), 'Report of the Principal's Psychiatry Committee', June 1960, p. 2.

accommodated in the same hospital.[527]

> If prestige factors are important, and if psychiatry is to take its place alongside medicine and surgery as a major branch of medicine in this country as elsewhere, then the medical student must be introduced to it in a place freed from the aura of prisons, and preferably in the teaching hospital.[528]

The department and unit at Mulago Hospital would mark the start of a new, modern era of mental health care, providing a space for the training of African doctors as well as psychiatric nurses, psychiatric social workers, and occupational therapists.[529]

This collaboration, of course, had financial implications—salaries, equipment, and travelling expenses all required negotiation—but it also meant that the staff available for clinical, teaching, and forensic work was immediately increased: all government psychiatrists were appointed as honorary lecturers at Makerere University College, and the academic psychiatrists were consultants in government service.[530]

In contrast to other specialisms, this collaboration appears to have caused little tension or resentment on either side.[531] Indeed, the fierce negotiations between university and government over the duties of staff at Mulago Hospital during the 1960s, with its widespread 'ill-feeling', appears to have passed the psychiatrists by. Being a university teaching hospital as well as a government institution and the national referral hospital for Uganda, every specialist attached to Mulago Hospital was required to assist with teaching, if required. Responsibility for teaching and

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[527] Ibid., Item 7, D.L. Davies, 'Report on the Teaching of Psychiatry at Makerere College' (unpublished report, Kampala, December 1959), p. 7.
[528] Ibid.
[529] Ibid., 'Report of the Principal's Psychiatry Committee', June 1960, pp. 7-8.
[530] Personal communication with German, 29 January 2012.
[531] Personal communication with Wilson Acuda, 21 October 2011; Personal communication with German, 29 January 2012; Personal communication with John Orley, 25 September 2011; Personal communication with Wood, 7 October 2011.

clinical work remained ill-defined, however, and teaching requirements were not written into government contracts until the end of the decade.[532]

What united the psychiatrists in Uganda was an awareness of the extent of the work required to develop psychiatry, both at Mulago and Butabika Hospitals, and further afield. This did not, of course, prevent personality clashes between individual psychiatrists. The relationship between Bosa and Bulwanyi, for example, was plagued by constant personal disagreements, dividing staff at Butabika Hospital and eventually requiring Ministry of Health intervention.[533] The chronic underdevelopment of mental health care services by the mid-1960s, however, created a 'unity' among these specialists in ways not seen in other fields.[534]

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[532] UMOHA, ECC.29 (Consultants / Specialists - General), letter from I.S. Kadama, Chief Medical Officer, to Ian McAdam, Makerere Medical School, 6 September 1967; ibid., minute from M/H to Chief Medical Officer, 8 January 1963; TNA, BW 90/190 (Makerere University, Mulago Medical School and Hospital), letter from A. Williams to I.C.M. Maxwell, Inter-University Council, London, 29 April 1959.
[533] See correspondence in UMOHA, C90/ACR (Bosa).
[534] Personal communication with German, 29 January 2012.



Image 9: Department of Psychiatry staff, Makerere Medical School, c. 1970
Credit: Courtesy of G. Allen German
From left to right: medical student; John Cox, medical student, Lovette Coelho (Secretary), medical student, G. Allen German, John Orley, Henry Osenge (Chief Office Messenger), Klaus Minde, medical student

Collaboration between university and government took official form through the establishment of the Mental Health Advisory Committee in early 1967. Initiated by German and officially sanctioned by the Ministry of Health, this advisory body comprised of a range of Ugandan and expatriate psychiatrists, as well as other individuals with an interest in the development of mental health care.[535] While in 1967 the committee was small, consisting of German, Bosa, Wood, and a medical officer, mental nurse, and matron attached to Butabika Hospital, by 1971 it had

[535] UMOHA, PH/ASC/42 (Box 56, Old Arrangement) (Mental Health Advisory Committee: Association); Personal communication with German, 29 January 2012.

expanded to include psychiatrists, mental nurses, a high court judge, a police commissioner, and members of the Ministry of Health.[536]

The committee worked closely to advise and implement new plans for the extension of mental health services, lobbying the Ministry of Health for financial support, when necessary. Following pressure from the committee, for example, the Ministry of Health agreed in 1971 to recognise a six-month internship at Butabika Hospital as being eligible for the registration requirement of doctors.[537] Members of the committee also investigated and prepared papers on a range of topics, opening up a dialogue between the psychiatrists and the Ministry of Health on such themes as interpreters and the Uganda Psychiatric Service, psychiatric social work, and trial mental health clinics at Jinja and Mbarara Hospitals.[538]

Where the committee was most active, was in the extension of mental health services to up-country areas. They implemented monthly visits to Masaka, Fort Portal, Soroti, Jinja, Mbarara, and Mbale, arranging for the travel and subsistence of the Makerere psychiatrists to be met by the Department of Psychiatry, and equivalent funds for government psychiatrists to be met by the Ministry of Health.[539] This work was important, the committee noted in 1971, because of:

> the gross inadequacy of psychiatric services outside the Kampala area with the exception of those upcountry areas currently visited by consultants….it has been emphasized that the majority of mental patients, if brought under medical care when first picked up, could be

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[536] UMOHA, PH/ASC/42 (Box 56, Old Arrangement) (Mental Health Advisory Committee: Association), f. 6, 'Minutes of the Mental Health Advisory Committee Meeting held on 11 August 1971 in Mulago Hospital Board Room at 2.15 p.m.'.
[537] Ibid.
[538] Ibid., E.B. Ssekabembe, 'Report on the Mental Health Follow up Clinic at Jinja by Dr. Ssekabembe', nd.; ibid., S.B. Bosa and F.J. Harris, 'Memorandum on the Function, Training & Recruitment of Psychiatric Social Workers & Mental Health Assistants in Uganda', nd.; ibid., H.G. Egdell, 'Interpreters & the Uganda Psychiatric Service', 7 October 1968.
[539] Ibid., f. 2, 'Minutes of the 9th Meeting of the Mental Health Advisory Committee held on 29th October 1968'.

> free of symptoms within one or two weeks, and would not require in-patient custody for more than a few days. Their long stay in prison is largely due to the lack of medical care, to their illnesses becoming chronic, and to complications developing in the absence of proper treatment.[540]

Under the supervision of committee members, these wards started to be conceived of as full units, staffed by an MO and a small group of mental health nurses, housing an adequate supply of psychiatric drugs, and visited regularly by a consultant psychiatrist. While there is little evidence that shows how these units operated in practice, they were highly regarded by those in Kampala. In contrast to his earlier statement on the neglect of the up-country wards, Bosa reported in 1969 that the Mbarara Hospital Mental Health Clinic was a success. Not only had it reduced the number of referrals and readmissions to Butabika Hospital, but the 'physical appearance of a consultant psychiatrist at the hospital helped to improve the attitude towards mental illness, management and treatment in both staff and patients, and also in the general community'.[541]

The implementation of these schemes, while supported financially by Makerere University College and the Uganda Government, was due to the seemingly inexhaustible energy of the psychiatrists involved. German, for example, was in charge of the clinic at Soroti Hospital from 1968, located 300 miles northeast of Kampala. One Friday each month, following a week of research, teaching, and clinical duties, German would drive to Soroti, check-in to a hotel, and be at the Mental Health Unit by seven o'clock the following morning. On the Sunday, as German recalled, he would then devote three to four hours delivering a 'case

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[540] Ibid., 'Psychiatric Service Needs - Recommendations', nd., 1971.
[541] Ibid., S. Beyo Bosa, 'Report on the Development and Functioning of the Psychiatric Clinic at Mbarara Hospital, Ankole District', nd., 1969, p. 2.

conference and a lecture series given to most of the senior nursing staff and medical staff of the District Hospital, together with any town-based general practitioners who wished to attend'. Other weekend consultants, such as Bosa, did the same.[542] The time invested by these psychiatrists demonstrates not only their commitment to mental health care services in Uganda, but the urgency of the creation of a cadre of trained specialist workers.

Psychiatric training

Between 1966 and 1969, teaching provision in psychiatry at undergraduate level expanded from twenty hours to three hundred,[543] more than that in most medical schools in the United Kingdom.[544] Such was the extent of the changes that on a return visit in 1969 Davies remarked that:

> one is bound to be impressed not only by the amount of time now given to psychiatry in the curriculum – some 300 hours – but the way in which it is spread over the years. Maximum advantage has been taken of the geographical proximity of the medical school to the university, so that help is forthcoming from other departments for a well integrated course of 50 hours in the behavioural sciences, which is in line with the most advanced views in medical education.[545]

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[542] Personal communication with German, 29 January 2012.
[543] 'Department of Psychiatry Annual Report, 1966-1967', *Makerere University College Reports, 1966-1967* (Kampala: Makerere University College, copy in possession of author, 1967); 'Department of Psychiatry Annual Report, 1968-1969', *Makerere University College Reports, 1968-1969* (Kampala: Makerere University College, copy in possession of author, 1969); Personal communication with German, 29 January 2012.
[544] In a study of psychiatric education in medical schools in the United Kingdom in 1967-8, G.M. Carstairs *et al*. found that the mean number of hours devoted to psychiatric training was 185 hours. The range was 66 hours (Charing Cross) to 468 hours (Middlesex). G.M. Carstairs *et al.*, 'Psychiatric Education: Survey of Undergraduate Psychiatric Teaching in the United Kingdom (1966-1967)', *British Journal of Psychiatry* 144 (1968), pp. 1411-6.
[545] D.L. Davies, 'Report on the Teaching of Psychiatry at Makerere University College Department of Psychiatry' (unpublished report, copy in possession of author, 1969).

Teaching consisted of clerking on in- and out-patients, lectures, and small group seminars designed to prepare doctors to have 'sufficient grounding in Psychiatry to be capable of providing basic psychiatric care in district hospitals and up-country areas' not just in Uganda but across East Africa.[546] While the syllabus broadly followed that of medical schools in the United Kingdom, the lecturers were aware of the need to make teaching locally relevant. John H. Orley, a researcher attached to the Department of Psychiatry, gave occasional lectures on his research on mental illness and epilepsy among the Baganda. Wood, moreover, took organic causes of mental illness as one of his subjects, something he felt was key to reducing the high number of unnecessary referrals to the mental health clinic. As Wood recalled:

> Whilst a wide range of psychiatric illness was evident in Uganda it was clear that Organic Confusional States, Delirious States or Acute Brain Syndromes were very common, reflecting the many physical disease causes of such mental illness reactions. Finding the physical cause, diagnosing the physical disease and treating it was central to the remission of these states. Getting this message to the trainee medical and nursing staff of the general outpatient and inpatient units was an initial and vitally important task of our developing service and it did take about 6 months of effort to reduce the flow of primarily physically ill patients to our clinic![547]

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[546] WHOA, M-PROJECTS UGANDA-38 (Assistance to the Department of Psychiatry, Makerere University College), 'Application to the World Health Organization for a grant-in-aid', 1966. The training of mental nurses at the Butabika School of Psychiatric Nursing also expanded towards the end of the 1960s, if this was more to do with the efforts of its Principal, Alexander S. Hamilton, than the Department of Psychiatry. By 1969, the school had developed a full Uganda Registered Mental Nurses Course, with a theoretical and practical syllabus, and started accepting students in 1970. Towards the end of this year, a Ugandan psychiatric nurse, Vincent Wankiiri, trained in the United Kingdom, also took over as Principal. The Ministry of Health were not keen for him to take on this role, however. Aware of the desperate shortage of general nurses, the government would have preferred him to remain as a general nurse tutor at Mulago and Gulu Hospitals. TNA, DT 18/567 (Uganda: Butabika Hospital, 1968-1974); Interview WAN-01.

[547] Personal communication with Wood, 7 October 2011.

His lectures on the topic included the definitions, features, and causes of mental confusion and acute brain syndromes, as well as the steps involved in a basic examination.[548]

While the teaching at undergraduate level aimed primarily at producing general practitioners who had a good understanding of how to recognise and manage mental illness, these lecturers also hoped to encourage African medical practitioners to specialise in psychiatry. Those wishing to attain an MMed, introduced at Makerere Medical School in 1968, were required to complete a three-month attachment to Butabika Hospital.[549] By 1971, the one-year course of instruction for the Diploma in Public Health (DPH), a requirement for doctors aspiring to be a Medical Officer of Health or to any senior administrative post in the Ministry of Health, included a full week of thirty-seven hours (practical and theoretical) in mental health.[550]

These training schemes were supported by grants from international bodies, which allowed the Department of Psychiatry to appoint new lecturers and researchers. Orley, whose interest in East Africa had been developed by studying under E.E. Evans-Pritchard and John Beattie while at the University of Oxford, was funded during his first two years in Uganda by a Nuffield Foundation research grant.[551] The Norwegian aid agency, NORAD, sponsored the secondment of Arvid Aas, a Professor of Clinical Psychology at the University of Oslo, to Makerere University College for a period of two years.[552] The WHO, too, provided financial

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[548] J.F. Wood, 'Acute Brain Syndromes (or Organic Confusional States)' (unpublished lecture, copy in possession of author, 1969).
[549] Davies, 'Report on the Teaching of Psychiatry 1969'.
[550] WHOL, SEA/ME/Meet.Dir.Sch.P.H.4/23 (Makerere University Medical School Country Report - Uganda, East Africa), p. 4.
[551] 'Department of Psychiatry Report, 1966-7'; Personal communication with Orley, 25 September 2011.
[552] Three months into his secondment, however, Aas suffered a major heart attack and died shortly afterwards. 'Department of Psychiatry Report, 1968-9'; Personal communication with German, 29 January 2012.

support for a lecturer in psychiatry, a position that was awarded to H.G. Egdell, a specialist in child psychiatry, in 1968.[553]

In contrast to the early 1960s, when Makerere University College had found it impossible to secure funding for research or teaching in psychiatry, international bodies like the WHO were developing policies to assist psychiatry in developing countries by making clinical and teaching staff available.[554] Rather than use the lectureship to try to define policy in Uganda, the WHO had chosen to support the Department of Psychiatry because they believed that it was 'progressive and fully in line with our own long-term planning in the field of mental health services'.[555] As Maria Pfister, Chief of the Mental Health Section, WHO, Geneva, noted in January 1967: 'The programme aims at enabling the future physicians to give basic psychiatric care in rural and urban areas. This is essential since the general physician will be the backbone of integral mental health care in countries where not enough specialists will be available for a long time to come'.[556]

Despite these efforts, the number of African doctors specialising in psychiatry remained low throughout the 1960s. Just as Bosa had been transferred to Mulago Mental Hospital in 1949, throughout the 1960s African doctors were placed at Butabika Hospital, rather than opting to pursue it themselves after graduation. Once attached to Butabika Hospital, graduates were assessed for their suitability for further training, and if interested might then be allowed to pursue a formal postgraduate qualification. E.B. Ssekabembe, who had qualified as a doctor in India, had been

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[553] 'Department of Psychiatry Report, 1968-9'.
[554] World Health Organization, *The Undergraduate Teaching of Psychiatry and Mental Health Promotion: Ninth Report of the Expert Committee on Mental Health* (Geneva: World Health Organization Technical Report Series, No. 208, 1961), pp. 35-6. Nigeria also received WHO support during the 1960s and 1970s. WHOA, M4/181/55 (CTS Agreement with the Nervous Diseases Hospital, Benin City, Nigeria, in Respect of Comparative Studies of Specific Mental Disorders).
[555] WHOA, M-PROJECTS UGANDA-38 (Assistance to the Department), memorandum entitled 'Makerere College – Department of Psychiatry', by Maria Pfister, 20 January 1967.
[556] Ibid.

attached to Butabika Hospital since 1964 at least, and by 1966 was in London preparing for the DPM.[557] Wilson Acuda, too, graduated from Makerere Medical School in 1970. His initial placement at Butabika Hospital for a period of one year was not of his choosing, but he 'fell in love with Psychiatry within a few weeks' and was determined to specialise in it. After six months at Butabika Hospital he was offered a scholarship by the British Council to study at the Institute of Psychiatry from April 1972, an opportunity that he accepted.[558]

The expansion of training at postgraduate level was assisted by the creation in 1966 of three Senior House Officer (SHO) positions in psychiatry. These were designed for doctors who had not undertaken formal training in psychiatry but who had considerable experience in psychiatric practice.[559] A.T. Kikwanguyira, who had been attached to Butabika Hospital since 1966 at least, was raised to one of these positions, allowing for the recognition of his experience with the mentally ill.[560] Intending to make full use of these new positions, German noted in 1967 that '[i]t is envisaged that S.H.O.s will train on an in-service basis and that, for the moment, they will continue to proceed to London to take their Diploma in Psychological Medicine. A series of lectures at postgraduate level has been given over the past session and the present S.H.O. is due to take the first part of the D.P.M. in London in May 1967'.[561] This SHO was Joseph Muhangi, who on his return to Uganda worked as a Special Grade Medical Officer (Psychiatry) before being appointed as a lecturer in the

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[557] UMOHA, C90/ACR (Bosa), f. 81, note listing staff on duty and on leave at Butabika Hospital, 4 June 1964; 'Department of Psychiatry Report, 1968-9'; Personal communication with German, 29 January 2012.
[558] Personal communication with Acuda, 21 October 2011.
[559] Personal communication with German, 29 January 2012.
[560] UMOHA, C90/ACR (Bosa), f. 104, letter from J. Bulwanyi, Medical Superintendent, Butabika Hospital, to M. Kooyman, Medical Officer, and J. Muhangi, Medical Officer, 14 September 1966; Personal communication with German, 29 January 2012.
[561] 'Department of Psychiatry Report, 1966-7'.

Department of Psychiatry in November 1969.[562] Another SHO, A.M. Kitumba followed a few years later, completing the MRCPsych in London in 1972.[563]

That part of the postgraduate training was undertaken in the United Kingdom was not unusual. Makerere Medical School had prepared graduates to take higher qualifications in the United Kingdom since the 1950s,[564] and when Makerere University College discussed the training of African psychiatrists in 1959, they concluded that '[p]art of their training undoubtedly should be undertaken in Britain. Equally important is it to have a department here in which as House Physicians and later as Registrars they can begin their training and later, after a period overseas, consolidate it in the African environment'.[565] In Nigeria, too, T. Adeoye Lambo, Professor of Psychiatry at the newly opened Department of Psychiatry, University of Ibadan, in 1963, encouraged recent graduates to start their training in the Department and complete it in the United Kingdom under fellowships arranged by Lambo.[566] It was not until 1971 that academic and clinical psychiatry developed to the point that German was able to design an MMed in Psychiatry. The upheavals of the Idi Amin years, however, disrupted teaching across Makerere Medical School, and the course was set aside until the late 1970s.[567]

Such was the esteem with which psychiatric teaching was regarded by the late 1960s, that it was used as a model on which to develop training programmes elsewhere in East Africa. In Kenya, the failure to develop programmes for the

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[562] *Mental Health Services in the Developing World: Reports on Workshops on Mental Health, Edinburgh (1986) and Kampala (1969)* (Hove, Sussex: Hove Shirely Press, Commonwealth Foundation Occasional Paper No. IV, 1969), p. 51; Davies, 'Report on the Teaching of Psychiatry 1969'.
[563] UMOHA, C90/ACR (Bosa), f. 134, letter from S.B. Bosa to Permanent Secretary for Establishments, Ministry of Public Service and Local Administration, 31 May 1972.
[564] Iliffe, *East African Doctors*; Odonga, *The First Fifty Years*, pp. 131-2.
[565] TNA, BW 90/190 (Makerere University), 'Application to the Nuffield Foundation', p. 2.
[566] R.O. Jegede, 'Nigerian Psychiatry in Perspective', *Acta Psychiatrica Scandinavica* 63 (1981), pp. 45-56 at p. 47.
[567] Personal communication with German, 29 January 2012.

training of medical doctors and psychiatrists meant that by 1966, Mathari Mental Hospital had yet to employ an African psychiatrist.[568] In the years following the establishment of Medical Faculties at the University of East Africa Colleges in Kenya and Tanzania, the psychiatrists in Uganda offered advice and expertise, and became involved in the search for professorial heads and visiting lecturers.[569] This advisory role ensured that Ugandan psychiatry became internationally relevant—psychiatry was firmly in its 'golden age'.

Research on an international stage

Psychiatric epidemiology, culture, and student mental health

When the Department of Psychiatry opened in 1966 there was little tradition of research on mental illness on which to build. As indicated in Chapter I, Tewfik and Young recognised the extent to which proximity to the mental hospital encouraged admission, but did little to investigate mental illness outside of the in-patient population. The new group of psychiatrists made the collection of epidemiological data one of their main priorities, looking not just at the mental hospital, but at general hospitals, out-patient clinics, villages, and schools.[570] H.G. Egdell undertook a study of child psychiatric morbidity in a defined area in Toro District, an age-group and geographical area that had previously been invisible to Uganda's psychiatrists.[571] Orley, too, carried out a prospective study of 372 admissions to Butabika Hospital,

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[568] S. Basch and L. Basch, 'Observations on Patients in a Mental Hospital in East Africa', *East African Medical Journal* 43(9) (1966), pp. 359-65 at p. 359.
[569] Personal communication with German, 29 January 2012.
[570] Ibid.; Wood, 'A Half Century of Growth', p. 118. An example of one of these studies is Egdell and Stanfield, 'Paediatric Neurology in Africa: A Ugandan Report'.
[571] 'Department of Psychiatry Report, 1968-9'.

focusing on the events leading up to committal.[572] In such research, the collection of diagnostic data was frequently hampered by questions of reliability, and exacerbated, as Wood pointed out for Butabika Hospital, by 'an always changing and initially unskilled junior staff'.[573]

The ability to conduct this research was strongly influenced by the international reputation and facilities already developed by Makerere Medical School, which attracted over £280,000 in medical research grants between 1964-7 (over 4 million pounds in today's terms).[574] One of the sites used by researchers was Kasangati Health Centre, located nine miles north of Kampala. Kasangati was conceived in 1959 as a collaborative project of the Department of Preventive Medicine, the Buganda Government, and the Rockefeller Foundation, training medical students in rural public health while also collecting information on the backgrounds of the patients attending the out-patient clinic and dispensary. By 1965, Kasangati had one of the most exhaustive medical records systems in East Africa, employing coded cards and 'family files' that allowed researchers from Makerere Medical School to conduct a range of demographic surveys, notably on infant and child health.[575] Those attending Kasangati were hardly representative of those in rural areas, however, being 'among the most economically and educationally advanced groups in East Africa', and having 'had more aspects of their existence studied and described than most other communities'.[576] Despite this drawback, which was not always openly acknowledged in published work, the psychiatrists made extensive use

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[572] John Orley, 'A Prospective Study of 372 Consecutive Admissions to Butabika Hospital, Kampala', *East African Medical Journal* 49(1) (1972), pp. 16-26.
[573] Wood, 'A Half Century of Growth', p. 123.
[574] Sicherman, *Becoming an African University*, p. 153.
[575] F.J. Bennett *et al.*, 'Kasangati Health Centre 1959-1972', in F.J. Bennett (ed.), *Nkanga: Special Edition on Medicine and Social Sciences in East and West Africa* (Kampala: Makerere Institute of Social Research, 1973); Sicherman, *Becoming an African University*, pp. 156-8.
[576] Bennett, Saxton, and Mugalula-Mukiibi, 'Kasangati', p. 15.

of Kasangati and a new Friday afternoon mental health clinic to investigate mental illness among 'rural' groups, pregnant women, and Banyarwanda immigrants.[577]

The addition of psychiatrists to the burgeoning intellectual community at Makerere Medical School encouraged, for the first time in Uganda, collaboration between psychiatry and other disciplines, particularly in the fields of student and maternal health. In addition to research conducted at Kasangati Health Centre, links were established with the Department of Paediatrics, the Department of Sociology, and the Medical Research Council's Infantile Malnutrition Unit in a study of the long-term effects of infant malnutrition on mental functioning.[578] German became involved in a project with the Virus Research Laboratories, Entebbe, in examining the role of virus infection of the central nervous system in producing confusional states.[579] Other psychiatrists, meanwhile, were engaged in a study of peripheral nerve conduction time in hypomanic and depressive illnesses, a project that spanned the Department of Physiology, the Department of Psychiatry, and the Ministry of Health.[580]

Collaboration was important because it allowed the Department of Psychiatry, whose staff was largely new to Uganda's disease environment, to draw on the expertise of other specialists, and to widen the areas of study. In so doing, the psychiatrists contributed to a wider endeavour at Makerere Medical School that aimed to show that 'diseases of civilisation', such as heart disease, blood pressure,

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[577] Bennett *et al.*, 'Kasangati Health Centre', p. 45. See, for example, M.I. Assael, 'Changing Society and Mental Health in Eastern Africa', *Israel Annals of Psychiatry and Related Disciplines* 8 (1970), pp. 52-74; M.I. Assael *et al.*, 'Psychiatric Disturbances During Pregnancy in a Rural Group of African Women', *Social Science & Medicine* 6 (1972), pp. 387-95; F.J. Bennett and A. Mugalula-Mukiibi, 'An Analysis of People Living Alone in a Rural Community in East Africa', *Social Science & Medicine* 1 (1967), pp. 97-115.
[578] 'Department of Psychiatry Report, 1966-7'.
[579] Ibid.
[580] Ibid.

and mental illness, were as common in East Africa as they were elsewhere.[581] A study at Kasangati Health Centre in 1969-70, for example, brought together German and M.I. Assael, an Israeli psychiatrist, with J.M. Namboze, Uganda's first female doctor, and F.J. Bennett, of the Department of Preventive Medicine, to interview one hundred expectant mothers who attended the clinic and who were able to express themselves in Luganda.[582] They found that depressive reactions were a common pattern of disturbance among these women, something that was 'in keeping with the recent realization that depression is a frequent disorder in the rural African'.[583]

Such statements were typical in research into mental illness in Africa during this period, as psychiatrists continued to distance themselves from the generalisations and misconceptions that had plagued ethnopsychiatry under colonial rule.[584] In his study of admissions to Butabika Hospital, Orley stressed that claims that 'retarded depressive illnesses are rare in Africans' were false. In a comment that reinforces the argument made in this thesis in Chapter II, Orley added that 'the popular conception of Butabika Hospital amongst Ganda villagers is of an institution where patients may be taken when they become unmanageable at home….The author [Orley] has seen some mildly excited women patients whose relatives felt that there was little or no need for them to go to Butabika Hospital'.[585] German, too, declared that:

> For too long have the real problems of African psychiatry been obscured by the unduly publicised pronouncements of psychiatric tourists returned from witchdoctor safaris. Witchdoctors and bewitchments, the occult and the sadistic, are not the peculiar heritage of the African. They are rather the unsurprising accompaniments of

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[581] On research on the 'diseases of civilisation', see Iliffe, *East African Doctors*, pp. 143-4.
[582] Assael *et al.*, 'Psychiatric Disturbances During Pregnancy', p. 394.
[583] Ibid.
[584] For other examples, see Chapter I.
[585] Orley, 'A Prospective Study of 372 Consecutive Admissions', p. 24. Orley's work on understandings of mental illness among the Baganda was considered briefly in Chapter II.

> poor social conditions, of fear, of ignorance and despair, and as such they are found, even today, in every civilization on earth.[586]

While psychiatrists like German and Orley were encouraging a more culturally sensitive approach to mental ill-health, they could not always escape the assumptions of their discipline. By referring to 'witchdoctors' and 'bewitchments', German was implying a linear scale of development on which African 'civilization' was passing through one stage. Reinforcing this assertion, German further noted in 1972 that:

> The general picture of African psychiatry that emerges at the present time has an overall similarity to psychiatry in other parts of the world. Differences seem to be determined in part by physiological deprivations and physical disease and in part by cultural differences and widespread illiteracy. It seems probable that if the comparison were to be made between psychiatric disorder today and psychiatric disorder in Europe one hundred years ago the differences would be even less marked.[587]

These comments were not only reminiscent of older theories of recapitulation, but also spoke to one of the key tensions that emerged in transcultural psychiatry during the 1950s and 1960s regarding explanations for mental ill-health.[588] As P.-M. Yap, of the Hong Kong Psychiatric Centre, asserted in 1951, psychiatric conditions 'are seen everywhere, but the detailed symptomatology of these broad symptoms may vary from one culture to another, reflecting as they do prevailing beliefs, customs,

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[586] G. Allen German, 'Forward', in Orley, *Culture and Mental Illness*.
[587] German, 'Aspects of Clinical Psychiatry', p. 477.
[588] Recapitulation theory rose to prominence in the second half of the nineteenth century, and stressed anatomical similarities between Africans and European children. Gould, *The Mismeasure of Man*, pp. 114-9.

interests and conflict'.[589] The question of how to reconcile the two would eventually divide its proponents into those (primarily psychiatrists) who preferred to stress the universal nature of disease and those (primarily anthropologists) who felt that it was more important to understand disease in terms of a patient's culture.[590]

The relationship between culture and mental illness was one that preoccupied psychiatrists in Uganda during this period, particularly with regard to student mental health. As indicated in Chapter I, ideas about 'educability' had been discussed in different cultural and geographical contexts in Africa since the 1930s, with researchers asking why there appeared to be so many cases of breakdown among students, and how mental instability might be linked to a 'clash of cultures'. By the 1960s, the debates were additionally influenced by Raymond Prince's 'brain-fag' concept. This syndrome, which Prince applied to unmarried adult Nigerian males studying in England, was marked by 'intellectual impairment, sensory impairment (chiefly visual), and somatic complaints most commonly of pain or burning in the head and neck'.[591] These symptoms, Prince hypothesised, were 'in some way related to the imposition of European learning techniques upon the Nigerian personality'.[592]

Prince's work was of considerable interest to researchers looking at the mental health of students at Makerere University College. Rather than seeing education or 'acculturation' as a pathological force in itself, however, the researchers in Uganda focused more on the stresses and anxieties that might cause individuals to break down. In 1969, German, together with O.P. Arya, a lecturer attached to the Department of Preventive Medicine, undertook a study of psychiatric morbidity

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[589] P.-M. Yap, 'Mental Diseases Peculiar to Certain Cultures: A Survey of Comparative Psychiatry', *Journal of Mental Science* 97 (1951), pp. 313-27 at p. 326.
[590] Arthur Kleinman, 'Anthropology and Psychiatry. The Role of Culture in Cross-Cultural Research on Illness', *British Journal of Psychiatry* 151 (1987), pp. 447-54 at p. 151.
[591] Prince, 'The "Brain Fag" Syndrome', p. 559.
[592] Ibid., p. 569.

among students at Makerere University College. 'This student population', they noted, 'is of peculiar interest to psychiatrists, partly because it is predominantly African, but also because these African undergraduates occupy a central position in the whirl of social and cultural changes sweeping across East Africa'.[593] Bennett similarly noted that students at Makerere faced a series of unique stresses:

> The majority of students are the first generation of the educated. Great expectations rest upon their shoulders. For most, arrival at Makerere means a sudden change from a traditional, family centred way of life to the novel freedoms and restraints of a European patterned centre of learning set in the forefront of the intellectual, political and technological revolution of mid-20th century Africa.[594]

That students might break down while studying was unsurprising, given 'the enormous emphasis placed on academic success by families and society'.[595]

In conducting this research, the Department of Psychiatry established a reputation for work that was not only well grounded in international psychiatric theory, but politically relevant to development and health in East Africa. German in particular received recognition for his expertise in psychiatry, and in 1971 was invited by the *British Journal of Psychiatry* to write a twenty-page review of the psychiatric literature on Africa under the general heading of 'Psychiatry in Developing Countries'.[596] While the published outputs of the psychiatrists do not appear to have been widely cited outside of Africa before the mid-1970s, their research on psychiatric epidemiology, child psychiatry, student mental health, and

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[593] G. Allen German and O.P. Arya, 'Psychiatric Morbidity Amongst a Uganda Student Population', *British Journal of Psychiatry* 115 (1969), pp. 1323-9 at p. 1323.
[594] F.J. Bennett, 'The mental health of African students in Africa' (unpublished paper, 1967), as summarised in: ibid.
[595] Ibid., p. 1327.
[596] German, 'Aspects of Clinical Psychiatry', p. 461.

cultural understandings, had lasting significance for the discipline in Africa, and continue to be cited in literature reviews today.[597]

Pan-African networks

The growing importance of the psychiatrists in Uganda was reinforced by their active participation in the development of an African psychiatric community. The first major meeting of psychiatrists in Africa had taken place in Bukavu in 1958 under the auspices of the Scientific Council for Africa South of the Sahara and the WHO. Of the thirty-four participants, only ten were psychiatrists practising in Africa (excluding South Africa, which sent one delegate), including A.C. Raman (Mauritius), E.L. Margetts (Kenya), C.G.F. Smartt (Tanganyika), and G.I. Tewfik (Uganda).[598] Three years later, with the express intention of increasing connections between psychiatrists working in Africa, T.A. Lambo organised the First Pan-African Conference of Psychiatrists at Abeokuta, Nigeria, at which psychiatrists from Africa and Europe were in attendance.[599] What these meetings made clear, was that those working in Africa had as much, if not more to contribute, than those working elsewhere in the world. As German and Raman noted in 1976, international delegates to African conferences and congresses were '[i]nexperienced in the sense that their view of African problems was rarely based on the reality of the African situation, and tended to be heavily influenced by theoretical formulations and current Western

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[597] See, for example, M. Miles, 'Children with Hydrocephalus and Spina Bifida in East Africa: Can Family and Community Resources Improve the Odds?', *Disability & Society* 17(6) (2002), pp. 643-58; E. Ovuga, J. Boardman, and D. Wasserman, 'Undergraduate Student Mental Health at Makerere University, Uganda', *World Psychiatry* 5(1) (2006), pp. 51-2; Vikram Patel, 'Explanatory Models of Mental Illness in Sub-Saharan Africa', *Social Science & Medicine* 40(9) (1995), pp. 1291-1298.
[598] *Mental Disorders and Mental Health in Africa South of the Sahara: CCTA/CSA-WFMH-WHO Meeting of Specialists on Mental Health* (Bukavu: CSA Publication No. 35, 1958).
[599] T.A. Lambo (ed.), *First Pan-African Psychiatric Conference Report* (Ibadan: Government Printer, Nigeria, 1961).

attitudes and ideologies concerning developing countries and "primitive" societies'.[600]

The Department of Psychiatry fostered relationships through visits and correspondence. Following a brief stopover in Uganda in 1967, for example, T. Asuni, a Nigerian psychiatrist, became close friends with German, and started to correspond regularly over the next few years.[601] During the 1968-9 academic year, moreover, visitors to the Department of Psychiatry included J.C. Likimani (Director of Mental Services, Kenya), A. Boroffka (Nigeria), R. Giel (Ethiopia), A. Howarth (Zambia), T. Baasher (Sudan), C.R. Swift (Tanzania), and C.C. Adomakoh (Ghana).[602] Most significantly, however, was the organisation of a Commonwealth Foundation funded workshop on 'The Delivery of Mental Health Care', held in conjunction with the University of Edinburgh at Makerere University College in 1969. The workshop brought together twenty-nine participants, primarily from Africa, to discuss the ways in which psychiatric care could be extended to the population in countries with few resources and specialists. In exploring the role of psychiatrists in developing countries and the place of traditional healers, among other issues, the meeting reinforced the importance of an intellectual community of psychiatrists living and working in Africa.[603]

On the last day of the workshop, a Steering Committee was set up to decide on the best way to establish an Association of Psychiatrists in Africa, with German as Chairman, and Asuni, Swift, Howarth, and Boroffka as members.[604] The idea of an Association of Psychiatrists had been mooted since 1961, being, as Lambo described

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[600] G.A. German and A.C. Raman, 'From Birth to Maturity – Historical Aspects of the Association of Psychiatrists in Africa', *African Journal of Psychiatry* 2(2) (1976), pp. 255-65 at p. 258.
[601] Ibid., p. 257.
[602] 'Department of Psychiatry Report, 1968-9'.
[603] These issues will be explored further in Chapter VI.
[604] German and Raman, 'From Birth to Maturity', p. 258.

it, an Association 'meant entirely for psychiatrists working in Africa; actively engaged in some form of mental health work in Africa, irrespective of their origin or nationalities'.[605] While it seems likely that the Association would have been formed even without the input of the Department of Psychiatry at Makerere Medical School, the work put in by German to its foundation, and his continued support as Associate Secretary when the Association was formed in 1970, was nevertheless significant.[606]

Conclusion

The rapid expansion of clinical and academic psychiatry during the 1960s and early 1970s was prompted by the interest of Makerere University College in promoting psychiatry as a field of study and research. The Uganda Government, by contrast, were deaf to the calls of those working at Butabika Hospital that investment and greater personnel were required if an effective mental health service was to be viable in Uganda. The agreement that followed between the Uganda Government and Makerere University College relieved the Ministry of Health of sole responsibility for psychiatry and mental health care, and bolstered the staff available for clinical work. The energy and zeal of this new group of psychiatrists, headed by German, and with considerable input from Bosa, developed psychiatric training and research to a point where it could no longer be ignored by other health professionals, and ushered in a 'golden age' for psychiatry. Such was the importance of the work of these psychiatrists that their model of training and delegating responsibility to a range of health care workers—a model also adopted by a number of other African countries during early 1970s—would later be promoted by the WHO as the most effective way

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[605] Lambo (ed.), *First Pan-African Psychiatric Conference Report*, p. 264.
[606] A.C. Raman, 'Association of Psychiatrists in Africa', *British Journal of Psychiatry* 117 (1970), p. 479.

of delivering mental health care in developing countries.[607] 'Mental health services in Uganda', as the WHO African Mental Health Action Group noted in 1987, were 'once the best in the region'.[608]

In the years following the opening of the Department of Psychiatry in March 1966, Uganda saw an increase in the number of expatriate psychiatrists from one to six by 1969 (including one psychiatric social worker). With formal and informal programmes designed to train African doctors, too, the number of African psychiatrists also rose from one to three.[609] When Davies returned to Uganda in 1969 to re-evaluate the state of psychiatry, he was particularly impressed by the speed of change, and reported finding a united group of psychiatrists, led by German, but with posts filled evenly between Ugandans and expatriates.[610] This divide between expatriates and Ugandans broadly reflected that at Makerere Medical School more generally, where by 1971, 38% of staff was Ugandan. While this was better than the situation in 1965, when only 11% of the academic staff was Ugandan, it was still nowhere near that of the university administration, where 81% of staff was Ugandan.[611] 'Despite political pressure to "Africanize" as rapidly as possible,' Foster noted, 'the senior Ugandan members of the college were as unwilling as anyone to see unsuitable men appointed to chairs merely because they were Ugandans'.[612]

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[607] Personal communication with German, 29 January 2012; G. Allen German, 'The Psychiatry of Poverty', *Psychopathologie Africaine* 7(1) (1971), pp. 113-7; World Health Organization, *Organization of Mental Health Services in Developing Countries: Sixteenth Report of the WHO Expert Committee on Mental Health* (Geneva: World Health Organization Technical Report Series, No. 564, 1975); World Health Organization, *The Third Ten Years of the World Health Organization: 1968-1977* (Geneva: World Health Organization, 2008), p. 213.
[608] WHOL, MNH/POL/87.3 (African Mental Health Action Group, Tenth Meeting, Geneva, 8 May 1987), p. 8.
[609] 'Department of Psychiatry Report, 1966-7'; 'Department of Psychiatry Report, 1968-9'.
[610] Davies, 'Report on the Teaching of Psychiatry 1969'.
[611] Carol Sicherman, 'Building an African Department of History at Makerere, 1950-1972', *History in Africa* 30 (2003), pp. 253-82 at p. 254.
[612] Foster, 'Makerere Medical School', p. 678.

One of the ways Makerere Medical School dealt with the process of Africanisation was to increase the turnover of expatriate staff, appointing new lecturers on contracts of up to six years rather than on a permanent basis.[613] This was certainly the case in psychiatry, where the underdevelopment of psychiatric education under colonial rule meant that expatriates were needed in the short-term. While there appears to have been little difference between the Ugandan and expatriate psychiatrists in terms of their outlook and priorities for mental health care, the increase in expatriates was not without its limitations. Indeed, as Bennett noted in 1965, the 'disadvantages of employing foreigners on short contracts in a country with at least 25 language groups can be imagined'.[614] The question of how 'African' psychiatry was, or would become, will be explored in the last two chapters.

[613] F.J. Bennett *et al.*, 'Medical Manpower in East Africa: Prospects and Problems', *East African Medical Journal* 42(4) (1965), pp. 149-61 at p. 154; Personal communication with Orley, 25 September 2011; Sicherman, *Becoming an African University*, ch. 14.
[614] Bennett *et al.*, 'Medical Manpower in East Africa', p. 154.

Chapter V:

'A disease of that time': Multiple Explanations for Mass Hysteria, 1962-4

In the early 1960s, medical officers and administrators in Uganda and Tanganyika began to receive reports of what was being described as 'mass madness' and 'mass hysteria' in the areas around Lake Victoria. Starting with a case of 'laughing mania' at Bukoba, Tanganyika, in January 1962, further reports of 'running manias associated with violence' followed in Kigezi, Uganda, in July 1963, and Mbale, Uganda, in November 1963. Each epidemic reportedly affected between 300 and 600 people, and coming in the wake of independence from colonial rule, became evidence that East Africans were suffering from a 'mental conflict' brought on by education and 'westernisation'.[615]

Two different teams investigated the epidemics. The first, led by A.M. Rankin, Professor of Medicine, Makerere University College, and P.J. Philip, MO, Tanganyika, focused on Bukoba. They conducted a series of laboratory tests to rule out organic causes for the disorder, before reaching a tentative diagnosis of mass hysteria by process of elimination.[616] The second investigation was based at Mbale,

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[615] KDA (Minutes of the Kigezi District Team), August 1963 - July 1964; 'Mystery of the Laughing and Crying Disease', *Uganda Argus,* 15 August 1963, p. 3; Robert Conley, 'Laughing Malady Puzzle in Africa', *New York Times,* 8 August 1963, p. 29; G.J. Ebrahim, 'Mass Hysteria in School Children: Notes on Three Outbreaks in East Africa', *Afya* 3(10) (1969), pp. 7-9; Kagwa, 'The Problem of Mass Hysteria'; A.M. Rankin and P.J. Philip, 'An Epidemic of Laughing in the Bukoba District of Tanganyika', *The Central African Journal of Medicine* 9(5) (1963), pp. 167-70.
[616] Rankin and Philip, 'An Epidemic of Laughing'.

and led by the Ugandan psychiatrist Benjamin Kagwa.[617] Kagwa conducted a series of neuropsychiatric tests, analysing his findings alongside a series of historical examples of mass hysteria from sixteenth-century Europe and the work of ethnopsychiatrist J.C. Carothers on 'the African mind'. At the same time, Kagwa showed little interest in local explanations for madness, which linked it to the anger of ancestral spirits.[618] It was his paper, the first psychiatric study of mass hysteria in Africa, that presented the epidemic as a particularly East African 'problem'.

As we saw in the previous chapter, long-held concerns about the effects of 'westernisation' and 'detribalisation' merged in the mid-1950s with plans for the expansion of medical training at Makerere Medical School, prompting calls to develop psychiatry into a subject that would adequately prepare all African doctors to respond to mental ill-health. African psychiatrists, it was claimed, would be particularly well suited to this challenge because they possessed a natural cultural 'insight'.

In this context of a shift in intellectual psychiatry in Africa, the investigations into the epidemics of mass hysteria raise questions about the place of Ugandan psychiatrists within the newly independent Uganda, as well as the legacies of colonial psychiatry more generally. As a case study, it offers a rare opportunity to interrogate the nature of early post-colonial psychiatry by incorporating the voices of both psychiatrists and patients into the analysis. These epidemics were significant enough to be remembered by people living in eastern Uganda in 2011 as a 'disease of that time', and focused enough for eighteen Bagisu elders to share their fears, anxieties,

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[617] Kagwa's educational background is described in Chapter IV.
[618] Interview with Mugisu female, approximately 61 years old (MLE-07), Manyonyi Lower Village, Bungokho Sub-County, Mbale District, 27 October 2011; Interview with Mugisu female, approximately 78 years old (MLE-16), Malukhu Housing Estate, Mbale District, 1 November 2011; Kagwa, 'The Problem of Mass Hysteria'; Interview with Mugisu male, approximately 74 years old (MLE-06), Manyonyi Lower Village, Bungokho Sub-County, Mbale District, 27 October 2011.

and experiences of a specific event in interviews.[619] This chapter juxtaposes these interviews with Kagwa's report into the epidemic in order to explore competing explanations for mass hysteria, as well as the ideas and practices of Africa's first generation of psychiatrists.

The history of psychiatry in late colonial and early post-colonial Uganda, as I demonstrate in this thesis, is marked by the emergence of African psychiatrists. In national case studies elsewhere in Africa, historians have argued that indigenous-born psychiatrists transformed the nature of psychiatry within their own countries, and with it, the relationship between race, culture, and mental disorder.[620] The most famous of the early African psychiatrists is T. Adeoye Lambo, a western-trained Nigerian psychiatrist who engaged with local concepts and methods of healing through the Aro Village project. Founded in 1954, the community consisted of a day hospital attached to four villages. Patients, who were accompanied by at least one relative, were boarded out in villages where, in addition to the physical therapies received at the hospital, they could be employed on nearby farms and participate in daily village life. According to Lambo, in these villages '[c]onfession, dancing, rituals, suggestions inherent in traditional cults, flexibility and tolerance of the environment, to mention a few, could be mobilised and utilised as powerful psychotherapeutic armament, especially in psychoneurosis'.[621] Moreover, it was only with the help of traditional healers, Lambo claimed, that the psychiatrists at Aro were

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[619] All interviews were conducted in Lugisu and recorded with a digital voice recorder. I had one research assistant, Ronald Muruya, a Mugisu researcher attached to the JCRC, Mbale. The interviews were transcribed and translated by Eugene Malimba, a recent graduate from Makerere University.
[620] Bullard, 'Imperial Networks and Postcolonial Independence'; Heaton, 'Stark Roving Mad', p. 106; Oyebode, 'History of Psychiatry in West Africa'.
[621] 'The Village of Aro', *The Lancet,* 5 September 1964, pp. 513-4 at p. 513.

able to find out the 'psychological causes of neuroses that are so common in African communities undergoing rapid change'.[622]

This chapter does not deny that psychiatrists such as Lambo actively shaped psychiatry in their own countries. Rather, it contends that schemes like Aro were exceptional. In Uganda, psychiatrists such as Kagwa were required to work within the same structures and institutions of 'western' psychiatry established by the British under colonial rule. In their daily practice, moreover, they found it just as difficult as their expatriate colleagues to bridge what Frederick Cooper and Ann Laura Stoler have called 'the stretch between the public institutions of the colonial state and the intimate reaches of people's lives'.[623] Not only did their education, class, and language skills set them apart from their patients, but there remained fundamental differences between their understandings of mental illness and the types of treatment deemed to be effective.

The chapter starts by examining accounts of mass instability in colonial Africa, asking how ideas about witchcraft, fear, and suggestibility built on and fed into ideas about African psychopathology. The chapter then turns to the multiple ways people understood and responded to the epidemics of madness of the early 1960s. In so doing, it argues that the epidemic in eastern Uganda demonstrates the limits rather than the strengths of Ugandan psychiatry in the early post-colonial period. There remained a distance between psychiatrists and their patients that was only reinforced by the methods of examination, the explanations used, and the treatments suggested.

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[622] T.A. Lambo, 'The Village at Aro', in Maurice King (ed.), *Medical Services in Developing Countries* (Nairobi: Oxford University Press, 1966).
[623] Frederick Cooper and Ann Laura Stoler, *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley & Los Angeles, California: University of California Press, 1997), pp. vii-viii.

Witchcraft, fear, and suggestibility

The idea that Africans were prone to periodic outbursts of mass instability had been present in medical and ethnographic literature since the mid-nineteenth century. Writing in 1867, the Scottish medical missionary and physician to the Court of Madagascar, Andrew Davidson, recalled how a few years previously parts of Madagascar had been taken over by a strange disease. People had become 'restless and nervous, and if excited in any way, more especially if they happened to hear the sound of music or singing, they got perfectly uncontrollable, and, bursting away from all restraint, escaped from their pursuers, and joined the music, when they danced sometimes for hours on end with amazing rapidity'.[624] Davidson labelled these behaviours as choreomania, which he defined as 'a psycho-physical disease, in which the will, intellectual faculties, and moral feelings are all more or less perverted'.[625]

Such accounts formed part of a broader attempt to describe and define what constituted 'normal' and 'abnormal' behaviour. Infusing their work with notions of European racial and cultural superiority, authors dismissed indigenous cultural practices and beliefs as evidence of psychopathology. Indeed, as Megan Vaughan has demonstrated, the distinction between witchcraft and madness was frequently blurred: 'It was 'normal' (if punishable) for an African to believe in witchcraft—it

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[624] Andrew Davidson, 'Choreomania: An Historical Sketch, with Some Account of an Epidemic Observed in Madagascar', *Edinburgh Medical Journal* XIII (1867), pp. 124-36 at pp. 131-2.
[625] Ibid., pp. 125-6. Another account can be found in Andrew Davidson, 'The Ramanenjana or Dancing Mania of Madagascar', *Antananarivo Annual and Madagascar Magazine* IV (1889), pp. 19-27. Davidson added that 'No one who saw it can doubt that it was perfectly real as a psychopathy, and no one of candour or discrimination will deny that a certain amount of imposture was practised. It was more difficult however than one might suppose, to feign this disease and act it out consistently'. Ibid., p. 25.

was not 'normal', however, to suffer from paranoid delusions'.[626] Such was the power of these beliefs, it was said, that Africans could will themselves to die.[627]

In Uganda, medical missionaries certainly presented fear of witchcraft, spirits and 'superstition' as a form of pathology, employing it as a pertinent symbol in the battle against 'heathenism'. The Bishop J.J. Willis commented in 1911 that beliefs associated with heathenism, such as spirit possession, had serious physical and mental consequences on the African: 'the mind becomes from childhood terrorized. It lives in an unreal world of its own creation. Nervous diseases and mental derangement are the result only too often, especially among women and girls'.[628] Writing in 1927, A.T. Schofield, of Toro Hospital, noted how he could:

> best illustrate the effects of heathenism and the difficulties of the Christian teacher by telling you the story of this man's daughter, whom we had in hospital recently, suffering from the effects of witchcraft. It may seem strange to some of you that a doctor seriously talks of witchcraft, but I have had too many emphatic cases not to take it as a fact. Whether it is in the nature of hypnotism, or something in the little explored sphere of psychology, I do not know, but the fact remains that this "possession by demons" is a very common thing out here….She was rather an attractive girl of about 16, intelligent, and hoping to become a teacher. She had been threatened by a man who had often been suspected of these heathen practices, and, finally, in the presence of two other people, he further threatened to bewitch her if she would not do as he wanted. On her refusing him again, and still with these witnesses present, he used his "arts" to such an effect that she fell down unconscious. Her friends tried all they could for a whole day, but nothing could bring her round. They then brought her into hospital, and I thought she was actually dying, though I could find nothing whatever the matter with her.[629]

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[626] Vaughan, *Curing Their Ills*, p. 106. See also Parle, 'Witchcraft or Madness?'.
[627] See, for example, Margaret Wrong, 'Mass Education in Africa', *African Affairs* (1944), pp. 105-11 at p. 109.
[628] J.J. Willis, 'The Mind of an African', *Church Missionary Review* 62(749) (1911), pp. 532-9 at p. 536.
[629] A.T. Schofield, 'Some Patients at Toro', *The Mission Hospital* no. 353 (1927), p. 138.

Schofield's comments would not have been unusual to readers back home—the C.M.S. medical mission journal had included reports of possession by demons and spirits from other parts of Africa, as well as Persia and India, since its inception in 1897.[630] Moreover, the study of mesmeric and spiritualist phenomena in Europe had led some Christian physicians in England to speculate on the reality of demonic possession, drawing on new theories of hypnotism, unconscious suggestion and parasitic invasion.[631] Indeed, while Schofield's comments were clearly designed to demonise Batoro beliefs and practices, there is some evidence to suggest that Schofield actually believed his own account of possession: according to the admissions register for Toro Hospital, in January 1927 a sixteen year old girl, Ruzi M., was admitted to the hospital, with the entry under 'Diagnosis' reading 'Bewitched'. The girl stayed at the hospital for eleven days, before being discharged 'cured'.[632] Indeed, in his account of the possession of Ruzi, Schofield stressed the power of western medicine and Christianity to cure:

> By means of emergency restoratives and forcible feeding we kept her alive for a day or two, and then gave her very strong hypnotics to try to get her free from the coma she was in. When we saw the effects of this somewhat working off, we prayed for her, and told her in a loud voice that Jesus was going to drive out the "demons," and later that they had left her, producing an effect such as our Lord's miracles must have had on those who saw them. She sat up and was her healthy self from that moment.[633]

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[630] See, for example, 'Items: Home and Foreign', *Mercy and Truth* no. 53 (1901), p. 161; W.D. Charis Pigott, 'Opportunities in Kerman', *The Mission Hospital* no. 429 (1933), pp. 259-62.
[631] On spiritualism and mesmerism in Europe, see especially: Rhodri Hayward, 'Demonology, Neurology, and Medicine in Edwardian Britain', *Bulletin of the History of Medicine* 78 (2004), pp. 37-58; Janet Oppenheim, *The Other World: Spiritualism and Psychical Research in England, 1850-1914* (Cambridge: Cambridge University Press, 1985); Alison Winter, *Mesmerized: Powers of Mind in Victorian Britain* (Chicago: University of Chicago Press, 2000).
[632] KHR (Toro Hospital Admission Registers), 1927, no. 79.
[633] Schofield, 'Some Patients at Toro'.

Just as Ruzi had potentially been affected by unconscious suggestion, so suggestion and prayer cured the patient, producing a visible transformation that both the girl and those present could witness. In so doing, Schofield was commenting as much on his personal role as a medical missionary as he was about Christianity's power.

Accounts of mass instability proliferated with the expansion of colonial rule from the end of the nineteenth century. Observers of the *amandiki* women in Zululand at the beginning of the twentieth century offered a number of different explanations for *indiki* possession, including witchcraft, healing cults, and 'hysterical mania'. In describing the behaviour of the *amandiki*, many colonial officials and missionaries also drew on the gendered language of hysteria that was prominent in Europe at the time.[634] In Nigeria in 1940, M.D.W. Jeffreys, a colonial administrative officer, included an outbreak of 'religious fervour' in the Calabar Province in his account of 'psychical phenomena' in Africans. 'Victims', he noted, 'declared themselves possessed of the spirit and giving way to paroxysms of dancing [and] finally collapsed in insensibility which usually ended in a return to sanity. Large masses moved about the country singing religious hymns'.[635] In Kenya, too, ethnologists described how 'psychical disturbances of a religious character pass like epidemics over the Kamba country'. These disturbances, known locally as *kijesu*, were categorised variously as 'infectious hysteria' and 'epidemic mania', and were given a distinctly political tone—at Ulu, according to Gerhard Lindblom, people went into convulsions at the mere sight of a European.[636]

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[634] Parle, *States of Mind*, ch. 3; Parle, 'Witchcraft or Madness?'.
[635] M.D.W. Jeffreys, 'Psychical Phenomena among Negroes', *Journal of the Royal African Society* (1940), pp. 354-60 at p. 355.
[636] Gerhard Lindblom, *The Akamba in British East Africa: An Ethnological Monograph* (Uppsala: Archive d'Etudes Orientales, 1920), p. 239. For a fuller treatment of *kijesu* see Mahone, 'The Psychology of Rebellion', pp. 243-4.

The epidemic nature of these disturbances was particularly worrying for medical practitioners and colonial administrators: if unchecked, mass instability had the potential to spread and destabilise whole regions.[637] These fears were reinforced from the 1920s and 1930s, when, as described in Chapter I, psychologists and anthropologists started to discuss how education and urbanisation could 'detribalise' the African and trigger a particularly 'European' type of insanity, characterised by delusions of power and control.[638]

Such ideas were certainly present in reports on 'outbreaks' of mass fervour and spirit cults in Uganda, where they operated as useful explanatory tools. One of the most threatening movements for administrators in early colonial Uganda was that of the fertility goddess *Nyabingi* in Kigezi District, characterised by contemporary observers as an anti-colonial 'society' or 'cult', and refigured more recently as a set of logics and practices associated with attempts to gain redress for misfortune.[639] In one of the most notorious incidents linked to *Nyabingi*, a horde of Bakiga stormed a local government station at Nyakishenyi, killing sixty-three government employees and family members working under the supervision of a Muganda Agent. Responding to the attack in a report in 1917, the DC of Kigezi District, J.M.M. McDougall, dismissed the suggestion that the rebellion indicated anti-Baganda sentiment.[640] Instead, witchcraft was to blame: '[a]s might be expected among unsophisticated savages the powers of superstition are enormous. This explains the influence of the local witchdoctors, who initially combine their claims to supernatural powers with promises of liberation of the natives from European rule and restoration

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[637] Mahone, 'The Psychology of Rebellion'.
[638] Carothers, 'A Study of Mental Derangement'; Vaughan, *Curing Their Ills*, ch. 5.
[639] Vokes, *Ghosts of Kanungu*, ch. 2.
[640] F.S. Brazier, 'The Incident at Nyakishenyi, 1917', *Uganda Journal* 32(1) (1968), pp. 17-27; Vokes, *Ghosts of Kanungu*, pp. 35-6.

to their former condition'.[641] Two years later, a new DC, Captain J.E.T. Philipps, updated this theory, drawing, as Schofield had done with Ruzi M., on ideas about hypnotism and unconscious suggestion. For Philipps, *Nyabingi* practices were spreading '[b]y means of an unusually developed form of Witchcraft, in which hypnotic suggestion plays a leading part, the country within the sphere of its operations is completely terrorised'.[642]

Even more worrying for the colonial administration were the actions of the prophet 'Mathias', whose speeches to crowds in Kampala in 1955 not only urged the Baganda to withhold taxes until the return of the exiled Kabaka Mutesa II, but culminated in an outbreak of violence and the death of a European police officer.[643] According to a government intelligence report, Mathias Sewanyana claimed he was:

> inspired by the old Buganda god of war, Kibuka, and started a series of prophecies from a tree on a hill near Mpigi (about 20 miles west of Kampala), which is a traditional burial place of this god. Two days later he transferred the scene of this activities to Mutundwe Hill, two or three miles from Kampala. He told the crowds who flocked to see him that if they produced beasts and chickens for sacrifice, he would secure the return of Mutesa. He went on to advocate a return to the old form of Kiganda religion and told people to stop going to Church or to the Mosques, and also incited people not to pay the new graduated tax, until Mutesa returns to Buganda. Many credulous Baganda credited Kibuka with supernatural powers, and in a very short time he had gathered around himself a crowd of fanatical supporters. As time went on his speeches became wilder and more aggressive and it appeared

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[641] Elizabeth Hopkins, 'The Nyabingi Cult of Southwestern Uganda', in Robert I. Rotberg and Ali A. Mazrui (eds), *Protest and Power in Black Africa* (New York: Oxford University Press, 1970), p. 291.
[642] As cited in Holger Bernt Hansen, 'The Colonial Control of Spirit Cults in Uganda', in David M. Anderson and Douglas H. Johnson (eds), *Revealing Prophets: Prophecy in Eastern African History* (London: James Currey, 1995), p. 154. On Nyabingi see especially Steven Feierman, 'Colonizers, Scholars, and the Creation of Invisible Histories', in Victoria E. Bonnell and Lynn Hunt (eds), *Beyond the Cultural Turn: New Directions in the Study of Society and Culture* (Berkeley & Los Angeles: University of California Press, 1999); Vokes, *Ghosts of Kanungu*.
[643] TNA, CO 822/812 (Disturbances Caused by the Activities of a Young Muganda "Mathias", in Uganda).

that he was practising certain forms of witchcraft.[644]

As with accounts produced elsewhere in colonial Africa, the belief that Africans were highly susceptible to prophets such as Mathias was not questioned. Discussions about individual 'outbreaks' in Uganda, however, appear to have been treated in a localised manner. Colonial administrators made no reference to other prophet or spirit cult movements in East Africa in their consideration of Mathias in 1955, despite the brief extension of *Dini ya Msambwa* activities from Kenya to eastern Uganda in 1948 and the infamy of its leader Elijah Masinde, who was committed to Mathari Mental Hospital for two years.[645]

Sloan Mahone has argued that accounts of 'mass instability' in colonial Kenya formed a body of 'remembered evidence' that had practical applications for colonial rule and eventually fed into Carothers' infamous account of Mau Mau in 1954.[646] While accounts of mass fervour in Uganda drew on the same types of psychologised language, they never had the same political gravitas as they did in Kenya. As Holger Bernt Hansen has suggested on official attitudes towards spirit cults, '[w]ith the changing personnel, the memory span of the colonial service was evidently short, and policy as a consequence often appeared random'.[647] When *Nyabingi* became active again in 1928, for example, the DC Kigezi was asked to prepare a new report into the movement's origins, history, and objectives—the Uganda Secretariat apparently unaware of previous correspondence and statements

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[644] Ibid., Uganda Monthly Intelligence Appreciation for the period ended 28th February 1955, para. 15.
[645] Pamela Khanakwa, 'Masculinity and Nation: Struggles in the Practice of Male Circumcision among the Bagisu of Eastern Uganda, 1900s to 1960s' (unpublished PhD thesis, Northwestern University, 2011), pp. 179-81; Mahone, 'The Psychology of Rebellion', pp. 250-1.
[646] Mahone, 'The Psychology of Rebellion'.
[647] Hansen, 'The Colonial Control', p. 155.

on the subject.[648] The 'hysterical' symptoms shown by six girls at the CMS Namutumba School in Busoga in 1941, moreover, was presented by the local MO and Provincial Education Officer as an isolated incident, prompted more by menstruation, over-crowding, and poor ventilation in the school, than any fear of witchcraft.[649]

The early 1960s saw the emergence of what was deemed to be a new and troubling phenomenon of mass hysteria. Despite regional administrative memories and explanations for mass instability, medical officers and administrators in Uganda failed to draw connections with their own national experience. Instead, when the expatriate and African medical practitioners came to investigate the epidemics of mass hysteria of the early 1960s they would turn to other explanatory frameworks of African psychopathology.

Epidemics of laughing, crying, and violence

In 1963, A.M. Rankin, Professor of Medicine and P.J. Philip, MO, described how a 'disease' of 'laughing, crying and restlessness' had started the previous year at a mission-run girls' school twenty-five miles from Bukoba, Tanganyika. In the subsequent months, the condition spread to other schools, affecting male and female pupils equally, but none of the European or African teachers.[650] A typical patient, according to Rankin and Philip:

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[648] Ibid.
[649] JDA, M/5/1 (Medical Department Correspondence), f. 47, letter from M.E. Laight, CMS Iganga, Busoga, to the Provincial Education Officer, Eastern Province, 29 December 1941. Other isolated examples can be found in KDA, MED 4I (Infectious and Contagious Diseases I), f. 126, letter from Yeremiya Bigombe, Saza Chief, Ruzhumbura, to the District Medical Officer, Kabale, 8 May 1958; MMU, MED 1076(294) (Medical: Monthly Reports and Policy), f. 235, 'Monthly Commentary for April, 1962'.
[650] Rankin and Philip, 'An Epidemic of Laughing', p. 168.

> has had some very recent contact with someone suffering from the disease. The incubation period is from a few hours to a few days. The onset is sudden, with attacks of laughing and crying lasting for a few minutes to a few hours, followed by a respite and then a recurrence. The attack is accompanied by restlessness and on occasions violence when restraint is attempted.[651]

In their discussion, Rankin and Philip pointed to some of the local explanations for the epidemic, which included a 'belief that the atmosphere has been poisoned as a result of the atom bomb explosions'.[652] Many of their patients, they continued:

> say that they are frightened of something, but do not give any further information. They appear to fear that someone is chasing them. There is a definite belief that this is a contagious condition of some kind. One villager described it as a spreading madness.[653]

Rather than pursuing these explanations as signs of psychopathology, Rankin and Philip took blood and lumbar puncture samples, conducted physical examinations, and tested local food substances, searching for an organic cause that they could identify and treat pharmaceutically.[654] The invasiveness of their approach is striking, particularly in light of widespread anxiety over the use of needles in public health campaigns. Lumbar punctures were not only extremely painful, but required the patient to be forcibly held down, an experience that could in itself evoke horror and psychic disturbance.[655] If Rankin and Philip's patients were indeed 'frightened of something', then their encounters with western medical technologies would hardly

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[651] Ibid., p. 167.
[652] Ibid., p. 168.
[653] Ibid.
[654] Ibid.
[655] Lyons, *The Colonial Disease*, p. 84; Luise White, *Speaking with Vampires: Rumor and History in Colonial Africa* (Berkeley & Los Angeles: University of California Press, 2000).

have eased any anxiety. Nevertheless, when the tests came back negative, Rankin and Philip concluded that mass hysteria was the only remaining explanation.

A few months later, the District Medical Officer (DMO), Kigezi, reported that there had been an 'out break [sic.] of lunacy' in the District. Kigezi High School was closed, and large sections of the rural population affected.[656] The DMO took steps to request assistance from Mulago Hospital, as well as the services of a government psychiatrist. Yet while blood tests were carried out among those affected, and 'tablets' distributed 'in order to mitigate the effects of the attack', no specialist help was forthcoming.[657] Ten months later, the Kigezi District Team complained that despite the fact that the epidemic was still ongoing, 'no Government psychiatrist had come for investigation', and urged the DMO to take the matter more seriously.[658] The historical record leaves no further traces of the epidemic. Neither does it provide any indication of why no specialist help was available during an epidemic that was reported to have affected well over 600 people.[659] When similar reports were received from MOs in Mbale, over 400 miles away, the response from Entebbe was quite different. As the Kigezi District Team continued to struggle with their epidemic, Kagwa was released from his duties at Butabika Hospital to travel to eastern Uganda, and to initiate a scientific investigation.

Benjamin Kagwa's paper on the epidemic at Mbale in 1963-4 came to the same conclusion as that of Rankin and Philip. Rather than reaching his diagnosis by process of elimination, however, Kagwa felt that he was able to prove, 'without

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[656] ACMM, 'Ministry of Health, Uganda, Annual Report for the Year from 1st July 1963 to 30th June 1964', p. 16; KDA (Minutes of the Kigezi District Team), Tuesday, 6 August 1963, 'Minute 45/63: Lunacy Epidemic in Kinkizi'.
[657] KDA (Minutes of the Kigezi District Team), Monday, 14 October 1963, 'Minute 59/63 (b): Lunacy Epidemic'.
[658] Ibid., Monday, 4 May 1964, 'Minute 36/54 (b): Lunacy Epidemic'.
[659] This figure may, of course, have been exaggerated. My research assistant and I were unable to locate anyone who could remember such an event.

doubt', the diagnosis of hysteria. In describing the epidemic of 'running mania', Kagwa divided the madness into three stages. The first came on suddenly and lasted three to four days. It was characterised by 'marked agitation, talkativeness, violence, attempted assaults and petty robbery, with anorexia and a craving to smoke'. The second was marked by sporadic relapses of hyperactivity, lasting one to two weeks. And the third was characterised by 'improvement in mood, affability and a willingness to be interviewed'.[660] According to his research, all of the original cases were Bagisu men and women, either illiterate or near-illiterate, and in no position of authority.[661]

In discussing possible causes for the outbreak, Kagwa noted that while those affected believed very strongly that the madness was caused by ancestral spirits. 'All this was said to be done', Kagwa asserted:

> in response to the orders of the spirits of dead family elders. This phase had a quality of a quasi-manic reaction with obvious transparent delusions and hallucinations. Those affected stated that they could see the faces and hear the voices of their dead elders.[662]

Surprisingly, Kagwa did not pursue this line of inquiry, despite the prominence of psychiatric theories, influenced by psychoanalysis, which stressed how an individual or group's ideas, fears, and anxieties could produce hysteria.[663] Like Rankin and Philip, Kagwa instead initiated a series of invasive physical and neuropsychiatric tests that included lumbar punctures, hypnosis, drug abreaction, and the pushing of

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[660] Kagwa, 'The Problem of Mass Hysteria', pp. 560-1.
[661] Ibid., p. 561.
[662] Ibid., p. 560.
[663] Arthur P. Noyes and Lawrence C. Kolb, *Modern Clinical Psychiatry* (Philadelphia & London: W.B. Saunders Company, 1963), pp. 430-6.

pins an inch deep into the flesh in order to show total anaesthesia.[664] Ignoring the possibility that his actions had caused distress, Kagwa asserted that his tests and interviews showed 'several objective classical hysterical findings'. These included 'sudden onset of the attacks, sudden clearance of symptoms', and total numbness. For Kagwa, 'all clinical studies proved, without doubt, the diagnosis of conversion hysteria'.[665]

In making this statement, Kagwa was using his physical examination of individuals to diagnose the collective. This, he justified by noting that 'one striking feature' of the three epidemics was 'the stereotypy of symptoms in each particular ethnological group. The "attacks" and spread of similar symptoms ran along tribal lines. Even in instances where it spread over geographical borders the epidemics affected only members of the same tribe and culture'.[666] These comments mirrored those made by administrators and physicians under colonial rule in so far as they assumed that Africans, as a group, were highly susceptible to mental instability. In his analysis of the epidemics as an East African 'problem', however, Kagwa would look to a wider variety of sources for an explanation. In so doing, he would conflate ethnicity and culture, with race.

The 'problem' of mass hysteria

Discussing the historical background of mass hysteria, Kagwa noted that '[h]ysteria, as a human behavioural phenomenon, can be traced as far back as the beginning of man's rational psycho-social development'; it was functional, providing

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[664] Kagwa, 'The Problem of Mass Hysteria', p. 565.
[665] Ibid.
[666] Ibid.

an 'outlet for dammed-up instinctive demands'.[667] In so doing, Kagwa stressed the existence of a single humanity and the universal applicability of psychiatry: Africans were different from Europeans, but they were not totally out of reach. Instead, Africans were at a stage in their development in which they were particularly susceptible to psychological breakdown:

> In the less developed countries of Africa young people are between Scylla and Charybdis. At the schools and churches they are indoctrinated with new beliefs, but at home they live continuously exposed to traditional mores and folkways. This results in a moral and emotional conflict which must be resolved in one way or another. To allay or eliminate the anxiety one may choose between reverting to "going native" and total Westernization.[668]

The ideas informing this assertion had gained credibility in Africa during the 1930s and 1940s, particularly among those working in Southern Africa.[669] B.J.F. Laubscher, a strong proponent of psychoanalysis, declared in his study of the Tembu of South Africa in 1937 that:

> The native's attitude and reactions towards witchcraft have some analogy to the thinking and acting of the compulsive neurotic patient. Both are struggling against the dynamic expressions of forbidden impulses. The obsessional neurotic is defending himself against the impulses from his own mind, while the native is defending himself against impulses from the world of mythical beings.[670]

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[667] Ibid., p. 562.
[668] Ibid., p. 566.
[669] For more on psychoanalysis and ethnopsychiatry in Southern Africa, see especially: Saul Dubow, 'Wulf Sachs's Black Hamlet: A Case of 'Psychic Vivisection'?', *African Affairs* 92(369) (1993), pp. 519-56; Khanna, *Dark Continents*; Wulf Sachs, *Black Hamlet* (Baltimore: John Hopkins University Press, 1996, first published 1937).
[670] B.J.F. Laubscher, *Sex, Custom and Psychopathology: A Study of South African Pagan Natives* (London: George Routledge, 1937), p. 51.

These works saw human psychology as operating on an evolutionist spectrum, with Africans and Europeans occupying different places in their psychological development. Thus for Laubscher, while Europeans were subject to mental conflict brought on by repression and infantile urges, they were largely capable of adapting to the demands of society. Africans, by contrast, relied on 'rituals, ceremonies and sacrifices' to deal with change and the 'forbidden impulses' of the mythical world.[671]

In his analysis, Kagwa drew heavily on Carothers' notion that the introduction of western culture into Africa was upsetting an 'equilibrium', and that Africans were ill-equipped, both racially and environmentally, to cope with these changes.[672] Echoing these ideas, Kagwa noted that:

> Consciously or unconsciously, at this period of their development, the majority of Africans have conflicts of great psychological dimensions, though they may differ in character. For example, among the educated the conflict may be verbalized in terms of political, economic or educational unrest and action, while among the illiterate and near-illiterate confusion of ideas and emotions, as well as substitution of mysticism for logic, is the rule….the latter group, which is of course in the majority, has been thrust into sudden religious and political changes without preparation.[673]

Statements about the dangers of 'development', as with a number of contentions in Carothers' *The African Mind in Health and Disease*, were highly controversial among psychiatrists, psychologists, and anthropologists during the 1950s and 1960s. Yet while the WHO, which had commissioned the text, acknowledged that it 'does not command general agreement on its particular theme', the WHO stood publicly by

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[671] Ibid., pp. 50-1.
[672] Kagwa quoted from J.C. Carothers, *The African Mind in Health and Disease: A Study in Ethnopsychiatry* (Geneva: World Health Organisation, 1953).
[673] Kagwa, 'The Problem of Mass Hysteria', p. 565.

the text as late as 1962 as a 'good example' of an investigation 'of the peculiar qualities of mental organization in individual cultural groups'.[674]

While Kagwa drew on ideas about 'psychic trauma', 'culture contact', and 'deculturisation' that had been used by psychiatrists and anthropologists since the 1930s, he was also keen to stress that his analysis did not mean that mass hysteria was a cultural or racial peculiarity. There was 'much historical evidence', Kagwa noted, 'to prove that emotional upheavals associated with hysteria occur whenever a people's cultural roots and beliefs become suddenly shattered'.[675] These precedents included demon possession in the Bible, the hysterical deliria of saints, and epidemics of dancing mania in Metz, Cologne, and Aix-la-Chapelle in the fourteenth and fifteenth centuries.[676] In looking for an explanation for the events in Bukoba, Rankin and Philip had also turned to historical examples of mass hysteria from thirteenth and fourteenth-century Europe. They noted that:

> The middle ages in Europe produced several epidemics of mass hysteria, of which the dancing manias of Germany and Italy are the best known (Major, 1954). These followed on the Black Death and are assumed to be a product of the dislocation of normal life caused by the plague.[677]

By including these examples, Rankin, Philip, and Kagwa were following a trend in medicine in Europe and America of analysing historical accounts of disease, as if it might aid understanding of why and when epidemics of hysteria might occur.[678] An

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[674] World Health Organization, *WHO and Mental Health 1949-1961* (Geneva: World Health Organization, 1962), p. 34. Copies of reviews and complaints about *The African Mind* can be found in WHOA, M4/445/13 (Carother's Study on Mental Health in Africa).
[675] Kagwa, 'The Problem of Mass Hysteria', p. 565.
[676] Ibid., pp. 562-3.
[677] Rankin and Philip, 'An Epidemic of Laughing', p. 170.
[678] See, for example, George Rosen, 'Psychopathology in the Social Process: I. A Study of the Persecution of Witches in Europe as a Contribution to the Understanding of Mass Delusions and

editorial on mass hysteria published in the *British Medical Journal* in 1966, for example, proclaimed that:

> Mass outbreaks of alterations of consciousness, seizures, hyperventilation, and severe emotional upsets were much commoner in the Middle Ages than they are today, at least in Europe. Their frequency declined as it became generally recognized that the symptoms were due to mental disturbance and not to the work of the Devil or other supernatural influences. But epidemics do recur from time to time when conditions are propitious.[679]

The problem with this approach was the way it assumed that mass hysteria had always existed in a universal and recognisable form and that retrospective diagnoses could shed light on present understandings.[680] Indeed, for Rankin, Philip, and Kagwa, mass hysteria was an objective reality; it could spread from person to person just as other types of epidemic disease were 'caused by the spread of viruses, bacteria or parasites'.[681]

Rankin and Philip concluded their article by noting that mental illness 'is influenced by the culture of the particular community'. Referring to Amok, Latah, Koro, and 'Arctic Hysteria in Siberia', they stressed that a study of the cultural context would be necessary if further conclusions were to be drawn from the epidemic in Tanganyika. Kagwa, confident of his understanding of mental illness across different cultures, was more certain in his analysis of the relationship between culture, westernisation, and mass mental instability. He saw no contradiction between

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Psychic Epidemics', *Journal of Health and Human Behavior* 1(3) (1960), pp. 200-11; F.K. Taylor and R.C.A. Hunter, 'Observation of a Hysterical Epidemic in a Hospital Ward', *Psychiatric Quarterly* 32(4) (1958), pp. 821-39.

[679] 'Epidemic Hysteria', *British Medical Journal,* 26 November 1966, p. 1280.

[680] Robert E. Bartholomew, 'Tarantism, Dancing Mania and Demonopathy: The Anthro-Political Aspects of 'Mass Psychogenic Illness', *Psychological Medicine* 24 (1994), pp. 281-307.

[681] Rankin and Philip, 'An Epidemic of Laughing', p. 167.

his finding that the epidemics ran along ethnic lines and his belief in the existence of a homogenous African culture that was susceptible to mass instability.

This 'African culture' was the only useful unit of analysis, just as it had been for Carothers—there was little room for socio-economic change, cultural diversity, or individual patients. As we shall see in the final two sections, it was Kagwa's attempt to understand the epidemics through this particular theoretical lens that accounts for the conceptual gap between him and the local Bagisu community.

Multiple explanations for madness

Kagwa could have found plenty of socio-economic tensions in the Mbale region had he looked for them. Not only were administrative structures at the local level being dismantled as President Milton Obote and the Uganda People's Congress attempted to assert their control over the districts.[682] Moreover, in an already densely populated area, there was increasing pressure on land and fluctuating coffee prices, contributing to a perception that theft, bhang growing, drinking, witchcraft, and violence were getting out of control.[683] Such was the extent of fear over these issues that from the mid-1960s two types of neighbourhood organisations—vigilante groups and drinking companies—were formed across Bugisu in order to curb social activities that were deemed to be dangerous.[684] The local administration, too, started to meet regularly to question how they could respond to the rising homicide rate and general unrest in the area.[685]

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[682] Suzette Heald, *Controlling Anger: The Anthropology of Gisu Violence* (Oxford: James Currey, 1998), p. 245.
[683] MDA, MBL/4/57 (Marriage, Customs, Witchcraft etc.), letter from DC Bugisu to District Forestry Officer, Bugisu, Mbale, 9 May 1960; Heald, *Controlling Anger*, pp. 1.
[684] Heald, *Controlling Anger*, pp. 229-30.
[685] MDA, MBL/4/68 (Homicide in Bugisu).

If this prompted mass action or healing in the form of a protest cult, it was not recognised as such by anthropologists, psychiatrists, or those affected.[686] Nevertheless, Bagisu elders living in the area surrounding Mbale recalled that there was a time when madness was common, when 'so many people were attacked around the villages'.[687] They remembered how some people became aggressive, felt hot, and cried uncontrollably, while others suffered from headache, itchiness, and ran wild. 'At times I would feel like I was losing my senses', one informant recalled, 'and some times could not trace my home'.[688] 'He was very much aggressive and sometimes silent', as another informant spoke of a man in a neighbouring village. Such was his confusion in his final days, she added, that he wandered into the path of a vehicle and was killed.[689]

Although there was some uncertainty about the exact period, the madness (*tsitsoli*) was said have come suddenly at some point during the years immediately preceding and following independence, lasted a few months, and never recurred. It was if mass madness, as a number of elders described it, was a 'disease of that time' (*lufu lwembuka yo*), just as HIV/AIDS is regarded as a disease of today.[690] This way of remembering the epidemic both indicated the extent to which it had affected families and communities, and pointed to the ways elders in Bugisu periodised time

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[686] Terence Ranger, for example, has argued that prophets in eastern and southern Africa have arisen during periods of unrest, and 'the collapse or perceived inadequacy of 'traditional' public health control systems'. Terence O. Ranger, 'Plagues of Beasts and Men: Prophetic Responses to Epidemic in Eastern and Southern Africa', in Terence O. Ranger and Paul Slack (eds), *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* (Cambridge: Cambridge University Press, 1992), p. 247.
[687] Interview MLE-06.
[688] Interview with Mugisu male, approximately 71 years old (MLE-11), Marere Village, Bukasakya Sub-County, Mbale District, 27 October 2011.
[689] Interview with Mugisu female, approximately 70 years old (MLE-15), Malukhu Housing Estate, Mbale District, 31 October 2011.
[690] Interview with Mugisu female, approximately 80 years old (MLE-09), Marare Village, Bukasakya Sub-County, Mbale District, 27 October 2011; Interview with Mugisu female, approxiately 74 years old (MLE-13), Marare Village, Bukasakya Sub-County, Mbale District, 27 October 2011; Interview MLE-15; Interview with Mugisu male, approximately 77 years old (MLE-12), Marere Village, Bukasakya Sub-County, Mbale District, 27 October 2011.

by major events and disturbances. Gisu circumcision names (*kamengilo*), as Pamela Khanakwa has explained, were usually associated with significant social, economic, and political events.[691] The 1966 circumcision name, for example, was *muwambe*, meaning 'capture, catch or hold him', and referred directly to a spate of forced circumcisions that had occurred across Bugisu.[692]

The madness was said to have come and spread with the wind (*imbewo*)[693]. According to Bagisu elders, while it was more common among the youth, it did not discriminate by gender, education, or age.[694] This, they added, was due to the will of *were*, the creator spirit.[695] In explaining the madness, a number of explanations were put forward, including a curse from the ancestors and witchcraft (*liloko* and *bulosi*).[696] One informant stressed her uncertainty over the cause of the madness, instead adding that other people had a theory that it was due to 'sophisticated bombs'.[697] Another was certain that it had come from 'outside', being perhaps an

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[691] Khanakwa, 'Masculinity and Nation', p. 53.
[692] Ibid., p. 236. Circumcision year names from 1801-1970 are listed in Margaret Macpherson *et al.*, 'Circumcision Year Names (Kamengilo) in Masaba & Their Meanings', *Uganda Journal* 39 (1980), pp. 59-75. In 1964, the age-group name was *umuinga*, referring to the appointment of Y.S. Mung'oma as the first constitutional head of Masaba (Mount Elgon). Ibid., p. 73.
[693] Interview with Mugisu female, approximately 81 years old (MLE-03), Manyonyi Lower Village, Bungokho Sub-County, Mbale District, 27 October 2011; Interview with Mugisu female, approximately 75 years old (MLE-04), Manyonyi Lower Village, Bungokho Sub-County, Mbale District, 27 October 2011; Interview with Mugisu female, approximately 60 years old (MLE-05), Manyonyi Lower Village, Bukasakya Sub-County, Mbale District, 27 October 2011; Interview MLE-07; Interview MLE-09; Interview with Mugisu male, approximately 81 years old (MLE-02), Manyonyi Lower Village, Bumageni Sub-County, Mbale District, 27 October 2011. Heald has noted that the Bagisu describe the *basambwa*, ancestral spirits, as 'like the wind'. Heald, *Controlling Anger*, p. 205.
[694] Interview MLE-03; Interview MLE-04; Interview MLE-05; Interview MLE-07; Interview with Mugisu female, approximately 80 years old (MLE-08), Marare Village, Bukasakya Sub-County, Mbale District, 27 October 2011; Interview MLE-09; Interview MLE-13; Interview MLE-15; Interview MLE-16; Interview with Mugisu male, approximately 80 years old (MLE-01), Manyonyi Lower Village, Bumageni Sub-County, Mbale District, 27 October 2011; Interview MLE-06; Interview with Mugisu male, approximately 70 years old (MLE-10), Marere Village, Bukasakya Sub-County, Mbale District, 27 October 2011; Interview with Mugisu male, approximately 77 years old (MLE-18), Maranga Village, Bungokho Sub-County, Mbale District, 1 November 2011.
[695] Interview MLE-08; Interview MLE-15; Interview MLE-16; Interview MLE-10; Interview MLE-12; Interview MLE-18.
[696] Interview MLE-03; Interview MLE-04; Interview MLE-05; Interview MLE-07; Interview MLE-08; Interview MLE-13; Interview MLE-16; Interview MLE-01; Interview MLE-06; Interview MLE-12.
[697] Interview MLE-07.

unknown force from Europe.[698] No contradiction was seen in the diversity of explanations: ideas about agency behind the madness reflected the more general belief that while the creator spirit was in charge of fate, agency could be ascribed to sorcery, the anger of the ancestors, or other spirits.[699] It is interesting, however, considering Kagwa's description of one of the main symptoms as a 'running mania', that one of the words for witchcraft or supernatural attack, *bulosi*, is also used by the Bagisu to denote violence and aggression.[700]

Looking at the *amandiki* of early twentieth century Zululand, Julie Parle has highlighted the ways in which ideas about spirit possession and mental illness reflect 'a variety of opinions, the diversity of which is testimony to its complicated and shifting nature, and the 'accuracy' of which may reflect only one of a variety of meanings across both time and space'.[701] This insight is reinforced by the competing explanations of mass hysteria in 1960s Uganda: the extent to which Bagisu elders recalled uncertainty and suspicion, both towards the behaviours they witnessed and the people who came to investigate, remind us that historians should not focus solely on diagnosis. One male Mugisu, for example, recalled two Europeans coming to conduct an investigation into the local water supply at the same time as people in his and nearby villages were running mad. These Europeans, he believed, were only interested in the water because the madness had 'started from abroad….In countries like Germany'.[702] This explanation might be best attributed to anxieties about the nature of medical research and colonial rule. But it could also be taken as an

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[698] Interview MLE-02.
[699] Jean La Fontaine, *The Gisu of Uganda* (London: International African Institute, 1959), p. 50; Jean La Fontaine, 'Witchcraft in Bugisu', in John Middleton and E.H. Winter (eds), *Witchcraft and Sorcery in East Africa* (London: Routledge & Kegan Paul, 1963), p. 191, fn. 1.
[700] Heald, *Controlling Anger*, p. 6; La Fontaine, 'Witchcraft in Bugisu', p. 192.
[701] Parle, *States of Mind*, p. 157.
[702] Interview MLE-02.

indication of the cultural and political gulf between the Bagisu, the local authorities, and western medical practitioners. What for the two Europeans was have been a routine and unobtrusive water test, became for this Mugisu something altogether more disturbing.[703]

These different ways of 'seeing' and understanding were not resolved with the coming of independence or with the emergence of African psychiatrists. Kagwa may have been an African by birth, but he was a Muganda, not a Mugisu, and his years in the United States had further distanced him from the people he was trying to help. As Kagwa noted later, he had returned to Uganda with a set of assumptions about the African mind that were rooted in western psychiatric theory, rather than any special 'insight' derived from being a Ugandan psychiatrist.[704] His analysis of the epidemic as a wider cultural and developmental issue stands starkly against the social, political, and economic tensions that existed in the area, as well as the explanations of the local Bagisu community. In spite of this, or perhaps because of it, there remained a large question mark over how the 'problem' of mass hysteria should be handled.

Multiple treatments for madness

If Kagwa believed in the universal applicability of psychiatry for understanding mental illness, he was nevertheless aware of the limits of his power in Uganda. A Psychiatric Unit to serve the whole Eastern Region had opened at Mbale Hospital in 1963-4, staffed by a small group of psychiatric nurses, but with only four

[703] For discussion of these themes elsewhere in East Africa, see especially Melissa Graboyes, 'Surveying the "Pathological Museum": A History of Medical Research and Ethics in East Africa, 1940-1965' (unpublished PhD thesis, Boston University, 2010); White, *Speaking with Vampires*.
[704] Kagwa, 'Observations on the Prevalence', p. 673.

beds.[705] Kagwa, moreover, was only able to apply his neuropsychiatric 'test' to those in the recovery stage of the epidemic, and does not appear to have been allowed to offer any treatment. Just because Kagwa was Ugandan, it did not mean that families and communities were any more likely to turn to him for help.

Such were the limits of Kagwa's role in the Mbale region that he was left to describe how it was Bagisu elders 'who perform the healing ritual'. These elders, Kagwa continued:

> start at sunrise by visiting the burial grounds of the clan and by weeding the tombs, near which they build small huts. White chickens are slaughtered and their blood used to anoint the tombs. Pieces of chicken, baked plantains and calabashes of wine are then placed in the huts. These are gifts to the spirits of dead clan elders. Finally, one elder sips the wine and spits it on the feet of the "possessed", who then becomes instantaneously and dramatically healed. Interestingly enough, the word for this ritual is equivalent to the English word "exorcism".[706]

Kagwa's account fits with that described by anthropologist Jean La Fontaine on the sacrificing of white animals to 'good' spirits and to the ancestors.[707] By focusing on the dramatic, however, such accounts ignored the importance of other types of medicine, including herbs, protective charms, and western medicine more generally.

Like other ethnic groups in Uganda, the Bagisu distinguished between the symptomatic and etiological treatment of illness, focusing first on relieving symptoms before looking for a deeper cause.[708] Numerous informants referred to the widespread availability of herbal medicine, something that was regarded as the first

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[705] ACMM, 'Ministry of Health Annual Report, 1963-4', pp. 16, 23
[706] Kagwa, 'The Problem of Mass Hysteria', pp. 561-2.
[707] La Fontaine, *The Gisu*, p. 53.
[708] Susan Reynolds Whyte, 'Penicillin, Battery Acid and Sacrifice', *Social Science & Medicine* 16 (1982), pp. 2055-64.

line of treatment in cases of sickness.[709] One male Mugisu, for example, described how he had become mad for a short period around the time of independence, at the same time as many others. He was unable to recall much about his experience, but stressed how disoriented he felt, and how it caused him difficulties in finding his way home. His mother was in charge of making decisions about his treatment, and, with the approval of the rest of his close family, she chose to visit a healer who specialised in herbs. While herbalists were usually relied upon largely because of their proximity, in this case an additional reason was given: through herbal medicine 'they had seen other victims heal'.[710]

In addition to herbs, families could turn to other forms of traditional medicine, which included protective charms (*tsisale*) being placed under the skin, and ritual specialists who had the ability to remove bad omens and curses.[711] The methods and meetings of these specialists were usually highly secretive, but could include sacrifices to appease the spirits or to drive out misfortunes.[712] Western medicine was also an option for those seeking relief, and, despite the long distances that needed to be travelled, a number of people were taken to hospitals or clinics at Mbale and Bududu.[713] One female Mugisu recalled how family members would only initiate treatment when people became aggressive, and then a person would either be tied up, taken to hospital, a traditional healer, or left to die. One of her neighbours, she added, was first taken to the government hospital at Mbale, in part because it was not far from their home, but also because that was what their local chief was

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[709] Interview MLE-11.
[710] Ibid.
[711] Interview MLE-01; Interview MLE-02. For fuller treatment of the types of ritual specialists in Bugisu, see La Fontaine, 'Witchcraft in Bugisu', p. 190.
[712] Interview MLE-03; Interview MLE-04.
[713] Interview MLE-08; Interview MLE-09; Interview MLE-18.

encouraging them to do. This particular person recovered in the hospital, and as a result, others from her village were also taken for treatment there.[714]

Distance was a key factor in the decision-making process for families affected by the epidemic. More often than not, distances were perceived to be too great,[715] particularly for those who were not convinced of the ability of western medicine to deal with illnesses associated with ancestral spirits.[716] Moreover, a few also regarded hospitals as places of danger, in the way Luise White has highlighted more generally for East and Central Africa.[717] 'Some people had a false belief', one Mugisu recalled, 'that in hospitals medicines were made out of dead people'.[718] Such a comment reveals concern over the power of European therapies, and the control that was felt over bodies and minds.

As elsewhere in Africa, it was families and the larger kinship group who played a central role in making decisions about care and treatment, displaying a pragmatism that allowed for alternative treatment options to be explored.[719] Indeed, as John Orley noted on his experience of illness and disease among the Buganda, 'Africans, being pragmatists, looked for a system that worked, and if one traditional remedy failed then another could be tried and so on until eventually Western medical treatment could also be given its chance'.[720]

In Bugisu, such was the extent of this pragmatism that different methods of treatment might even be used simultaneously. One female Mugisu, for example,

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[714] Interview MLE-05.
[715] Interview MLE-13; Interview MLE-16; Interview MLE-01; Interview MLE-02; Interview MLE-10; Interview MLE-12.
[716] Interview MLE-18.
[717] White, *Speaking with Vampires*.
[718] Interview MLE-12.
[719] Feierman, 'Change in African Therapeutic Systems'; John Janzen, *The Quest for Therapy: Medical Pluralism in Lower Zaire* (Berkeley: University of California Press, 1978).
[720] Orley, 'Indigenous Concepts', p. 127. Ssekamwa gives some examples of this in Ssekamwa, 'Witchcraft in Buganda'.

described how her brother was among those who went mad, becoming extremely aggressive and feeling cold to the touch. As a family they had first taken him to Mbale Hospital, but then decided that in addition to western medicine, they would also consult two different healers. When questioned as to why they tried three kinds of treatment at a go, she laughed, before responding: '[w]e wanted him to get cured'.[721] This was not a question of selecting traditional or western medicine, but rather a process of searching for relief.

Conclusion

During the colonial period, outbreaks of mass instability in Africans were linked to witchcraft, fear, and suggestibility. By the early 1960s, these episodes had been re-framed by MOs and psychiatrists in ways that allowed them to stress the universality of mental illness, and to draw connections with European societies in the past. Despite this shift in analysis, the investigators were not completely free from the assumptions that had pervaded ethnopsychiatry under colonial rule. While Kagwa was influenced by transcultural psychiatry, he continued to see explanations given by his patients as signs of pathology. Moreover, like psychiatrists and psychologists before him, Kagwa believed it was possible to generalise about mental illness in African communities, and to identify broad cultural traits and 'experiences'.

The epidemics of the early 1960s demonstrate the limits rather than the strengths of psychiatry in Uganda. They remind us that psychiatry was not necessarily transformed by the emergence of African psychiatrists, even if contemporaries credited them with having natural cultural 'insight' into 'the African mind'. In Mbale, Kagwa was unaware of the widespread uncertainty and suspicion

[721] Interview MLE-07.

about the epidemic, both in terms of the behaviours communities had to deal with, and the strangers who came to investigate. When the Bagisu looked for options for relief, they turned to their own methods of healing—methods that did not include psychiatry. Kagwa, himself an outsider, was unable to intervene, his role reduced from psychiatric expert to that of observer.

Over the course of the 1960s, the epidemics of mass hysteria began to receive international attention, as transcultural psychiatrists in particular came to ask what they could learn about the relationship between culture and mental illness.[722] Members of a symposium organised by the CIBA Foundation in 1965 determined that the East African epidemics were an increasingly familiar occurrence around the world. While no Ugandan psychiatrist was present at the symposium, Edward Margetts, previously a Government Psychiatrist in Kenya, and T.A. Lambo both claimed to have direct experience of the outbreaks.[723] In discussing the relevance of the epidemics for understandings of mass hysteria, the events in Uganda were linked to hysteria among nuns at Loudin in seventeenth-century France, 'frustration syndrome' of the Western Pacific in 1958, and Beatlemania, among other instances.[724] Only one of the participants, J.B. Loudon, of the M.R.C. Social Psychiatry Research Unit, Llandough, questioned whether or not mass hysteria could

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[722] Discussions of this kind continue in case studies of mass hysteria today, with researchers attempting to unpick (somewhat uneasily) the relationship between culture, mental illness, and (since the 1990s) post-traumatic stress. Interestingly, a number of these discussions reference and paraphrase sections of Kagwa's article, now widely regarded as the first case of mass hysteria in Africa. See, for example, C.C. Adomakoh, 'A Pattern of Epidemic Hysteria in a Girls' School in Ghana', *Ghana Medical Journal* 12(4) (1973), pp. 407-11; M. Dhadphale and S.P. Shaikh, 'Epidemic Hysteria in a Zambian School: "The Mysterious Madness of Mwinilunga"', *British Journal of Psychiatry* 142 (1983), pp. 85-8; Demobly Kokota, 'View Point: Episodes of Mass Hysteria in African Schools: A Study of the Literature', *Malawi Medical Journal* 23(3) (2011), pp. 74-7; L. Nakalawa *et al.*, 'Demon Attack Disease: A Case Report of Mass Hysteria after Mass Trauma in a Primary School in Uganda', *African Journal of Traumatic Stress* 1(1) (2010), pp. 43-8.

[723] I was unable to find any evidence of their visits to eastern Uganda.

[724] J.B. Loudon, 'Social Aspects of Ideas About Treatment', in A.V.S. de Reuck and Ruth Porter (eds), *Transcultural Psychiatry* (London: J. & A. Churchill, Ltd., 1965), pp. 163-4.

be talked about transculturally, highlighting the socioeconomic factors that appeared to be important in hysterical epidemics, and urging for more individual studies to be undertaken before the wider implications could be explored.[725]

In these discussions about mass hysteria, just as we have seen in this chapter, the attention was on the causes of mental instability, rather than its prevention or cure. Indeed, the 'problem' of mass hysteria was one that raised more questions about psychiatry and psychiatrists than it answered. The attempts of psychiatrists to deal with these questions will be examined in the final chapter.

[725] Ibid., pp. 166-7.

Chapter VI:

Spreading the Message: Psychiatrists, Psychiatry, and the Ugandan Public, 1966-1972

The 'psychic' epidemics of the early 1960s raised questions about the place of psychiatrists in the newly independent Uganda: should they remain in primarily custodial and curative roles? Did they have a duty to reduce the cultural and political gulf between them and their patients? And could they contribute their expertise to issues of social planning and national development? Under colonial rule, psychiatrists in other African countries had long promoted themselves as social commentators, highlighting how their theories on educability and detribalisation had implications for the ways African countries should be governed.[726] As indicated in Chapter I, however, there was no history of psychiatrists taking on this role in Uganda. It was only with the establishment of the Department of Psychiatry in 1966 and the increase in psychiatrists—Ugandan and expatriate—that psychiatrists sought to establish roles for themselves within society that went well beyond their teaching, research, and clinical duties.

The question of what role psychiatrists could and should have in Africa was one that preoccupied African and expatriate psychiatrists across Africa in the early post-colonial period, being discussed on a transnational level at psychiatric conferences and workshops from the 1950s. At a workshop on mental health in

[726] For example: Carothers, *The Psychology of Mau Mau*; Carothers, 'A Study of Mental Derangement in Africans'.

developing countries, held in Kampala in 1969, psychiatrists from Africa and the United Kingdom pushed the issue to the top of the agenda. The attendees fell into two groups: the first saw the psychiatrist's role as primarily curative, particularly as knowledge about the causes of mental ill-health and the significance of social changes was limited; the second, by contrast, 'felt that the psychiatrist could not be so confined, particularly in a developing society where his intelligence and expertise are at a premium. He must be prepared to take on many mantles, and must be prepared to offer advice in those areas of social planning which were likely to influence the mental health and happiness of people'.[727] These views, according to the discussion's chairman, G. Allen German, reflected differences in human personality, the variety of which could be accommodated in mental health services in the developed world. 'In developing countries, however,' German added, 'where personnel are few, it may be that one man will have to adopt different roles, and this is one of the problems of working in a developing society which has to be accepted'.[728]

This chapter explores the activities of psychiatrists outside of the mental hospital in order to examine the roles psychiatrists attempted to create for themselves in early post-colonial Uganda. From 1966 to 1972, a small group of psychiatrists turned their attention to a range of educational activities, including the establishment of the Uganda National Association for Mental Health (UNAMH), training courses for police officers and lawyers, and a television series entitled 'The Sick Mind'. These activities aimed not only at spreading western ideas about mental ill-health to the wider Ugandan public, but to mobilise supportive professionals in order to extend

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[727] *Mental Health Services in the Developing World*, p. 33.
[728] Ibid.

the reach of psychiatry beyond that which could have been achieved by the psychiatrists alone. In so doing, the psychiatrists were concerned more with improving the mental health care system than they were about being a voice for patients and their beliefs. Nevertheless, along with other professionals, notably lawyers, these psychiatrists were not afraid to criticise policies and legislation that they felt had negative implications for mental health, and to suggest change where they felt it necessary.

The chapter starts by extending the discussion started in Chapter V about the relationship between psychiatrists and their patients. It considers the attitudes of psychiatrists towards traditional medicine and the ways psychiatrists attempted to alter beliefs about mental ill-health. It then turns to the educational activities of a small group of these psychiatrists—Ugandan and expatriate—who aimed to spread western ideas about mental health care. Looking at the UNAMH, professional training, homosexuality, and 'The Sick Mind' in turn, the chapter highlights the extent to which these psychiatrists worked tirelessly to improve what they perceived to be problems with the treatment and handling of the mentally ill across Uganda. However, this involved creating a 'modern' psychiatry, with little room for alternative healing systems or beliefs.

Psychiatrists and their patients

Transcultural psychiatry raised important questions about the links between culture, society, and mental illness, but offered little guidance on how this knowledge might inform the relationship between psychiatrists and their patients. As indicated in Chapters IV and V, the training of Ugandans in psychiatry was premised on the assumption that Africans would be best placed to practice psychiatry in their own

countries, but did that mean that they, or indeed any psychiatrist in Africa, should embrace indigenous belief systems and healing practices?

The idea that traditional healers could offer some value in the treatment of the mentally ill was not new. Over a period of two years in the 1930s, for example, Wulf Sachs followed and psychoanalysed John Chavafambira, a Manyika healer-diviner in South Africa who was eager to learn the methods of European medicine. Having allowed John to accompany him to a mental hospital, Sachs noted how John was able to extract:

> from the insane a wealth of information far exceeding any that I did. Most of the patients not only willingly submitted themselves to his interrogation, but regarded his efforts with confidence and trust. John, with his bones, horns, magical formulae, and rituals, meant to them the real medical man. And I wonder if it wouldn't be advisable, from a psychological point of view, to employ ngangas in the treatment of insane natives. In any case, there is nothing to lose, for our methods fail lamentably.[729]

While Sachs was at first sceptical of John's desire to help the mentally ill, he being able 'only to throw bones for them', Sachs stressed the psychological uses of traditional healers, for both diagnosis and treatment.[730]

This tension between the dismissal of the methods used by traditional healers and the belief that they may still be effective, particularly psychologically, had also been present in statements made by Uganda's western-trained African medical practitioners since the age of the tribal dresser.[731] Indeed, while many AMOs, educated by missionaries, were particularly virulent in their rejection of 'magic' and

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[729] Sachs, *Black Hamlet*, p. 253.
[730] Michael Gelfand also considered the value of traditional healers in Michael Gelfand, *Witchdoctor: Traditional Medicine Man of Rhodesia* (London: Harvill Press, 1964).
[731] Iliffe, *East African Doctors*, p. 59. On medical auxiliaries and traditional medicine in colonial Zambia, see Kalusa, 'Language, Medical Auxiliaries'.

'superstition',[732] from the 1930s a number also called for investigations into the benefits traditional medicine could have for western medicine.[733] Articles on traditional medicine by AMOs tended to focus on scientific studies of the properties of medical herbs and plants, but they also touched upon the importance of healers in treating the mind.[734] As A.P. Bulengo noted in 1958:

> Despite his ignorance of the Causation of Disease and the complete lack of anything anywhere near an organised system of practice, the indigenous African medicine-man certainly leaves one greatly impressed by the number of cures he achieves in his calling and service to the community in which he lives…There can be no doubt at all that the native medicine-man has, to begin with, a deep insight into human nature, and that he exercises due regard to care in the handing over of the art, limiting this only to those of his like. He expects them in their turn to behave the same and to keep to and maintain the tradition of the practice. He is a psychologist whether he be aware of this or not. He has a deep interest in the problems and sufferings of men. He knows the conquering power of sympathy towards people and their troubles. Lastly, and most important, he possesses that commanding personality which appeals to the people among whom he has a calling to administer.[735]

Of course, doctors such as Bulengo were more interested in learning from than collaborating with traditional healers, and there is little evidence that Ugandan medical practitioners tried to combine 'modern' and 'indigenous' medical practices.[736] Over the course of the colonial period, they would have to fight long and

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[732] Edward C. Green, 'Can Collaborative Programs between Biomedical and African Indigenous Health Practitioners Succeed?', *Social Science & Medicine* 27(11) (1988), pp. 1125-30 at p. 1126.
[733] Stacey Langwick has described how efforts to investigate and develop traditional medicine have always privileged science as the medium through which it might be recognised and declared to be 'real'—what she has termed the 'ontological politics' of healing. Stacey Langwick, *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania* (Bloomington, IN: Indiana University Press, 2011).
[734] E.B.S.L., 'Makerere Medical Students Society', *Makerere College Magazine*, December (1941), p. 86; A.K. Kibaya, 'Native Medicines', *Makerere College Magazine*, April (1937), pp. 82-3.
[735] A.P. Bulengo, 'The Healing Powers of the Indigenous African Medicine-Man', *Medmak* (1958), pp. 26-7.
[736] Iliffe, *East African Doctors*, p. 26.

hard for recognition of their professional status, and setting themselves apart as 'scientific' men was a vital part of this.[737]

With independence came a more direct engagement with traditional medicine. In 1962, the newly independent Uganda Government set up the Natural Chemotherapeutics Research Laboratory (NCRL), charged with investigating the pharmacological properties of indigenous plants and medicines.[738] To this end, between 1968 and 1973, the NCRL collected samples from sixty plants used by traditional healers in the treatment of epilepsy and mental illness.[739] In 1965, moreover, A. Chibule suggested that Makerere University College initiate research into traditional medicine.[740] And in 1966, a member of a symposium at Makerere University College even went so far as to suggest that traditional birth attendants be provided with cotton, umbilical tape and razor blades until sufficient numbers of western-trained midwives were available.[741]

Medicinal plants and traditional birth attendants, however, were features of indigenous medical systems that were easiest to incorporate into western medicine. Opinions on the roles traditional healers might play in diagnosing and treating mental illness were, by contrast, more divided. Indeed, Lambo's use of traditional healers in his Aro Village scheme, described in Chapter V, was exceptional—while his methods and findings were followed with interest by psychiatrists, few attempts were made to incorporate local concepts and methods of healing into psychiatric practice

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[737] Ibid., ch. 5. Much of this fight can be traced through UMOHA, PH/ASC/46 (Box 29) (Makerere Medical Graduates Association).
[738] UMOHA, GCS 1/3 II (Box 60 old) (Drugs: Native Drugs), f. 14, 'The Natural Chemotherapeutics Research Laboratory, Ministry of Health, nd.; Zeller, 'The Establishment of Western Medicine', p. 390.
[739] UMOHA, GCS 1/3 II (Box 60 old) (Native Drugs), f. 29, G.C. Davidson, 'Investigations into Traditional Medicines and the Cultivation of Medicinal Plants in Uganda: 1968-73', 1973, p. 2.
[740] Zeller, 'The Establishment of Western Medicine', p. 391.
[741] Ibid., pp. 391-2.

elsewhere.[742] This was in part due to the financial costs of such community schemes, but it also stemmed from a more prominent belief that while traditional healers might be important for their patients, they had no place in 'modern' psychiatry in Africa.

Collaboration with traditional healers was particularly controversial at the Dakar School of the early 1960s. Henri Collomb, based at the Fann Psychiatric Hospital, championed a form of transcultural psychiatry that included integrating traditional healers into medical practice. The Senegalese psychiatrists were more ambivalent about this engagement. As Alice Bullard has noted, '[c]ollaborating with traditional healers and thereby at least partially abandoning the privileged position of the scientist, incurred a backlash from the Senegalese scientists and health workers, who felt somewhat abandoned by the European doctor who turned to native ways.[743] Given the challenges these African psychiatrists had successfully overcome in order to train as doctors and then specialise in psychiatry, it is unsurprising that they wished to safeguard their claim to being modern, scientific men.

There was little open discussion about traditional medicine among Ugandan psychiatrists either. Kagwa had described how those affected by mass hysteria in Mbale had turned to traditional healers, but made no comment on their effectiveness in responding to the epidemic.[744] Bosa also questioned why some people could, on a Sunday morning, go to church, and in the evening visit a traditional healer, but certainly did not consider himself to be one of them.[745] According to German:

> the usual African psychiatrists' response was to denigrate them - or scoff at their lack of training - probably an understandable reaction in those seeking to be "modern" and very proud (and sensitive) about

[742] *Mental Disorders and Mental Health in Africa South of the Sahara*, p. 116.
[743] Bullard, 'Imperial Networks and Postcolonial Independence', p. 211.
[744] Kagwa, 'The Problem of Mass Hysteria'.
[745] Personal communication with Joseph Bossa, 6 July 2012.

> their own learning and achievements - quite rightly so. But when discussed a bit they accepted that for the bulk of African people these healers were very important channellers of cultural beliefs and notions.[746]

Indeed, while Bosa was open to the idea that his patients might derive benefits from visiting a traditional healer, he could never openly acknowledge it, lest he be seen to be practising or believing in traditional medicine.[747]

Matthew Heaton has suggested that in Nigeria the context of decolonisation and the emergence of transcultural psychiatry created an 'existential crisis' for the African psychiatrists of the 1950s and 1960s. While on the one hand they recognised that mental illness was shaped by culture, they also maintained that western medicine was universal, and offered some form of 'truth' about the mind. In attempting to reconcile these two facets of psychiatry, Heaton has argued, African psychiatrists attempted to position themselves as gatekeepers of the line between 'modern' psychiatry and 'traditional' medicine.[748] Heaton's argument could certainly be extended to the Ugandan context, but it is important to remember that African psychiatrists were not the only medical practitioners grappling with these issues. In Uganda, African and expatriate psychiatrists were equally ambivalent on the topic of traditional medicine: while most acknowledged that traditional healers could serve a useful function in remote areas, particularly with regard to psychoneuroses, they were concerned that traditional healers might cause real harm to their patients, and so had no place in 'modern' psychiatry. In discussions with other psychiatrists, for example, German warned against the danger of imbuing traditional healers with a 'false mystique', noting that 'there are many examples of such people in Western

[746] Personal communication with German, 29 January 2012.
[747] Ibid.
[748] Heaton, '"Traditional" Healers and "Modern" Psychiatry'.

society'.[749] As the son of a clergyman, he could see 'little difference between the African Healers' role and that of British clergymen - especially Catholic or High Church clergy - whose potency in relieving anxiety and depression through the confessional and various prescribed prayers and Hail Mary rituals were…psychologically identical, playing on deeply held superstitions'.[750] Orley, too, felt that the uses of traditional healers could be compared to the psychotherapeutic benefits derived from church attendance or visits to the local pub: '[n]o attempts are made however, to integrate these activities into psychiatric practice, nor to recognise the priest, publican or patron as a psychiatric colleague'.[751]

The distinction between 'modern' and 'anti-modern' practices in psychiatry was not one that was limited to the African context, but it took on particular significance given the scale of the cultural and political gulf between psychiatrists and their patients. Indeed, while traditional healers were never given a place at Butabika Hospital or the out-patient clinic at Mulago Hospital, the psychiatrists—African and expatriate—felt obliged to acknowledge the importance of the cultural beliefs and practices held by their patients. During the late 1960s, for example, certain patients were prescribed a period of leave to return home to consult traditional healers.[752] According to German, '[t]his was usually a very successful manoeuvre for those whose panic/anxiety/depression etc stemmed from feelings of fear about bewitchments, or doubts about having failed to observe some culturally required ritual'.[753]

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[749] *Mental Health Services in the Developing World*, p. 41.
[750] Personal communication with German, 29 January 2012. German expands on this theme in G. Allen German, 'Paganism, Faith and Mental Illness', *Uganda Practitioner* 2(3) (1969).
[751] Orley, *Culture and Mental Illness*, p. 59.
[752] Personal communication with German, 29 January 2012; Personal communication with J.F. Wood, 3 November 2012.
[753] Personal communication with German, 29 January 2012.

An understanding of the importance of community in the treatment of mental illness also informed a number of the rehabilitation activities at the hospital. Rhythm and drumming, for example, were encouraged among the patients.[754] Group psychotherapy was also introduced among selected patients in 1968. On the one-hand this was premised on the desire to draw on the 'therapeutic potential' of less qualified hospital staff, such as nurses and ward sisters, to ensure that treatment went beyond solely physical therapies;[755] on the other it was argued elsewhere in Africa that using groups brought psychiatry closer to the traditional 'social fabric' of African life.[756] The groups were unorthodox in the sense that 'gaining insight' was not emphasised, but they provided a forum in which patients could discuss how a ward could deal with a particularly disruptive patient, how patients would be greeted on their return home, and comparisons of 'European' and 'African' treatment.[757] In this, the role of the hospital staff, as Africans, was key:

> They may not have learned psychology as a science but they live in a community and have experience of human relationships. They may not talk the official language, but they talk the patients' languages. If they do better work they deserve better pay. And they are surprisingly interested in the patients' welfare. After all they come into closer contact with the patient than do any other cadre of hospital staff.[758]

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[754] Personal communication with Wood, 3 November 2012.
[755] J.F. Wood, 'Utilising Therapeutic Potential in Psychiatric Hospital Staff', *Psychopathologie Africaine* 6(3) (1970), pp. 301-20 at p. 301. The importance of small social groups was also emphasised by Wood in J.F. Wood, 'Rehabilitation & Psychiatry' (unpublished lecture, copy in possession of author, nd.).
[756] E. Corin and H.B.M. Murphy, 'Psychiatric Perspectives in Africa Part I: The Western Viewpoint', *Transcultural Psychiatry* 16(2) (1979), pp. 147-78 at p. 168; T.A. Lambo, 'Psychotherapy in Africa', *Psychotherapy and Psychosomatics* 24(4-6) (1974), pp. 311-26.
[757] Lambo, 'Psychotherapy in Africa', pp. 120, 122.
[758] Wood, 'Utilising Therapeutic Potential', p. 305.

These activities hardly constituted engagement with traditional medicine, as was seen at Aro and the Fann Psychiatric Hospital; traditional medicine was kept separate from psychiatry, its usefulness being acknowledged only outside of the mental hospital.

Indeed, such was the distinction that was made between 'modern' psychiatry and 'traditional' medicine, that the psychiatrists were not averse to attempting to alter beliefs they felt might be dangerous to the mental health of their patients. Orley, for example, was keen to promote the value of local understandings of mental illness in Buganda not only to assist in diagnosis, but to suggest to patients alternative ways of looking at their own mental ill-health. 'If one has some idea of the beliefs about an illness', Orley wrote in 1970:

> it is possible at times to modify them somewhat and to create new beliefs that may be more beneficial to the patient. This is obviously a complex matter and only suggestions can be given. *Akawango*, a persistent headache, may be thought by the patient to be spoiling his brain and the anxiety resulting from such a belief can make things even worse. The name of the illness however is derived from *ekiwanga*, meaning "the skull", and it is possible, while also giving medication, to explain to the patient that the illness is in the bone of the head only, and not in the brain.[759]

Of course, while Orley believed this was in the best interests of his patients, it had serious ethical implications. 'A more dubious procedure', Orley continued:

> which I have used successfully in cases of epilepsy, is to tell the relatives of a patient that the tablets prevent the illness spreading to others, and so the patient need no longer be isolated. When it is seen that the tablets do in fact prevent fits as forecast, then the assumption is that the statement about the illness being no longer infectious is also true. This particular approach may be thought to be of doubtful value, since it does seem to indicate that epilepsy is sometimes infectious,

[759] Orley, *Culture and Mental Illness*, p. 52.

> but in the present situation some such compromise with the truth might well reduce the incidence of disastrous practices such as enforced isolation of the epileptic.[760]

At a workshop on mental health services in developing countries, held in Kampala in 1969, Ravi Kapur, an Indian psychiatrist undertaking postdoctoral training in psychiatric epidemiology at Edinburgh University, asked if 'psychiatrists had ever thought of the harm they themselves could be doing'.[761] Orley and his colleagues certainly believed they were working in the best interests of their patients, but their actions were premised on a belief in the superiority of western ideas about mental ill-health; local concepts and methods of healing could serve a function, they acknowledged, but traditional medicine had no place in 'modern' psychiatry. As we shall see in the following sections of this chapter, psychiatrists, along with other interested professionals, brought this distinction to their educational activities, making active attempts to educate the wider Ugandan public about western ideas of mental ill-health.

Uganda National Association for Mental Health

Attempts to change ideas about mental health took official form in the Uganda National Association for Mental Health (UNAMH), founded in 1967 under the leadership of German.[762] The concept of an association for mental health was not completely new: G.I. Tewfik had established a Mental Hospitals Voluntary

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[760] Ibid., p. 53.
[761] *Mental Health Services in the Developing World*, p. 13. On Ravi Kapur, see Gilles Bibeau and Ellen Corin, 'Dr Ravi L. Kapur (1938-2006): A Psychiatrist at the Crossroads of Multiple Worlds', *Transcultural Psychiatry* 47 (2010), pp. 159-80.
[762] Personal communication with German, 29 January 2012. Bosa was elected Chairman of the Uganda National Association for Mental Health in November 1968. 'Department of Psychiatry Report, 1968-9'.

Association in 1956, which ran with a committee of five Europeans, five Asians, and five Africans until Tewfik's departure in 1958.[763] Yet while Tewfik's Association had focused primarily on bringing in volunteer visitors into the mental hospital and giving comfort to the mentally ill,[764] the UNAMH was concerned with increasing public knowledge about mental health, improving the status of those who had a mental illness, and developing strategies for its prevention—the UNAMH looked to the world outside of the mental hospital, rather than in.[765]

The idea for the UNAMH grew from a series of conversations at social gatherings in Kampala at which psychiatrists and non-specialists—Ugandan and expatriate—were present.[766] Women, in particular, were prominent in the early stages of organisation, including Dorothy Wood (Wood's wife and German's sister), Harriet Kibukamusoke (wife of John Kibukamusoke, Professor of Medicine at Mulago Hospital and first African President of the Association of Physicians of East Africa), Mrs Kasirye (wife of J.W.S. Kasirye, then Medical Superintendent of Butabika Hospital), and Ethel Bosa (Bosa's first wife).[767] These members of upper class Kampala society worked in conjunction with (primarily male) medical specialists, to set the agenda for the Association's activities. In terms of membership, which by 1970 had reached 90, most were members of the Asian lay public; African

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[763] RHO, Micr.Afr.609(2) (Papers of J.N.P. Davies), 'Mental Hospital Annual Report 1956', p. 5.
[764] Ibid.; G.I. Tewfik, 'A Hospital Visitors' Association', *The Lancet* (1956), pp. 833-4 at p. 834.
[765] UMOHA, PH/ASC/42 (Box 56, Old Arrangement) (Mental Health Advisory Committee: Association), f. 7, 'Uganda National Association for Mental Health'. A minor philanthropic role was also played by Protestant and Catholic churches in East Africa. In 1961, the Uganda Protestant Medical Bureau proposed funds for a chapel at Butabika Hospital. UCU, RG1 159/930/39 (Archives of the Bishop of Uganda: Correspondence), letter from J.J. Hillman, Secretary, The Uganda Protestant Medical Bureau, Nairobi, Kenya, to the Bishop of Namirembe, Kampala, 16 March 1961.
[766] UMOHA, PH/ASC/42 (Box 56, Old Arrangement) (Mental Health Advisory Committee: Association), f. 7, 'Uganda National Association for Mental Health'.
[767] Personal communication with German, 29 January 2012.

membership remained primarily among upper class Baganda women, with only a few men.[768]

The UNAMH was certainly the first association of its kind in East Africa, and appears also to have been the first in Africa (excluding South Africa).[769] With no known precedents for such an association, German turned to the National Association for Mental Health (NAMH), United Kingdom, for advice.[770] Established in 1946 through the merging of three inter-war voluntary groups—the Central Association for Mental Welfare, the National Council for Mental Hygiene, and the Child Guidance Council—the NAMH engaged extensively in public education campaigns—partly funded by the government—aimed at shifting public attitudes towards mental illness and creating a society in which 'care in the community' could be effective. These activities, which Nick Crossley has characterised as 'paternalist apologist', were by the late 1960s starting to become more critical of policies towards the mentally ill, taking a more legalistic and patient rights based approach.[771] An assessment of the work of the UNAMH is more problematic—certainly, while those involved worked tirelessly to educate the wider public about mental illness and were not afraid to criticise laws they felt were detrimental to mental health, patients and traditional healers were not given a voice.

One of the main concerns of the Association was to raise funds to establish a residential centre for mentally handicapped children.[772] Estimating that five to seven per cent of children were born each year with some kind of mental handicap, the

[768] UMOHA, PH/ASC/42 (Box 56, Old Arrangement) (Mental Health Advisory Committee: Association), f. 16, 'Notes from the Chairman's Report to the A.G.M. 5/12/70'; Personal communication with German, 29 January 2012.
[769] Kenya, for example, did not start a National Mental Health Association until 1986. WHOL, MNH/POL/87.3 (African Mental Health Action Group, 1987), p. 5.
[770] Personal communication with German, 29 January 2012.
[771] Nick Crossley, 'Transforming the Mental Health Field: The Early History of the National Association for Mental Health', *Sociology of Health & Illness* 20(4) (1998), pp. 458-88.
[772] Personal communication with German, 29 January 2012.

UNAMH stressed that many of these children were abandoned by their families and left to die, while 'others remain with their families and grow up but are unable to work and continue to be a burden on the often slender family resources'.[773] Linking the problem to advances in western medicine, German recalled how at an early meeting of the Association, 'a paediatrician spoke of rising numbers of brain-damaged children in Uganda, their lives saved and prolonged by modern medicine, but without provision to educate, rehabilitate, and counsel both them and their parents'.[774] While their ambition of establishing a residential centre was never realised, the fund-raising and awareness building that stemmed from this campaign demonstrates the extent to which the UNAMH felt that government mental health provision urgently required supplementing in the field of child mental health. Had the scheme been successful, it would have marked the start of community mental health care in Uganda, run by a voluntary organisation that comprised not only of psychiatrists, but informed members of the Ugandan public.

Just as the NAMH engaged in public education campaigns in the United Kingdom, so the UNAMH concentrated much of their time on attempting to shift public attitudes towards mental illness and the mentally ill. In a lecture designed to draw attention to the difficulties faced by those recovering from mental illness, Wood noted that:

> The disabilities of the polio cripple, the blind, the deaf and the spastic are obvious. The disability of the mentally ill does not show on the body so much and these mental "cripples" may just be considered as lazy, inept or good for nothing….Unfortunately the rehabilitated psychiatric patient suffers from yet another disability - not of his own illness but caused by prejudice in the community. When the time

[773] UMOHA, PH/ASC/42 (Box 56, Old Arrangement) (Mental Health Advisory Committee: Association), f. 16, 'Residential Centre for Mentally Handicapped Children' (nd.).
[774] Personal communication with German, 29 January 2012.

> comes to place him in work many employers are afraid to take him on when they hear he has suffered from a mental illness….This area of community attitudes to mental illness is one which requires much attention.[775]

By 1970, the UNAMH had arranged for weekly newspaper articles on various aspects of mental illness to be published in *Taifa Empya*, a Luganda newspaper. A Luganda article on epilepsy, moreover, had been translated into Karamajong, Runyankole, and Luo-Lango by students and staff at Bishop Tucker College, Mukono.[776] Given the widespread stigma attached to epilepsy in communities across Uganda, at times resulting in almost complete social isolation, it is unsurprising that the UNAMH focused on this condition in particular. Indeed, in spreading western ideas about mental ill-health the UNAMH were actively trying to improve conditions for the mentally ill in ways that are reminiscent of Orley's attempts to adjust the beliefs of his patients. At the same time, however, the UNAMH also touched on wider social and political issues it felt had negative implications for mental health. In so doing, the psychiatrists worked with other lay professionals and cultural and religious figures to extend their ideas of what constituted 'modern' psychiatry.

Seminars organised by the UNAMH covered a range of social and political issues, including suicide, alcoholism, and stigma.[777] In the seminar entitled 'Suicide and the Law', held in December 1970, Frank Farrelly, Consultant Psychiatrist, Butabika Hospital, presented alongside the Reverend Christopher Senynojo, Bishop Tucker Theological College, and Justice Fuad, of the High Court and the Law Development Centre. Suicide had been an area of concern for psychiatrists in Uganda

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[775] Wood, 'Rehabilitation'.
[776] UMOHA, PH/ASC/42 (Box 56, Old Arrangement) (Mental Health Advisory Committee: Association), f. 16, 'Notes from the Chairman's Report to the A.G.M. 5/12/70'.
[777] Ibid., f. 16, 'Uganda National Association for Mental Health membership form' (nd.).

for a number of years, with Kagwa noting in 1965 that '[b]ecause of the lack of psychiatric orientation in educational, police and welfare services, suicidal cases are treated as criminals and thus end up in prisons. Our preliminary inquiries at Luzira Prison indicate that about one person a year, usually a male, is arrested for attempted suicide'.[778] It was only with the establishment of the UNAMH and the links it formed with other professionals, that the psychiatrists were able to comment on the extent of the problem. Fuad's paper, entitled 'Insanity and the Law', highlighted how while attempted suicide was still an offence in Uganda, the High Court had 'attempted to discourage prosecutions'. Citing a judgement from 1965, Fuad noted that unless the accused required protection '"against himself"' through a Probation Order, '"perhaps the modern approach"' was to handle the issue outside of the courts entirely.[779]

The UNAMH placed itself firmly on the side of patients, extending ideas about mental health that it believed would benefit the mentally ill and their communities. It did not, however, give the patients themselves a voice; nor was there any room for traditional medicine and traditional healers. In so doing, the UNAMH claimed an exclusivity of expertise in the field of mental health in a way that would be mirrored in later attempts by traditional healers to carve out a role for themselves within national health care systems in Africa.[780]

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[778] Kagwa, 'Observations on the Prevalence', p. 675.
[779] Fuad, 'Insanity and the Law'.
'Uganda Law Development Centre', *Journal of African Law* 15(1) (1971), pp. 4-11 at p. 9.
[780] See, for example, Charles M. Good *et al.*, 'The Interface of Dual Systems of Health Care in the Developing World: Toward Health Policy Initiatives in Africa', *Social Science & Medicine* 13D (1979), pp. 141-54; Barbara L.K. Pillsbury, 'Policy and Evaluation Perspectives on Traditional Health Practitioners in National Health Care Systems', *Social Science & Medicine* 16 (1982), pp. 1825-34; David Simmons, 'Of Markets and Medicine: The Changing Significance of Zimbabwean *Muti* in the Age of Intensified Globalization', in Tracy J. Luedke and Harry G. Vest (eds), *Borders and Healers: Brokering Therapeutic Resources in Southeast Africa* (Bloomington, IN: Indiana University Press, 2006); WHOL, NUR/TRM/85.1 (Report of the Consultation on Approaches for Policy Development for Traditional Health Practitioners, Including Traditional Birth Attendants, Convened by the World Health Organization at the Regional Office for South-East Asia, World Health House, New Delhi, India, 4-8 February 1985). Examinations of the earlier relationship between traditional healers and western medical practitioners can be found in Karen Flint, 'Competition, Race, and

Professional training

Psychiatrists in Uganda were aware that they needed to mobilise supportive professionals in order to extend the reach of psychiatry. Not only were their numbers small, and their teaching, research, and clinical duties extensive, but mental health care provision was reliant on the cooperation of lay professionals such as lawyers and police officers. As knowledge about the social and cultural beliefs of communities in Uganda grew during the 1960s, the need for professional training in mental health became all the more urgent. 'It is important to bear in mind two very strong pernicious beliefs entertained by the Baganda which it is necessary to counter', Orley stressed in 1970:

> The first is that all violent individuals or those liable to violence, must be locked away in a custodial environment. The second is that in many conditions the patient's brain is "spoilt" and therefore the patient is not susceptible to control or cure and consequently is not worth bothering about; many think that these patients should also be locked away. A doctor or police officer must therefore be on his guard against giving way too easily to demands that a patient "must go to mental hospital".[781]

A shift in public attitudes towards mental illness was not enough: professionals involved at all stages of mental health needed educating about the methods and ideas of psychiatry.

In a lecture to lawyers in 1969, Jim Wood described the main symptoms, treatment, and legal considerations of personality disorders and reactions, illness

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Professionalization: African Healers and White Medical Practitioners in Natal, South Africa in the Early Twentieth Century', *Social History of Medicine* 14(2) (2001), pp. 199-221; Stacey Langwick, 'Geographies of Medicine: Interrogating the Boundary between "Traditional" and "Modern" Medicine in Colonial Tanganyika', in Tracy J. Luedke and Harry G. Vest (eds), *Borders and Healers: Brokering Therapeutic Resources in Southeast Africa* (Bloomington, IN: Indiana University Press, 2006).

[781] Orley, *Culture and Mental Illness*, p. 53.

caused by organic or physical diseases, and cryptogenic illness (schizophrenia and manic-depressive psychosis). Reflecting the predominant trend in international psychiatric theory at the time, Wood presented mental illness as both universal and shaped by culture. In a section on acute brain syndromes and hallucinations, Wood noted that:

> These hallucinations are very real to the subject….People with spears, lions and snakes come through windows and doors and crowd round him on his bed. He can hear the people talking, threatening and abusing him. Such subjects may jump through the window to escape their hallucinatory persecutors or may unfortunately pick up the ever ready panga from below the bed and "defend" themselves. Usually this results only in a chair being chopped up for a lion but occasionally and tragically a child, a father, mother or brother may be standing by the bedside and may be the victim.[782]

In so doing, Wood urged lawyers to be culturally sensitive not just in their management of the mentally ill, but in their interpretations of the law.

Building on the success of such lectures, Wood, with the aid of the Mental Health Advisory Committee, negotiated funding from the Uganda Government for a training course on mental health for police officers.[783] Fears over the threat posed by mental patients to the Ugandan public, explored in Chapter I, continued into the early post-colonial period, exacerbated by poor supervision at hospitals and prisons. In May 1969, for example, the District Medical Officer (DMO), Teso, was informed that:

> some patients, (mental cases) from your hospital, who have been moving about in public, and have terrorized teacher and children in

[782] J.F. Wood, 'Psychiatry for Lawyers' (unpublished lecture, copy in possession of author, 1970).
[783] Davies, 'Report on the Teaching of Psychiatry 1969'; Personal communication with German, 29 January 2012.

the Nursery School which operates in Soroti Club Building.

If such characters are patients from your hospital then, the public has to be protected from them and this would be your responsibility with the Police.

If they do not belong to any special institution and are roaming about freely the Police should step in to protect the public from any harm they could extend to it.[784]

The ward had been created with the intention of bringing 'psychiatry out of the prisons and into the hospital at upcountry districts'.[785] However, despite the attempts of the Mental Health Advisory Committee to improve the situation, as examined in Chapter IV, hospitals such as these still often lacked the expertise and the facilities to adequately treat the mentally ill.

Wood's topics included a history of psychiatric services in Uganda, the state of contemporary mental health provision, as well as the signs and symptoms of different types of mental illness. In one of his lectures, Wood noted that while it was hoped that in the future mental health visitors and psychiatric social workers might take over some of the responsibility for the mentally ill, the police had considerable legal and social duties to fulfil. Describing a situation that could have been applied to Uganda at any point during the last forty years, Wood reinforced how:

The officers in a peripheral police station especially may have to look after some very sick patients for several days and may have difficulty in getting medical attention for the patient or have difficulty in deciding whether they should take an apparently physically sick patient to the nearest local general hospital for immediate treatment or not. They may have difficulty coping with excited patients who may tend to become violent especially when restrained or locked up. They may have difficulties with patients who refuse food and fluids and

[784] SDA, JUD 1/2 (Lunatics), f. 111, letter from District Commissioner, Teso, to District Medical Officer / Medical Superintendent, Soroti Hospital, 20 May 1969.
[785] ACMM, Ministry of Health Annual Report, 1963-4', p. 23.

> who may become seriously and dangerously ill due to dehydration or starvation. They may find that if they put mentally ill patients together without someone to look after them that the patients may harm each other. These are only some of the duties and difficulties which the policemen can expect to encounter.[786]

Police officers, Wood stressed, were a vital part of Uganda's mental health system, not only identifying whether a person required medical treatment or restraint, but in acting 'as transporters, minders and providers until the mentally ill person could be safely delivered to Butabika Hospital or to the Mulago Hospital Psychiatric Outpatient Centre'.[787] As Wood added:

> Now and for many years ahead we in the psychiatric service look to the police service to fulfill a field-work role for us, in identifying, handling and bringing our patients to us. The policeman has to be proficient in so many fields. That of psychiatric patient management is yet another. If he is to do his work well in this field he needs to have some of the skills of the psychiatric social worker, the psychiatric nurse and the psychiatrist. It is these skills essential to psychiatric patient management and some basic underlying knowledge that we plan to teach and show you in the course ahead.[788]

Wood was urging police and prison officers not only to act as minders for patients, but take on the roles of psychiatric social workers, nurses, and psychiatrists. He was attempting to subtly remould the duties and attitudes of the police officers in ways he felt would be beneficial not just for Uganda's mental health service, but the patients themselves.

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[786] J.F. Wood, 'An Introduction to the Uganda Psychiatric Service' (unpublished lecture, copy in possession of author, 1969).
[787] Personal communication with Wood, 7 October 2011.
[788] Wood, 'An Introduction to the Uganda Psychiatric Service'.

Homosexuality and the law

As the psychiatrists built relationships with lay professionals, so their confidence grew in commenting on social problems that they felt could be more effectively dealt with by increased treatment services and possible changes in the law.[789] Homosexuality, which Wood defined as 'a sexual perversion resulting from a personality disorder', was one such issue that psychiatrists were not shy of addressing.[790]

While homosexuality is a highly charged topic in Ugandan politics today, it is difficult to establish how problematic it has been socially or politically in the past.[791] As Sylvia Tamale has noted, '[h]istorically, as was the case elsewhere in the world, homosexual practices were neither fully condoned nor totally suppressed',[792] but there remains great variety in accounts on the subject. Anthropologists and colonial administrators noted that hermaphroditism was accepted among the Lango, Iteso, and Karamojong.[793] Among the Banyoro, a young man undergoing initiation into the Cwezi cult was 'given to believe that he must demonstrate his genuine possession by

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[789] UMOHA, PH/ASC/42 (Box 56, Old Arrangement) (Mental Health Advisory Committee: Association), f. 16, 'Notes from the Chairman's Report to the A.G.M. 5/12/70'.
[790] Wood, 'Psychiatry for Lawyers'. This definition of homosexuality was in line with psychiatric thinking in Europe and the United States in the late 1960s. Roger Davidson, 'Psychiatry and Homosexuality in Mid-Twentieth-Century Edinburgh: The View from Jordanburn Nerve Hospital', *History of Psychiatry* 20(4) (2009), pp. 403-24 at p. 417; Wittkower, 'Transcultural Psychiatry', p. 702. Homosexuality was removed from the Diagnostic and Statistical Manual in 1973.
[791] Discussion of homosexuality in Uganda in historical contexts has tended to relate to the question of whether it is 'un-African'—brought in by foreign influences—or if it existed before the arrival of Europeans. Commentators have tended to focus on the (questionable) sexuality of the nineteenth-century Kabaka Mwanga II. Considering the significance of homosexuality for politics in Uganda today, it is surprising that there has been little historical treatment of homosexuality beyond Mwanga II and the Uganda Martyrs, and (rather selective) references to anthropologists who commented on the tolerance of pre-colonial societies for homosexuality and hermaphroditism. Kristen Cheney, 'Locating Neocolonialism, "Tradition," and Human Rights in Uganda's "Gay Death Penalty"', *African Studies Review* 55(2) (2012), pp. 77-95; Neville Hoad, *African Intimacies: Race, Homosexuality, and Globalization* (Minneapolis: University of Minnesota Press, 2007), ch. 1; Sylvia Tamale, 'Out of the Closet: Unveiling Sexuality Discourses in Uganda', in Catherine M. Cole, Takyiwaa Manuh, and Stephen F. Miescher (eds), *Africa after Gender?* (Bloomington, IN: Indiana University Press, 2007), p. 10.
[792] Tamale, 'Out of the Closet', p. 18.
[793] Driberg, *The Lango*, p. 210, fn. 2; Lawrance, *The Iteso*, p. 107.

the spirits by *becoming a woman*'.[794] Moreover, as John Middleton stressed, sexual perversions were deemed to be rare among the Lugbara: 'I have heard of only two cases of male homosexual relations between adults (children's sex play is not regarded as significant). Both men concerned were married with children and regarded as being 'mad', having been influenced by the Baganda or Congolese Africans'.[795]

Psychiatrists in colonial Africa had little to say on the subject of homosexuality, seeing it, along with transvestitism and paedophilia, as extremely rare.[796] According to Charles Smartt, in Tanganyika there were 'few sexual taboos and heterosexual relations begin early. Masturbation is accepted as normal up to the age of puberty but ridiculed after maturity. The same deterrent is applied to homosexuality. Romantic love as we know it does not exist'. The rarity of homosexuality was, for Smartt, part of the cultural norms of 'tribal life'.[797] In Uganda, Kagwa reiterated the rarity of homosexuality, drawing a link between sexual attitudes and weaning practices. In an article on mental illness among East Africans in 1965, Kagwa, informed by psychoanalysis, noted that tendencies towards 'vulgarity and obscenity' were rare, but could be explained by the failure of some

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[794] Rodney Needham, *Right and Left in Nyoro Symbolic Classification* (Chicago & London: University of Chicago Press, 1973), pp. 316-7.
[795] John Middleton, 'The Lugbara of North-Western Uganda', in Angela Molnos (ed.), *Cultural Source Materials for Population Planning in East Africa* (Nairobi: East African Publishing House, 1973), p. 296. Other examples can be found in Charles D. Laughlin and Elizabeth R. Laughlin, 'The So of Karamoja District, Eastern Uganda', in Angela Molnos (ed.), *Cultural Source Materials for Population Planning in East Africa* (Nairobi: East African Publishing House, 1973), p. 355; Musa T. Mushanga, 'The Nkole of South-Western Uganda', in Angela Molnos (ed.), *Cultural Source Materials for Population Planning in East Africa* (Nairobi: East African Publishing House, 1973), p. 181; Martin Southwold, 'The Baganda of Central Uganda', in Angela Molnos (ed.), *Cultural Source Materials for Population Planning in East Africa* (Nairobi: East African Publishing House, 1973), p. 170.
[796] Laubscher, *Sex, Custom and Psychopathology*, pp. 258-64; Alexander H. Leighton *et al.* (eds), *Psychiatric Disorders among the Yoruba: A Report from the Cornell-Aro Mental Health Research Project in the Western Region, Nigeria* (Ithaca, NY: Cornell University Press, 1963), p. 111; C.G.F. Smartt, 'Mental Maladjustment in the East African', *British Journal of Mental Science* 102 (1956), 441-66 at p. 442; W.H. Watson, 'A Case of Sexual Perversion in an African Male', *East African Medical Journal* 20(10) (1943), p. 354.
[797] Smartt, 'Mental Maladjustment', p. 442.

individuals to overcome the 'restrictive developmental experience' of African childhood, in which 'prolonged breast-feeding associated with the continuous contact with the maternal body must considerably delay the sense of self-identification, individuation and self-image formation of the Ugandan baby'.[798] Homosexuality was pathologised, but not seen as an issue that required change.

The psychiatrists of the late 1960s did not regard homosexuality to be a new problem, but were sensitive to the possibility that attitudes towards it could have an effect on mental health. These fears appear to be present in German and O.P. Arya's study of student mental health at Makerere University College in 1969. Noting that homosexuality was not seen among students attending the Student Health Clinic, they described how 'three African males referred because of anxiety related to study stress, and with long standing anxious traits in their personalities, admitted, during the course of the psychiatric examination, to occasional homosexual behaviour'. It was with a note of surprise, that German and Arya added that 'none appeared to be socially or psychologically disturbed by their bisexual orientation'.[799]

Changing attitudes towards homosexuality, according to Wood, stemmed directly from legislation introduced under colonial rule. The Penal Code criminalised homosexuality as an 'unnatural offence', placing it alongside bestiality. Any person found to have committed the offence could be charged with a felony and be liable for up to seven years in prison.[800] While only a few men were imprisoned under this legislation—one in 1956, four in 1959, and one in 1960, for example—the law has nevertheless had long-term ramifications.[801]

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[798] Kagwa, 'Observations on the Prevalence', p. 681.
[799] German and Arya, 'Psychiatric Morbidity', pp. 1328-9.
[800] CAP 302, 'The Penal Code Act', (Entebbe: Government Printers, 1950),
[801] Uganda Protectorate, *Annual Report of the Judiciary for the Year Ended 31st December, 1960* (1961), p. 2.

Referring to ‘homosexual acts between consenting adults in private’, Wood noted in a lecture to lawyers that it would appear that the ‘(male) homosexual has been debarred from exercising personal liberty in the matter of sexual practice and that such legislation might be seen to contribute to the causation of mental illness in that it directly (and indirectly by influencing social attitudes) increases the psychological stresses the homosexual must overcome’.[802] For Wood, the homosexual was not only suffering from a sexual perversion, but at risk of serious mental illness from outside pressures—from punitive legislation and the changes to social attitudes that stemmed from it. While Wood did not explicitly request that lawyers attempt to seek changes in the law, he emphasised that it was only those homosexuals who engaged in sex with minors who should be considered as a serious problem for society, as this ‘might tend to mould them also to the same sexual habit’.[803]

Wood drew attention to evidence ‘for both genetic determination of homosexuality and for environmental training’.[804] ‘Special psychotherapeutic measures particularly behaviour therapy’, according to Wood, ‘has been successful in changing the homosexual attitude. So that although not termed an illness to some extent homosexuality may be benefitted by treatment’.[805] While there is no evidence to suggest that homosexuals were treated in this way at Butabika Hospital, behavioural therapy—including aversion therapy—was applied to homosexual men in the United Kingdom throughout the 1960s and 1970s.[806] The situation was perhaps more extreme in South Africa, where Tiffany Jones has highlighted how psychiatrists

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[802] Wood, 'Psychiatry for Lawyers'.
[803] Ibid.
[804] Ibid., p. 5.
[805] Ibid.
[806] Michael King and Annie Bartlett, 'British Psychiatry and Homosexuality', *British Journal of Psychiatry* 175 (1999), pp. 106-13 at p. 109.

at the South African Defence Force (SADF) Military Hospital in the 1970s 'partook in human rights abuses by utilizing aversion therapy, hormone therapy, sex change operations, and barbiturates on young white homosexual men as a means to "cure" them from their homosexual "disease."'.[807]

In making comments on homosexuality in Uganda, the psychiatrists, notably Wood, acted as social advisors, contributing their expertise on mental health to a social and legislative issue. As with their other educational activities, the psychiatrists were not afraid to be critical, using their training of lay professionals as a way of attempting to effect change.

'The Sick Mind'

In November 1966, German and his colleagues turned their attention to a new medium for the dissemination of ideas—Uganda Television. Following his arrival, German had participated in a few live discussions on mental health, and one of Uganda Television's producers, 'a highly articulate Baganda woman', suggested that the discussions be formalised under the name of 'The Sick Mind'.[808] The programmes consisted of a fortnightly forty-five minute discussion between a psychiatrist—usually German, Wood, or Bosa—and a Chair Person, and aimed at de-stigmatising mental illness and disseminating 'basic knowledge about mental health to the lay public'.[809] The use of this medium was pioneering—not only were specialists working in maternal and public health, traditionally the most innovative in

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[807] Jones, *Psychiatry, Mental Institutions, and the Mad*, p. 116.
[808] Personal communication with German, 29 January 2012. On Uganda Television see Abraham Z. Bass, 'Promoting Nationhood through Television in Africa', *Journal of Broadcasting* 13(2) (1969), pp. 163-6 at p. 164; Deborah Haskell, 'Educational Television in Uganda', *Today's Speech* 19(4) (1971), pp. 43-9.
[809] 'Department of Psychiatry Report, 1966-7'; Personal communication with German, 29 January 2012.

health education campaigns, only just starting to experiment with television, but the Ministry of Health themselves complained in 1968-9 that while television was 'fully open to us to use….We had neither actors nor films for showing'.[810]

The topics covered by the psychiatrists reflected clinical diagnoses seen frequently at Butabika Hospital and Mulago Hospital Mental Health Clinic, including affective psychoses, schizophrenia, dementia, and neurosyphilis. These topics, according to Wood, were 'surprisingly popular', adding that 'following the episode discussing GPI and Syphilis the clinical laboratories were burdened by a huge increase in requests for Syphilis testing'.[811] The interest in syphilis—by both psychiatrists and viewers—is unsurprising considering the long history of medical and morality campaigns on venereal diseases that continued into the post-colonial period.[812] Yet the popularity of the show, which was significant enough to keep the show on Uganda Television for five years, relied primarily on the personalities of those involved and the information presented by the psychiatrists: no patients appeared on the programme; neither were there any demonstrations of treatment.[813] This stood in contrast to a BBC series of five television programmes, broadcast in the United Kingdom in January 1957 under the title 'The Hurt Mind'. In one episode, which dealt specifically with physical therapies, psychiatrists were shown interviewing patients about their experiences and even staging demonstrations of electro-convulsive therapy and drug abreaction.[814]

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[810] UMOHA, GCH 9/2 (Health Education), f. 140(2), 'Plan of Work for Health Education Unit of Ministry of Health Basis for Wider Planning', 1969, p. 3; F.J. Bennett and H. Senkatuka, 'Health Education Via Mass Media', *Journal of Tropical Pediatrics* 12(supp3) (1966), pp. 31-2.
[811] Personal communication with Wood, 7 October 2011.
[812] Tuck, 'Syphilis, Sexuality, & Social Control', ch. 7.
[813] Personal communication with German, 29 January 2012; Personal communication with Wood, 3 November 2012.
[814] G.M. Carstairs and J.K. Wing, 'Attitudes of the General Public to Mental Illness', *British Medical Journal,* 6 September 1958, pp. 594-7. A selection of clips from this series is available on YouTube:

'The Sick Mind' attempted to humanise psychiatry, making visible the psychiatrists that had previously been restricted to the mental hospital, Mulago Hospital, and Makerere Medical School. Indeed, while most Africans were unable to afford a television set, the Uganda Government, under Milton Obote, had pressed for the installation of large television screens in community centres across the country. While Obote's efforts were most likely prompted by political considerations, it had the effect of bringing educational programmes like 'The Sick Mind' to communities across Uganda. Certainly, German had the experience, 'on up-country clinic visits', of meeting patients and families who recognised him and his colleagues from his on-screen activities.[815]

Whether or not 'The Sick Mind' succeeded in bringing a human face to psychiatry in Uganda, it certainly politicised it. Shortly after Idi Amin's takeover on 25 January 1971, the programme was moved to a new slot in a production entitled 'Uganda Today', a weekly programme organised by Major Bob Astles, who later became notorious as 'the white rat of Uganda'.[816] The incorporation of this show may have been intended 'to show the Amin regime in a favourable light'.[817] Amin himself was among the programme's viewers, having watched the show from The Uganda Club prior to his takeover.[818] As German recalled: 'Apparently he liked it - and one evening, having been presented with a new Polaroid camera, he photographed me on the screen and sent me the photograph'.[819]

British Broadcasting Corporation, 'Physical Mental Health Treatments 1957, Part 1', accessed 12 December 2012, at http://www.youtube.com/watch?v=2KxU3dPeink.

[815] Personal communication with German, 29 January 2012.

[816] Ibid.; Haskell, 'Educational Television'. On Astles, see 'Obituaries: Bob Astles', *The Times,* 23 January 2013; Paul Vallely, 'I Genuinely Felt That by Being There I Could Moderate His Excesses', *The Times,* 10 December 1985, p. 5.

[817] Personal communication with German, 29 January 2012.

[818] Ibid.

[819] Ibid. This photograph is still in German's possession.

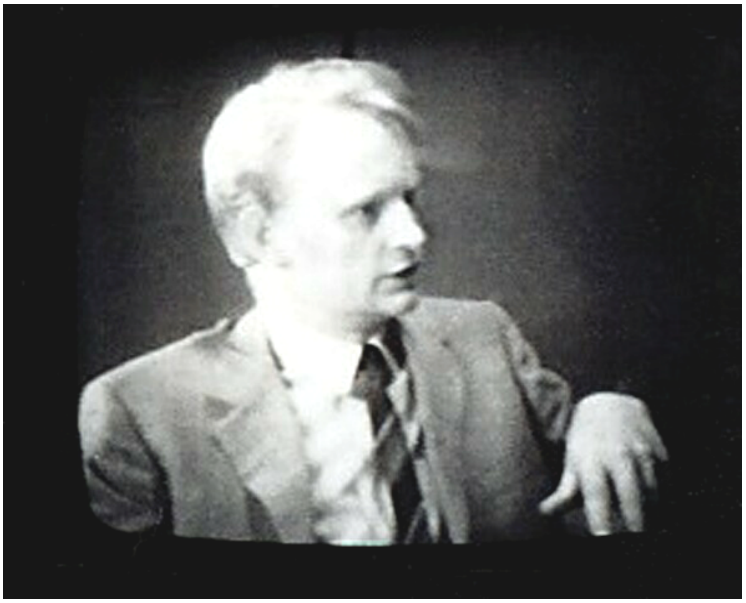

Image 10: G. Allen German on 'The Sick Mind', c.1970, taken by Idi Amin
Credit: Courtesy of G. Allen German

The photograph (Image 10), which shows German mid-conversation, appears at first glance to be innocuous, but it could be read as an attempt at the kind of intimidation Amin became notorious for; as a sign that German, and by extension all of Uganda's psychiatrists, had come to the attention of Amin, and into the world of politics.[820]

Conclusion

In their attempts to educate the wider Ugandan public on ideas about mental ill-health, the psychiatrists went well beyond their custodial and curative roles. Their actions were premised on a belief in the superiority of western ideas about mental ill-health, as well as a sense that they could contribute their expertise to issues of social planning and national development. In the United Kingdom, the shift towards a legalistic and rights-based role for the NAMH has been linked to anti-psychiatry and

[820] On Amin's use of the media see Patrick Keatley, 'Obituary: Idi Amin', *The Guardian,* 18 August 2003; Derek R. Peterson and Edgar C. Taylor, 'Rethinking the State in Idi Amin's Uganda: The Politics of Exhortation', *Journal of Eastern African Studies* 7(1) (2013), pp. 58-82.

the rise of patient user movements from the late 1960s and early 1970s.[821] The UNAMH and activities of the psychiatrists did not go this far, but they were not afraid to criticise laws and policies that they saw to be dangerous for the mental health of different groups of people. In so doing, they used their training of lay professionals in particular to effect social and legislative change.

Through their activities with the wider Ugandan 'public', the psychiatrists aimed at creating a 'modern' psychiatry in which there was little room for alternative healing systems or beliefs. The Ugandan psychiatrists in particular were wary of engaging with traditional healers, lest others see them as unscientific. In this context, the larger historiographical question appears to be less how 'African' psychiatry had become by 1972, and more how 'modern' these psychiatrists attempted to make it. What had started with an attempt by Makerere Medical School to expand psychiatric training to Africans had taken on a life and spirit of its own.

The announcement on 4 August 1972 that all Asians holding British passports had to leave to Uganda, would, as we shall see next, change everything.

[821] Crossley, 'Transforming the Mental Health Field'.

Conclusion

On 25 January 1971, Idi Amin and his army seized power in an apparently bloodless coup. Within a few minutes of the announcement on the radio, Kampala's streets were filled with hysterical crowds, rejoicing the overthrow of Milton Obote.[822] A large number of Makerere University students, too, joined in with celebrations in Buganda, having come to resent the violent and increasingly authoritarian nature of Obote's regime.[823] The initial optimism of Amin's coup, however, quickly faded as the realities of his rule became clear.[824] On 4 August 1972, Amin announced that all Asians holding British passports had to leave Uganda. The following day, midnight of 8 November was set as the deadline for departure. On 9 August, Amin extended the decree to Asian residents who were nationals of India, Pakistan, and Bangladesh.[825]

The Department of Psychiatry was immediately affected by these developments. Lovette Coelho, the Departmental Secretary, was among those required to leave Uganda. German's wife, moreover, as a Seychellois, was regarded by the Amin regime as Asian, and so, 'with some anxiety', German set about making preparations to leave. According to German, 'unbeknown to me Stephen Bosa had

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[822] S.R. Karugire, *A Political History of Uganda* (Kampala: Fountain Publishers, 2010), p. 197.
[823] Hugh Dinwiddy, 'The Ugandan Army and Makerere under Obote, 1962-71', *African Affairs* 82(326) (1983), pp. 43-59 at p. 59.
[824] Holger Bernt Hansen, 'Uganda in the 1970s: A Decade of Paradoxes and Ambiguities', *Journal of Eastern African Studies* 7(1) (2013), pp. 83-103 at pp. 87-92.
[825] Anneeth Kaur Hundle, 'Exceptions to the Expulsion: Violence, Security and Community among Ugandan Asians, 1972-79', *Journal of Eastern African Studies* 7(1) (2013), pp. 164-82; Klaus Neumann, "Our Own Interests Must Come First': Australia's Response to the Expulsion of Asians from Uganda', *History Australia* 3(1) (2006), pp. 10.1-10.17 at p. 10.1.

sought to intervene on our behalf. I believe he put his life and security at risk in so doing. His approaches were rebuffed'.[826]

The following months were characterised by a deteriorating security situation and increasingly erratic behaviour by Amin, for whom all Ugandan and expatriate staff at Makerere University were deemed to be potential threats.[827] As German recalled:

> The British High Commission telephoned me and asked me if I would help them by being their daily telephone contact at Makerere Campus. This involved them ringing me every morning to tell me of the security situation, as they saw it, for that day. I had then to walk around the various British families living at Makerere and alert them to the High Commission's advice – as to whether they should venture off campus to work that day, or stay at home etc.
>
> No doubt Amin's forces were monitoring my phone – I don't know for sure – but I became aware that I was being followed on these rounds. I was then detained and accused of being a British spy. Detention was unpleasant but mercifully brief. During it I learned of a TV broadcast in which Amin had personally warned all the British clinical heads at the Makerere Medical School, including myself, that we had been acting against him, and should leave Uganda within a week…..
>
> I was released from detention and driven back to Makerere by armed soldiers and ordered to pack and leave according to the President's directive. I was allowed no access to my office and documents.
>
> ….Amin's view was that anyone not with him was against him, and we had attracted his dangerous wrath.[828]

European and Asian staff at Makerere Medical School were in a relatively good position in terms of their options for relocation. Australia, for example, considered medical doctors, particularly those with degrees from British universities,

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[826] Personal communication with German, 29 January 2012.
[827] Hansen, 'Uganda in the 1970s', p. 96.
[828] Personal communication with German, 29 January 2012.

to be a 'migration gain'.[829] Having followed the developments in Uganda, an old colleague from Scotland had alerted German to the vacancy of the Chair of Psychiatry at the University of Western Australia, a position that he had applied for and accepted shortly before his arrest. 'So we left on October 5th, I think', German noted:

> driven by Drs Stephen Bosa and Minde in the Departmental van to the Airport at Entebbe. It was a dangerous trip given the numerous army-manned road blocks on the way to Entebbe – especially for Dr Bosa. It was a time when Amin was well launched into his attempts to eliminate the African educated class – especially Baganda members of that class.
>
> Looking back as I walked across the tarmac I saw Stephen Bosa waving until I entered the plane. I never saw him again.[830]

In the space of a few months the number of psychiatrists in Uganda dropped from twelve to nine. Those who remained did so at great risk to themselves. As Alex Odonga, previously Dean of the Medical School, recalled of the Amin years, '[k]illings and violation of human rights were everyday common things….like killing chickens'.[831] John Cox, moreover, highlighted the 'increased risk of student suicide, and the demoralisation and depression of staff that characterised the university campus during the worst years of the Amin regime in Uganda, as well as the lack of therapists'.[832]

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[829] Neumann, "Our Own Interests Must Come First", p. 10.5.
[830] Personal communication with German, 29 January 2012.
[831] Odonga, *The First Fifty Years*, pp. 160-1.
[832] John L. Cox, 'Cultural Psychiatry, Diversity and Political Correctness in a Shrinking World', *International Psychiatry* 5(2) (2008), pp. 27-8. Klaus Minde also commented on the problem of suicides in Normand Carrey, 'Interview with Dr. Klaus Minde, MD', *Journal of the Canadian Academy of Child & Adolescent Psychiatry* 21(1) (2012), pp. 65-9 at p. 67.

The loss of staff and the insecurity of the Amin years marked the end of the Department of Psychiatry's 'golden age' and the international reputation of Mulago Hospital more generally. By the beginning of 1974, Minde, Cox, Orley, and Egdell had also left the country; the WHO funded lectureship was vacant;[833] and Acuda, who had been studying at the Institute of Psychiatry in London in April 1972, felt unable to return due of the political situation.[834] Such was the shortage of psychiatrists in the early 1970s that Bosa, who was due to retire from the Uganda Medical Service at the end of 1972, was re-engaged on local contract terms as a Senior Consultant (Psychiatrist) on the request of Amin and the Ministry of Health in March 1973.[835] In increasingly trying circumstances Bosa was left to steer psychiatric services in Uganda almost singlehandedly. In 1975 he returned to Makerere Medical School to restart the postgraduate training scheme devised by German, and in 1979 convinced the Ministry of Health to set up a Psychiatric Clinical Officers Training School at Butabika Hospital.[836] 'During the unsettled years after the Amin regime', as Egdell noted, 'Steven [Bosa] continued to be the main-stay in the Ugandan mental health services'.[837] When, due to the absence of transport and security, staff at Mulago Hospital Mental Health Clinic abandoned their positions, Bosa's response was to camp in the wards with several days' food for the in-patients and himself.[838]

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[833] WHOA, M-PROJECTS UGANDA HMD-001 (Faculty of Medicine, Makerere University, Uganda), f. 3, 'First Semi-Annual Project Report 1st October - 30th November 1975'.
[834] Personal communication with Acuda, 21 October 2011. Acuda obtained his MRCPsych in April 1975. After working in London for 18 months he joined the University of Nairobi, eventually becoming Professor and Head of the Department of Psychiatry in 1983. He left for Zimbabwe in 1988 for the same post, and in 1998 returned to the United Kingdom. Acuda intended to finally return to Uganda on his retirement from the NHS in April 2012.
[835] UMOHA, C90/ACR (Bosa), f. 134, letter from S.B. Bosa, to the Permanent Secretary for Establishments, Entebbe, 31 May 1972; ibid., f. 138, letter from S.L.N. Serwanja, for Permanent Secretary for Establishments, to the Permanent Secretary, Ministry of Health, 28 March 1973; ibid., f. 139, letter from J.K. Barugahara, Ministry of Health, to the Secretary, Public Service Commission, 31 January 1973.
[836] Bosa's activities during the 1970s can be traced through ibid.
[837] H.G. Egdell, 'Obituary of Steven Bosa', *The Psychiatrist* 25 (2001), p. 36.
[838] Personal communication with Bossa, 6 July 2012; Egdell, 'Obituary'.

Such was his determination, according to his eldest son, that one day, 'medical students seeing him walk rather than drive into hospital (he had a house half a kilometer away) cheered him and said "Eh, Professor, you are walking on feet!" to which he replied, "Thank God I am not walking on my head."'.[839]

The problems of staffing continued into the 1980s, as Uganda's doctors were increasingly drawn into politics.[840] Joseph Muhangi, recently returned from Kenya, where he had been since 1975, was one of the victims. According to German:

> As the situation settled down, Professor Joseph Muhangi, then working at Kenyatta National Hospital in Nairobi, Kenya, applied for and was appointed to the Chair at Makerere. I went to Nairobi as an External Examiner in Psychiatry in 1979. I talked at some length with Joe Muhangi and I vividly recall, after congratulating him on his appointment at Makerere, warning him very strongly not to get mixed up in Ugandan politics. Joe duly moved to Makerere, and wrote me to tell me that he had two MMed students whom he planned to send to UK shortly. Some months later I learned through WHO sources in Geneva, that Joe had become a Minister in the Obote cabinet. I was saddened by this, although, aware of his enormous anger over what Amin had done, wasn't really surprised. About mid 1980 Joseph travelled with his two sons to visit family in his home state of Ankole. Returning home by road from Mbarara, he was stopped by armed anti-Obote guerrillas and shot dead in front of his sons who were left by the roadside. They were later picked up by a passing motorist.[841]

Between 1972 and 1982, the Ministry of Health's real expenditure per head of population was estimated by the World Bank to have fallen by eighty-five per cent.[842] Piped water and the mortuary's refrigeration system at Mulago Hospital broke down in 1974 and 1975 respectively, and remained in a state of disrepair for over a

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[839] Personal communication with Bossa, 6 July 2012. Bosa died at home in Kampala in 1999.
[840] On the role of Uganda's doctors in politics more generally during this time see Iliffe, *East African Doctors*, ch. 7.
[841] Personal communication with German, 29 January 2012.
[842] Iliffe, *East African Doctors*, p. 146.

decade.[843] While many left for private practice, a small group of doctors carried on, even as salaries eroded under inflation, working without drugs, adequate laboratory equipment, and sufficient staff numbers.[844]

In psychiatry, the decline of services was just as marked: the UNAMH, supported primarily by Asians and upper-class Baganda, ceased to exist; research slowed to a halt; and by the mid-1980s, the prolonged stagnation of psychiatric services stemming from civil strife and misgovernment meant that Butabika Hospital no longer had an adequate water supply or sewerage system, sufficient money for food or drugs, equipment for the Occupational Rehabilitation Unit, or funds to bury dead bodies outside of the hospital grounds.[845] As G.G.C. Rwegellera, Lecturer in Psychiatry, remarked in 1986, 'what is left now is nothing but a shadow of what was once a reasonably good and growing psychiatric care delivery system'.[846]

The almost complete collapse of psychiatry in the years following the expulsion of the Asian population by Amin in 1972 contrasts most obviously with the vibrancy of psychiatry in the late 1960s and early 1970s. Yet the political turmoil of the 1970s and 1980s, and the civil unrest that continued in northern Uganda into the 2000s, also saw widespread psychological trauma and social dislocation that pushed a much broader range mental health care options and coping mechanisms to the limits.[847] Indeed, as Patrick Bracken *et al*. reflected on attempts to establish a centre

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[843] Ibid., p. 147.
[844] UMOHL, Raphael Owor, 'Report and Recommendations of the Health Policy Review Commission (unpublished report, 1987), p.xvi.
[845] UMOHA, PH/HP/8 (Box 30 New) (Butabika Hospital), f. 111, 'Butabika Hospital: A Case for Rehabilitation', 25 January 1993, p. 1; UMOHL (Report and Recommendations), pp.72-3.
[846] ACMM, G.G.C. Rwegellera, 'The Present State of Mental Health Services in Uganda and Proposals for Their Re-Organization, 1985-1986', unpublished paper, p. 11.
[847] J. Boardman and E. Ovuga, 'Rebuilding Psychiatry in Uganda', *Psychiatric Bulletin* 21(10) (1997), pp. 649-55; Fred Kigozi and Joshua Ssebunya, 'Chronic Poverty, Wars and Mental Health: The East African Perspective', *International Psychiatry* 6(2) (2009), pp. 31-2; E. Ovuga, J. Boardman, and E.G.A.O. Oluka, 'Traditional Healers and Mental Illness in Uganda', *The Psychiatrist* 23(5) (1999), 276-279.

for victims of war-trauma and torture in Uganda in the late 1980s, '[t]he distress associated with trauma…[was]…often not conceptualized as a medical problem, and local family networks and traditional healers…[were]…felt to be the appropriate agents to deal with it'.[848]

Multiple responses to mental ill-health

Families and local communities have continued to respond to psychological trauma in their own ways in the years since 1972, just as they had throughout the period examined in this thesis. Mental ill-health did not start (or cease) to be a problem with the arrival of Europeans in 1894. As in other parts of Africa, the colonial government presented the asylum and mental hospital as a logical method of dealing with madness in a civilised society. Yet beyond the confinement of a small group of violent patients, the role of the mental hospital was limited: constrained by location, finances, and the interests of individual physicians and psychiatrists, psychiatry lacked the geographical reach and therapeutic power to be effective. Families continued to care for the mentally ill by themselves and to make decisions about treatment that were unrelated to government policy. Those families who did engage with the mental hospital did so largely on their own terms, and with their own expectations and priorities in mind.

One of the main aims of this thesis has been to push the history of psychiatry in Africa beyond the examination of government policy and colonial hegemony. It has done so primarily by focusing on a much wider range of historical actors than have usually been examined in the historiography. These have included families,

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[848] Patrick J. Bracken, Joan E. Giller, and Stella Kabaganda, 'Helping Victims of Violence in Uganda', *Medicine and War* 8(3) (1992), pp. 155-63 at p. 158.

traditional healers, salesmen, African medical practitioners, voluntary organisations, universities, and mission doctors.[849] These individuals, institutions, and organisations did not always operate independently of the state, but they nevertheless brought their own interests to their work. The decision to build a mental hospital on Mulago hill, for example, ensured that psychiatry was not isolated from the nascent intellectual community at Makerere Medical School, who were keen to set themselves apart from research being produced in Kenya. Moreover, the training of Africans as physicians created a new group of men through which psychiatry was able to operate in Uganda. As we saw through the examination of political dissent in 1940s Buganda, these western-trained African medical practitioners had their own ambitions and agendas, and acted both within and outside the confines of their assigned positions.

Contrary to histories of colonial psychiatry that imply a unity to European approaches to psychiatry and 'the African mind', this thesis has emphasised the complexity and contradictory nature of psychiatry and mental health care in the past. This theme has run through all of the chapters, but has been a particular focus of the two case studies presented in Chapters III and V. Chapter III, for example, argued that the diagnosis of neurasthenia was more than an intellectual construct. It was a condition that was as complicated and problematic when found in the hospital examination room as it was when it was debated in the medical literature. The case study presented in Chapter V, moreover, brought out competing explanations for mass hysteria in the early 1960s, as well as the widespread uncertainty and suspicion about the epidemic, both in terms of the behaviours communities had to deal with, and the strangers who came to investigate.

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[849] This list is not exhaustive, and it is likely that further research in Uganda will uncover additional historical actors. Indeed, while I was unable to locate any material relating to Asian health-care systems or independent churches, Parle's work on mental ill-health in Natal and Zululand suggests that these two groups were also invested in mental health care. Parle, *States of Mind*.

The importance of Makerere and its 'golden age'

Despite the involvement of a wide range of historical actors in the provision of psychiatry and mental health care, this thesis has argued that the reach of specialist government institutions remained limited. When active attempts to extend psychiatry were finally made in the 1960s and early 1970s, it was due to the efforts of Makerere University College and a handful of expatriate and Ugandan psychiatrists, rather than any effort by 'the state'.

The interest of Makerere University College in promoting psychiatry as a field of study and research came to define psychiatry and mental health care in late colonial and early post-colonial Uganda. While the Uganda Government continued to systematically neglect the development of psychiatric institutions and ignore the suggestions of government psychiatrists, a new Department of Psychiatry at Makerere Medical School took over responsibility for mental health care and bolstered the staff available for clinical work.

The activities of the Ugandan and expatriate psychiatrists during the late 1960s and early 1970s ushered in a 'golden age' for psychiatry in Uganda. Not only did they develop psychiatric training and research to a point where it could no longer be ignored by other health professionals, but they invested a significant amount of time and energy in advising the newly independent Ministry of Health on matters of policy. As this thesis noted in Chapter IV, such was the importance of the work of these psychiatrists that their programmes for training and delegating responsibility to a range of health care workers would later be promoted by the WHO as the most effective way of delivering mental health care in developing countries.

In its analysis of the development and role of psychiatry at Makerere Medical School, this thesis is the first to examine the history of psychiatric education in Africa

in any depth. Moreover, it has presented a history of psychiatry that is quite distinct from that in Kenya. Not only did the physicians at Makerere Medical School attempt to set themselves apart from the more racist theories that had been produced in Kenya, but the early emphasis on the medical training of Africans meant that the trajectory of psychiatry came to be quite different.

'African' psychiatry

The expansion of psychiatric education from the mid-1950s was premised on the assumption that Africans would be best placed to practice psychiatry in their own countries. This did not mean, however, that psychiatry became any more 'African' during the 1960s and early 1970s. As the epidemics of mass hysteria in the early 1960s demonstrate, even as a new generation of Ugandan psychiatrists started to play a central role in the provision of mental health care, there remained a conceptual gap in understandings of mental ill-health and in the types of treatment deemed to be effective. When the Bagisu looked for options for relief from 'mass madness', they turned to their own methods of healing—methods that did not include psychiatry.

While local concepts and beliefs about mental ill-health were acknowledged by Ugandan and expatriate psychiatrists as being important to their patients, they were accorded no formal place in 'modern' psychiatry. The educational activities the psychiatrists undertook in the late 1960s and early 1970s aimed not only at spreading western ideas about mental ill-health to the wider Ugandan public, but to mobilise supportive professionals in order to extend the reach of psychiatry beyond that which could have been achieved by the psychiatrists alone. In this context, both expatriate and Ugandan psychiatrists aimed less at creating a specifically 'African' psychiatry, than at promoting a 'modern' mental health care system—both informed by

international psychiatric theories and distinguished from 'traditional' methods of healing.

The madness of Ugandan history

In the early 1990s, the process of rebuilding psychiatry in Uganda began. Throughout this, Uganda's psychiatrists have had to contend with the effects of HIV/AIDS, increasing substance misuse problems, refugees from Sudan and Rwanda, and a high prevalence of post-traumatic stress disorder (PTSD)—a 'consequence of military violence and of being involved in a protracted war in which nearly all Ugandan families lost one member and many civilians were tortured and mutilated'.[850] Moreover, since 2009, psychiatrists, along with other health specialists, have had to deal with the puzzle of over a thousand cases of 'nodding disease' in northern Uganda. This disorder, for which the aetiology is unknown, primarily affects children between five and fifteen years, and is characterised by involuntary head nodding, an inability to eat food, and severe mental regression.[851]

In their efforts to redevelop mental health care, psychiatrists and policymakers in Uganda have looked primarily to international health organisations such as the WHO for guidance.[852] Following the WHO, the inclusion of mental health care in primary health care settings has become a major plank of Uganda's

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[850] Boardman and Ovuga, 'Rebuilding Psychiatry', p. 651. See also Kigozi and Ssebunya, 'Chronic Poverty, Wars and Mental Health'.
[851] Amy Fallon, 'Uganda: Nodding Disease Continues to Mystify', accessed 20 October 2012 at http://thinkafricapress.com/uganda/nodding-disease-continues-mystify; James J. Sejvar *et al.*, 'Clinical, Neurological, and Electrophysiological Features of Nodding Syndrome in Kitgum, Uganda: An Observational Case Series', *The Lancet Neurology* 12(2) (2013), pp. 166-74; Sarah C.P. Williams, 'Nodding Syndrome Leaves Baffled Scientists Shaking Their Heads', *Nature Medicine* 18(3) (2012), p. 334.
[852] Fred Kigozi *et al.*, 'An Overview of Uganda's Mental Health Care System: Results from an Assessment Using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO- Aims)', *International Journal of Mental Health Systems* 4(1) (2010), pp. 1-9.

mental health policy.[853] The irony of this situation, in which a country that once pioneered programmes of this kind is now receiving advice on the same subject, is lost on those in Uganda today. Indeed, when I explained to people in Uganda in 2010 and 2011 that I was interested in the history of psychiatry, they were unaware of the vibrancy that characterised mental health care in the late 1960s and early 1970s; their accounts of the history of psychiatry in Uganda were limited to brief chronologies of confinement at Hoima Lunatic Asylum, Mulago Mental Hospital, and Butabika.[854]

As this thesis has demonstrated, however, the history of psychiatry in Uganda is much richer than a narrative of government policy and confinement in a few specialist institutions. Through a long-held interest of physicians in promoting medical education in particular, psychiatry developed into a significant intellectual tradition that saw Uganda establish itself as a leader of mental health care in Africa. While the arguments made in this thesis contribute most readily to the historical literature on psychiatry, medical education, missionary medicine, and international health, it is hoped that this thesis will also be of interest to psychiatrists in Uganda today. In a country where 'development' is privileged over 'history', it would be easy for this thesis to be dismissed as esoteric. Yet many of the problems faced by psychiatrists in the past—financial neglect, under-staffing, and conceptual gaps between psychiatrists and their patients—continue to be challenges in Uganda's mental health care system today. The ways in which these problems were negotiated

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[853] Interview MUS-01; Interview NDY-01. For the ways this policy is working in practice, see: Fred Kigozi and Joshua Ssebunnya, 'Integration of mental health into primary health care in Uganda: opportunities and challenges', *Mental Health in Family Medicine* 6 (2009), pp. 37-42; Emilio Ovuga, Jed Boardman, and Danuta Wasserman, 'Integrating mental health into primary health care: local initiatives from Uganda', *World Psychiatry* 6(1) (2007), pp. 60-1.

[854] Interview MUS-01; Interview NDY-01. This chronology is repeated in almost every student dissertation on psychiatry at Makerere University. See, for example, Florence Baingana, 'The use made of Ward 16 Old Mulago and Butabika Hospital & patients views about the traditional healer' (unpublished MMed dissertation, Makerere University, 1990).

in the past could both shed light on some of the causes of current difficulties, and perhaps suggest innovative solutions.

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MLE-07: Female, Mugisu, approximately 61 years old. Interviewed in Lugisu at Manyonyi Lower Village, Bungokho Sub-County, Mbale District, 27 October 2011.

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MLE-09: Female, Mugisu, approximately 80 years old. Interviewed in Lugisu at Marare Village, Bukasakya Sub-County, Mbale District, 27 October 2011.

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