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“Madness”, emotions and loss of control in a colonial frontier: methodological challenges of crises of mind

Tracey has got the Delirium Tremens and is very ill and absolutely mad...

I know I was off my head for a couple of hours ...

-Excerpts from the diary of Edward Alston, 26 January and 16 July 1895-

Madness and (colonial) history

During his journey to take up a position in the colonial forces of British Central Africa Protectorate (now Malawi) in the mid-1890s, Edward Alston witnessed and experienced behaviours and feelings that he described as “mad” in his diary. The young officer noted that one of his fellow steamer passengers en route from Delagoa Bay to Chinde on the coast of Mozambique, a man named Tracey, had started “behaving dreadfully”: drinking heavily and becoming quarrelsome. Tracey told Alston that he had been dismissed from the navy because

of his drinking and that he was now on his way to British Central Africa in the hope of securing the command of a gunboat in the protectorate. Within two days of mentioning this drinking, Alston recorded that Tracey was suffering from “Delirium Tremens” and was “very ill and absolutely mad”. Although after being given injections by a doctor and nurse couple on board, the patient was a “little quieter”, he still at times shouted at Alston and declared that he wanted to “knife” the officer. The following day, Tracey disappeared: it was believed that he had jumped overboard and drowned himself. According to Alston, Tracey had seemed a little better in the morning, but he had looked “wild” and told people that he had “heard us talking about him, and he wanted to have it out with us”. He had calmer and more aggressive periods, but he had seemed “quite sensible” the last time Alston had seen him. The young officer concluded that Tracey ultimately jumped overboard in one of his “mad frenzies”.¹

In Tracey’s case, Alston clearly used “mad” in the sense of mental illness linked with alcoholism. His reference to “Delirium Tremens” denoted a more medicalised understanding, a formal-sounding diagnosis of Tracey’s condition, and one that helps a historian to argue that Alston did not just use “mad” as a casual description of unusual or disturbing behaviour. The association with more exact medical language provides grounds for a reading that Alston did believe that Tracey was mentally unwell, unstable, or ill.

The word “mad” had a wide range of meanings, of course. During the same journey, he also described Mrs Bernal (the wife of a British consul in Delagoa Bay) as being “mad with delight” upon hearing there was a white woman on board the steamer, (as she had not seen one in eleven months). Moreover, Alston described his own feelings as “mad” a few times: on 27 December he wrote that it was “so hot I thought I should go mad”, and on 28 January, as Tracey threatened to stab him, Alston’s own earache troubled him to the extent that “I feel almost mad with pain of ear” (original underlining).²

Although Alston was neither a medical specialist nor a diagnosed mental health patient, his diary leads us to consider “madness” and crises of mental health as subjects of historical enquiry, both more generally and especially in a colonial context. In this chapter, I explore connections between mental instability, fears of “madness” and colonial history. The general question, raised by Alston’s diary, is what people meant when they described something or

¹ Society of Malawi Library, Blantyre. Typescript copy of diary of Edward Alston, 1894–1896. Diary entries for 24–28 January 1895.

² Alston diary, entries for 27 December 1894, 19 and 27 January 1895.

someone (including themselves) as “mad”, and this leads us to consider what historians can say when interpreting such statements.

One of the challenges of the history of mental illnesses, or of madness, has been the question of understanding “the sufferer”, “the patient”, “the mad” of the past. While, for his part, Michel Foucault did not seem to believe that a genuine understanding of the mad was possible, Roy Porter held the opposing view.³ However, the issue of how to understand something beyond “normal” has been a challenging, but not unique, problem for historians: deeply religious experiences have prompted similar questions relating to conditions of understanding.⁴ Histories of strong individual experiences of emotions, pain, healing (and of course, death) raise the question of how, if at all, can historians (or anthropologists or social scientists, for that matter) discuss such things?⁵

In the case of madness and mental illness, a “safer” alternative has been to concentrate on the histories of conceptions, understanding and definitions of madness, mental illness and mental health: to shift the focus to the experts, organisations and institutions that strove to define these conditions, and which have left a rich historical archive for historians to consult. Such archives have also often enabled the study of practices of diagnosis, treatment, containment, punishment and prevention that were targeted at those defined as mad or mentally ill (or in danger of becoming so). Most chapters in this collection, for example, explore these themes in one way or another. Furthermore, there is now a rich historical scholarship on “madness”, mental health, psychiatry and colonialism in Africa, with emphasis on various colonial experts and institutions.⁶

Shifting the focus more directly to the experiences and understandings of the “mad” or mentally ill themselves, has been more difficult, but not impossible for scholars. Roy Porter, of course,

³ For a recent summary of this crucial question, see A. Bacopoulos-Vieau and A. Fauvel, “The Patient’s Turn: Roy Porter and Psychiatry’s Tales, Thirty Years on”, *Medical History* 60 (1), 2016, 1–18.

⁴ For challenges regarding historical study of personal religious life, see, for example, the concluding chapter of Paul S. Landau, *The Realm of the Word: Language, Gender and Christianity in a Southern African Kingdom* (London: James Currey, 1995).

⁵ For methodological intersections between histories of emotions, science and medicine, see, for example, Fay Bound Alberti, “Bodies, Hearts, and Minds: Why Emotions Matter to Historians of Science and Medicine”, *Isis* 100 (4), 2009, 798–10.

⁶ Richard C. Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago: University of Chicago Press, 2007); Sloan Mahone and Megan Vaughan (eds.), *Psychiatry and Empire* (Basingstoke: Palgrave Macmillan, 2007); Jock McCulloch, *Colonial Psychiatry and ‘the African mind’* (Cambridge: Cambridge University Press, 1995); Jonathan Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Berkeley: University of California Press, 1999); Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991).

pioneered this approach in Anglophone historiography. The collection of sources (both written and oral) authored by sufferers, patients or those diagnosed with mental illness has enabled the growth of research literature on the subject.⁷ In this volume, for example, “the voices” or “texts” of patients and sufferers are brought to the fore in different ways by Kirsi Tuohela and Anssi Halmesvirta.⁸ As a rule, however, these sources have been much harder to come by than those written by medical experts.

Although it has been particularly difficult to locate sufferer-authored sources in sub-Saharan Africa (and most of the colonial world), there have been important exceptions. Working with the archives of Aro Mental Hospital, Jonathan Sadowsky has analysed Nigerian patients’ statements in this hospital’s case files and thus gained insights into ideas and experiences of insanity in southwest Nigeria in the 1950s and early 1960s.⁹ Another exception is Shula Marks’ *Not Either an Experimental Doll*, which combines primary source correspondence and historical analysis. Marks provides a sensitive discussion of the mental suffering and anguish of Lily Moya, a young woman in apartheid-era Transkei. Although Moya was not diagnosed as mentally ill at the time of her correspondence, she ended her last letter to Mabel Palmer with a note “I’m very ill”.¹⁰ Marks’ own research revealed that Moya was subsequently treated by both African healers and Western psychiatric professionals. She was eventually diagnosed as schizophrenic (as Marks notes, a very common and “inexact” diagnosis given to black South Africans at the time) and hospitalised for twenty-five years.¹¹ For its part, *Not Either an Experimental Doll* highlights the problem of how to address the mental health of those who did not explicitly discuss their illness beyond a few words in a letter. Through later interviews of Moya’s relatives (and Moya herself), Marks was able to reconstruct events during and after the crisis that ended Moya’s education and correspondence – an exceptional study that is simply not possible for most historians of mental illness.

In this chapter, I explore the possibility, or danger, of “madness”, or a “crisis of mind” among early colonialists in Central Africa. During the colonial conquest and early colonial period there were only few Western alienists, “mad doctors” or psychiatrists in sub-Saharan Africa, and very few asylums. However, as a number of scholars have shown, many Europeans were keen

⁷ Roy Porter, *A Social History of Madness: The World Through the Eyes of the Insane* (London: Weidenfeld & Nicolson, 1987); Bacopoulos-Vieau and Fauvel, “The Patient’s Turn”.

⁸ See chapters of Tuohela and Halmesvirta in this collection.

⁹ Sadowsky, *Imperial Bedlam*.

¹⁰ Moya to Palmer 26 July 1951, in S. Marks (ed.), *Not Either an Experimental Doll: the separate worlds of three South African women*. (Pietermaritzburg: University of Natal Press, 1987).

¹¹ Marks, “Epilogue”, in *Not Either an Experimental Doll*, 198–209.

to assess and write about the psychology and mental health of Africans, generating a strong discourse that became gradually more medicalised and psychiatric in the early twentieth century with the emergence of colonial psychiatry. These discourses and practices have been a rich subject for scholarship, enabling both an exploration and critique of Foucault-informed analysis in colonial African contexts.¹² Psychiatry, as Richard Keller has noted, was rather unique among medical specialisations in its wide-ranging assessment of its subjects, encompassing “biological, physiological, behavioural and social dimensions”. This versatility also made psychiatry “a critical field in shaping ideas about race”.¹³ As the “gaze” of colonial psychology and psychiatry concentrated on Africans, and perceived African difference with Europeans, it tended by definition to equate European with “normal” or “healthy”. It was on the basis of this logic Frantz Fanon famously portrayed colonialism as a psychically destructive process for the colonised.¹⁴

There has been less work on the “madness” or mental illness of colonialists themselves, partly because of the nature of colonial psychiatry and its institutions. In most parts of Africa, there were no institutions for the European insane: it was more typical for people deemed mentally ill to be sent to Europe. Megan Vaughan has pointed out that European insanity and dementia in Africa was “acutely embarrassing” and regarded as a threat to colonial rule and culture.¹⁵ As was the case in India,¹⁶ the colonialists’ image and self-image as members of a superior race was seriously threatened by public displays and recognition of European insanity. Earlier research on madness, mental health and colonialism tended, as Anna Crozier points out, to focus on mental problems as part of the larger question of European acclimatisation in the tropics or on colonial psychiatry that analysed the colonised.¹⁷ Will Jackson’s recent study has drawn attention to the history of white asylum patients in Kenya. His analysis of more than 250 case files from between 1940 and 1960 emphasises the connections between insanity and late colonial weaknesses and fears. Fears of economic ruin, shame (particularly sexual stigma), violence, uprising of the colonised, and tensions of late empire are prominent in Jackson’s

¹² See, for example, McCulloch, *Colonial Psychiatry*; Vaughan, *Curing their Ills*.

¹³ Keller, *Colonial Madness*, 9.

¹⁴ Frantz Fanon, *Black Skins, White Masks* (London: Macgibbon & Kee, 1968: first French edition 1952); Megan Vaughan, “Madness and Colonialism, Colonialism as Madness: Re-Reading Fanon: Colonial Discourse and the Psychopathology of Colonialism”, *Paideuma* 39 (1993): 45–55.

¹⁵ Vaughan, *Curing their Ills*, pp. 122–123.

¹⁶ Waltraud Ernst, *Mad Tales from the Raj: The European Insane in British India 1800–1858* (London: Routledge, 1991).

¹⁷ 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 (2009): 520.

study. For its part, it highlights the importance of emotions and violence, both real and imagined, in the history of colonial “madness”.¹⁸

Crozier and Dane Kennedy have highlighted the early twentieth-century diagnosis of “tropical neurasthenia”: a peculiar condition that was as much a colonial construct as the pathologisation of the “African mind”, but which focused specifically on the white colonialists. Tropical neurasthenia became a more common diagnosis after about 1905, and in the British African Empire it seems to have been particularly prominent in East Africa, with its comparatively high number of white settlers. Crozier’s study of tropical neurasthenia in British East Africa provides a rare concentrated analysis of a particular diagnosis and its use. Tropical neurasthenia seems to have been exceptional as a specific, diagnosable condition that medicalised colonial concerns about encountering different climates and conditions in a modern way, linking them with neurology.¹⁹

Before the emergence of tropical neurasthenia in the early twentieth century, the 1890s and early 1900s marked a dynamic period for histories of colonialism and “madness” during which considerable changes in both colonial medicine and British psychiatry and neurology were underway. Mental health and illness in the early colonial period must be seen in the context both of older Victorian traditions and of newer trends in medicine and psychiatry.²⁰ The connections between encountering “alien”, particularly tropical, environments and cultures and colonial fears of degeneration, insanity, loss of control or “going native” has been highlighted in a number of studies.²¹ Fears of illness caused by tropical conditions have a longer history, of course. As Kananoja notes in this volume, eighteenth-century ideas about *banzo* in West Africa and Brazil can be placed in the tradition of spatial and climactic understandings of illness, but the recasting of notions of *banzo* also highlight changes in early modern medical thought about place, health and (mental) illness.²² Ideas and practices relating to mental health

¹⁸ Will Jackson, *Madness and Marginality: The Lives of Kenya’s White Insane* (Manchester: Manchester University Press, 2013).

¹⁹ Crozier, “What Was Tropical about Tropical Neurasthenia?”; Dane Kennedy, “The Perils of the Midday Sun: Climatic Anxieties in the Colonial Tropics” in J. Mackenzie (ed.), *Imperialism and the Natural World* (Manchester: Manchester University Press, 1990).

²⁰ Sloan Mahone, “East African Psychiatry and the Practical Problems of Empire” in Mahone and Vaughan (eds.), *Psychiatry and Empire*: 57–58; W.F. Bynum, “The Nervous Patient in Eighteenth and Nineteenth-Century Britain: the Psychiatric Origins of British Neurology”, in W.F. Bynum, R. Porter and M. Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry*, Vol. 1 (London: Tavistock, 1985).

²¹ See, for example, Dane Kennedy, *Islands of White: Settler Society and Culture in Kenya and Southern Rhodesia, 1890–1939* (Durham: Duke University Press, 1987); Ernst, *Mad Tales from the Raj*; Jackson, *Madness and Marginality*.

²² See Kananoja’s chapter in this collection.

and illness among colonial explorers, missionaries and officials of the “Scramble for Africa” period had their roots not only in Victorian ideas about nerves and health²³ but also in older medical traditions concerned with European acclimatisation.²⁴

Late nineteenth-century discussion of colonial mental health can be seen as part of a more general discourse about colonial *hygiene*: the question of how to stay healthy in the colonies. Mental hygiene played a crucial part in colonial and missionary hygienic regimes.²⁵ During this period, threats to mental health in the colonial world were often highlighted in the context of other diseases. In the period of exploration and conquest in Central Africa, malaria, or “malarial fevers” were the most significant of these, seen as they were as the greatest threats to European life and health.²⁶ Attention to mental, psychological and neurological dimensions of colonial thought about malaria highlights further connections between colonial fears of loss of control, madness, disease and medicine. I would argue further that, given their crucial role in the early construction of colonial culture and society, it is also necessary to study the thought and practice of colonial laymen, not only that of medical professionals. In colonial frontier zones laymen could, and often had to, practise medicine and self-medication, and experience and empiricism were generally valued.²⁷

Historical anthropologist Johannes Fabian has provided further perspectives on colonialism and “madness”, in *Out of Our Minds: Reason and Madness in the Exploration of Central Africa*. Drawing on a rich range of published sources by European explorers in Central Africa, Fabian explores and critically interrogates colonial processes of knowledge-making and the complications of colonial encounters. While he certainly does question individuals’ reason and rationality, Fabian’s aims are wider than those of a contained critical study of a set of

²³ Janet Oppenheim, *“Shattered Nerves”: Doctors, Patients and Depression in Victorian England* (Oxford: Oxford University Press, 1991).

²⁴ For the British in India, see Mark Harrison, *Climates and Constitutions: Health, Race, Environment and British Imperialism in India 1600–1850* (New Delhi: Oxford University Press, 1999); for geographers, explorers and African interior, see David N. Livingstone, *The Geographical Tradition* (London: Blackwell, 1992): 232–241.

²⁵ See, for example, Johannes Fabian, *Time and the Work of Anthropology*, (Chur: Harwood Academic Publishers, 1991): 158–163; Markku Hokkanen, “Moral Transgression, Disease and Holistic Health in the Livingstonia Mission in Late Nineteenth- and Early Twentieth-Century Malawi”, *Asclepio: Revista de Historia de la Medicina y de la Ciencia* LXI (2009): 244–257.

²⁶ Michael Worboys, “Germs, Malaria and the Invention of Mansonian Tropical Medicine” in D. Arnold (ed.), *Warm Climates and Western Medicine: the Emergence of Tropical Medicine, 1500–1900* (Amsterdam: Rodopi, 1996); Philip D. Curtin, *Death by Migration: Europe’s Encounter with the Tropical World in the Nineteenth Century* (Cambridge: Cambridge University Press, 1989).

²⁷ For lay missionary medicine, see Ryan Johnson, “Colonial mission and imperial tropical medicine: Livingstone College, London, 1893–1914”, *Social History of Medicine*, 23 (2010); for an example of lay medical discourse in British Central Africa, see *Central African Planter* 1, October 1895.

nineteenth-century explorers, however. He provides a critique of not only colonial knowledge, but also many underlying assumptions of scientific enterprise more generally, and those that underpin the discipline of anthropology in particular.²⁸ Here, I focus on the notions of “madness” and mental illness in Fabian’s study, which have methodological importance for historians and which further highlight the connections between madness, malaria and medication.

Despite its inclusion in his study’s title, Fabian does not explicitly discuss or define “madness” or mental illness. His critique of the rationality of explorers does, to an extent, depend on the reading that the explorers were, in some ways, “out of their minds” in their encounters with Africans and circumstances in Africa. The evidence for this is drawn partly from sources that record explorers’ evident suffering from (physical) illnesses and attendant fears of illness and death, as well as their seemingly rather common use of alcohol and drugs (particularly opiates such as laudanum).²⁹ In addition to the material evidence of drugs and disease, and the intellectual evidence of colonial hygienic thought, Fabian teases out evidence about explorers’ irrationality from the contradictions within their writings.³⁰

Fabian’s primary interests lie somewhere other than an assessment of the past state of mental health of colonial explorers. Rather than “madness”, he discusses the state of “ecstasis” in colonial encounters, a state that can be partly induced by alcohol, or drugs, or illness.³¹ It should be noted that he extends this discussion to anthropologists, including himself. Nevertheless, I would argue that whilst Fabian partly sidesteps the difficult question of what can we say about the mental health of the colonial writers whose texts we study, he argues that what we know of the physical conditions and influences under which explorers were likely to operate, combined with the contradictions that we can find in their texts, is sufficient justification to question their rationality. Without recourse to explicit medicalisation Fabian is nevertheless questioning the “sanity” of explorers. However, this reading is dependent on medical and material presuppositions: can a person of the past under the influence of opiates, large amounts of whisky, cannabis or high fever be considered mentally unstable, or “ecstatic”, or “mad” in the same way that a person of the present might be viewed.

²⁸ Johannes Fabian, *Out of Our Minds: Reason and Madness in the Exploration of Central Africa* (Berkeley: University of California Press, 2000).

²⁹ Fabian, *Out of Our Minds*: 58–71.

³⁰ *Ibid.*, 9–14 and *passim*.

³¹ *Ibid.*, 7–9 and *passim*.

The exploration of contradictions, or perceived irrationality, within sources written by the same person (or of their actions and behaviours described in other sources) are arguably an essential part of any critical historical reading, but this consideration carries special significance with reference to mental health of our subjects. Fabian, in his way, uses critical reading to make sense of the irrational, but, to reiterate, he stops short of diagnosing or defining their “madness”.

If we compare Fabian’s discussion of his subjects with explicitly psychohistorical approaches, we can see both differences and common ground. Historical psychiatrist Miles F. Shore, in his study of Cecil Rhodes, set out to understand “what did not make sense about [Rhodes]”. For Shore, ‘The clinician’s task begins when common sense fails’. He argued that the “data available in historical records of Rhodes” was actually not much less than that which is often available to clinical psychiatrists. Both the historian and the clinical psychiatrist interviewing their patient work with data that is fragmented, incomplete and “never final”.³² Shore was not attempting to provide a diagnosis of mental illness, but he did seek to explore the possible deeper psychological motivations of Rhodes. Shore was nevertheless reading Rhodes’ texts as a psychiatric clinician, for whom “incongruity and inexplicable behaviour” were “opportunities to open deeper layers of meaning”.³³

Both Fabian and Shore, an anthropologist and a psychiatrist, approach historical evidence in ways that depend on and accommodate the irrational, the contradictory and the inexplicable more explicitly than is the case for most traditional historians. Both of them discuss individuals who were not diagnosed as insane, but whose thoughts and actions had important irrational or inexplicable elements. And both are, in different ways, comfortable with the idea of their subjects’ seeming irrationality or strangeness, which they set out to understand and to explain, not merely dismissing irrationality away as human error or as insignificant, quirky details irrelevant to the bigger picture.

Malaria, drugs and “madness”

Unlike Shore’s study of Rhodes, however, Fabian’s study of explorers depends to an important extent on the materiality and physicality of their condition and circumstances. Drugs and malarial fever, and their effects on the bodies and minds of colonial explorers, are considered real and reliable.³⁴ The connection between disease, drugs and “madness” or mental illness in

³² Miles F. Shore, “Cecil Rhodes and the Ego Ideal”, *Journal of Interdisciplinary History* 10 (1979): 249–265.

³³ *Ibid.*, 250.

³⁴ Fabian, *Out of Our Minds*: 58–71.

the tropics is something that was largely shared by Victorian colonialists and later historians of colonialism. This connection appears, for instance, in Vaughan's 1983 study of colonialism and madness. Whilst this article primarily focused on colonial constructions of African insanity in the context of Zomba asylum in Nyasaland, Vaughan also touched upon the question of mental illness among early colonialists in Malawi. Vaughan located European fears of insanity and "going native" in the context of the fragile mental and physical health of colonialists, citing cases of illness, madness and morphine addiction. In particular, she highlighted the case of Third Assistant R. R. Racey, who "went mad at his post in the Lower Shire Valley". Racey seems to have become obsessed with the indigenous cult of Mbona, and described, in Vaughan's words, "his efforts to fight off an evil force using pseudo-scientific reasoning and Christianity."³⁵

In Racey's case, we can arguably see a rare example of "madness" in the situation of colonial encounters in Central Africa, as recounted by a mentally ill colonialist. Racey described the "spirit of unchaste love" (shaped "like a dolphin" that "absorbs the intelligence of its victims" and created "unlawful passions") which took control of his feet and legs. Racey seems to have displayed common colonial ideas about control, albeit in a distorted fashion: "the stronger and purer in essential quality the individual is, so in proportion will he have influence, not only amongst the native and climatic conditions here, but also the world over..."³⁶ These references to "native and climatic influences" and "unlawful passions" bring us back to connections between colonial hygiene, ideas of control, emotions and morality, fears of "madness" and disease.

For Edward Alston and his contemporary colonialists in Central Africa in the 1890s (like earlier European explorers), malaria and other "African fevers" were the most serious threat and potential obstacle to colonisation. This had been the view of David Livingstone in the 1850s, when he propagated quinine as a game-changing general drug that could secure European life in Central Africa. After Livingstone's death, his "Livingstone Pills" or "Livingstone Rousers", and quinine more generally, established a pivotal place in early colonial medical and hygienic

³⁵ Megan Vaughan, "Idioms of Madness: Zomba Lunatic Asylum, Nyasaland, in the Colonial Period", *Journal of Southern African Studies*, 9 (1983): 218, 232–233.

³⁶ Quoted in Vaughan, "Idioms of Madness", p. 218.

culture. One of the key British proponents of quinine was Horace Waller who as the editor of Livingstone's last journals framed the explorer doctor's legacy.³⁷

Waller viewed quinine as a general panacea in the fever zones of Central Africa. Like Livingstone, Waller held that most, if not all, incidences of illness (including mental illness) in the region were actually manifestations of fever. In his guidebook on health in Central Africa, malarial fever was characterised as the main enemy with quinine (both prophylactic and curative) posited as the most significant means of defence. One of the successful uses of quinine cited by Waller was a case of "raving mania" that had been treated promptly by Livingstone and John Kirk.³⁸

However, improper use of quinine could be dangerous to nervous and mental health. Waller warned his readers not to be "always at the quinine bottle". Overuse could, he claimed, make one nervous and feverish: in fact, one might display some of the symptoms of the dreaded fever itself. Nevertheless, Waller also saw value in quinine as a sedative.³⁹ Europeans in late nineteenth-century East and Central Africa often kept quinine, together with arsenic, on their dining tables.⁴⁰

In late Victorian and early twentieth-century medicine, quinine was a popular nerve tonic that was frequently combined with arsenic and iron. It was also prescribed for physical ills ranging from toothache to influenza.⁴¹ However, quinine had also its critics, and its use became a particularly contested issue in Central Africa in the 1890s, with several Europeans dying from blackwater fever. The defenders of quinine saw it as the "sheet-anchor" against all malarial fevers and argued that its bitter taste and the ringing of ears that accompanied its use were its only side-effects. By contrast, critics suspected that quinine could itself cause or contribute to

³⁷ G. C. Cook, 'Doctor David Livingstone FRS (1813–1873): "The Fever" and other medical problems of mid-nineteenth century Africa', *Journal of Medical Biography*, 2:1 (1994); Markku Hokkanen, *Medicine and Scottish Missionaries in the Northern Malawi Region 1875–1930: Quests for Health in a Colonial Society* (Lewiston: The Edwin Mellen Press, 2007): 66–68. For Waller, see Dorothy O. Helly, *Livingstone's Legacy: Horace Waller and Victorian Mythmaking* (Athens: Ohio University Press, 1987).

³⁸ Horace Waller, *Health Hints for Central Africa* (London: John Murray, 1893): 30–31.

³⁹ *Ibid.*, 55–57.

⁴⁰ Fabian, *Out of Our Minds*: 66–67

⁴¹ For nerve tonics see Oppenheim, "Shattered Nerves"; for the myriad uses of quinine in missionary medicine, see Hokkanen, *Medicine and Scottish Missionaries*.

the deadly blackwater.⁴² Furthermore, some, such as lay medic and planter Allan Simpson, argued that overuse of quinine could also cause “madness”.⁴³ Simpson, who drew on his extensive experience as a pioneer colonial survivor and experimental empiricist in Central Africa, did not specify how he believed quinine could cause such a state. However, it is likely that his suspicions stemmed from the established association between quinine and the nervous system: what could be a beneficial stimulating tonic, could also, wrongly used, cause nervous damage and compromise the mind. In principle, the same risks applied to quinine as to alcohol, which was a far more divisive medicine in early colonial culture: for some alcohol was seen as an absolute medical necessity, while others viewed it as being excessively dangerous in a tropical climate.⁴⁴

What is notable here is that the use of quinine (as well as alcohol) were contested and debated issues in colonial culture, discussed by laymen as well as medical professionals. In British Central Africa, contributions to *Central African Planter* (an early settler journal) displayed both interest in and scepticism towards professional medico-scientific discourse, with a common theme being the need for empiricist experimentation that would allow individuals to find out what worked for them.⁴⁵ For its part, Alston’s diary records unsystematic use of medication, including quinine, opiates as well as champagne (recommended in the treatment of blackwater).⁴⁶ However, it is often difficult to assess Alston’s state of mind on the grounds of his medication or fever experiences. Serious attacks of malaria usually rendered sufferers unable to write much during an episode.

Less deadly but painful ailments could be discussed in more detail than serious episodes of malaria. Alston’s mental and physical state were particularly shaken by his experience of “prickly heat”, a skin condition that affected his chest and shoulder and which he described as “torture, it makes me rush out and curse and swear and I can never eat or drink anything” (original underlining). One day he wrote “I am sure I shall go mad. Have been completely off my head with this damnable prickly heat.” Lacking “violet powder” or eau de cologne, Alston sprinkled flour on his body. At the same time, the cries of his young servant “boy”, Waya, who

⁴² *Life and Work in British Central Africa*, September and October 1894; Hokkanen, *Medicine and Scottish Missionaries*: 225–227.

⁴³ *Life and Work in British Central Africa*, November 1894.

⁴⁴ On alcohol and health in colonial culture, see for example, Fabian, *Out of Our Minds*: 66–71; Hokkanen, “Moral Transgression, Disease and Holistic Health”.

⁴⁵ *Central African Planter* 1, October 1895.

⁴⁶ For examples, Alston diary, entries for 16 March, 7–9 May, 5 September, 19 October 1895.

was suffering with toothache were also driving Alston “mad”.⁴⁷ Fear of insanity and illness is clear in Alston’s account, with the prospect of real “madness” ahead. This madness was clearly seen as a threat, although his writing displayed both colloquial and more pathological usages of the term. However, in writing about it casually, one might argue that Alston was attempting to control the fear of madness and assure himself of his continued sanity.

“Off my head”: Madness, grief, and violence

Arguably the most anguished, emotional and disturbed entries in Alston’s diary concerned the officer’s beloved collie, Don. While Don was alive, Alston expressed more concern about the dog’s health than about his own. His diary was filled with details of how he fed and nursed Don, and the loving kindness that the animal displayed in return.⁴⁸ Alston suspected that Don had developed malaria or blackwater fever and so treated him with quinine.⁴⁹ Reflecting on his mental state when he thought that his dog had gone into the grass to die, Alston concluded that he had been briefly mad with grief: “I know I was off my head for a couple of hours...and fairly bewailed my fate.” When Don was found alive, Alston carried him back to camp “crying for joy, and put him on my bed.”⁵⁰ Alston’s diary entry on the dog’s seeming recovery was elated, “Thank God for it. I am so glad” [original underlining].⁵¹ This diary entry can be read as evidence of emotional relief and also of a state of “ecstasy”.⁵²

However, Don’s condition worsened and he died three days later. Alston’s entry for the day reads in full:

*My sweetest Don died in my arms at 7.15 p.m. The best, most loving and truest friend I ever had or am likely to have. I adored him as he did me. He was perfectly human. This is very black day in my life, I shall never never have another collie again, I feel as if I could never have any more affection for anyone.*⁵³(original underlining)

⁴⁷ Alston diary, entries for 1-5 November 1895. Not without sympathy for Waya, Alston tried to treat the toothache with various remedies (including carbolic acid and bromide).

⁴⁸ Alston diary, entries for 17 April, 10 July, 13-15 July 1895.

⁴⁹ Alston diary, entries for 8 –10 July 1895.

⁵⁰ Ibid., entry for 16 July 1895.

⁵¹ Ibid., entry for 19 July 1895.

⁵² Fabian, *Out of Our Minds*, 7–9.

⁵³ Alston diary, entry for 22 July 1895.

Love, an extremely strong bond and identification with Don is clearly evident. The grief-stricken Alston wrote nothing more for six days. He dedicated time and effort to setting up Don's enclosed grave (using five thicknesses of bamboo fence) in the colonial capital, Zomba, and found that he could not "tear [himself] away" from it. In his diary, Alston noted that he missed Don so much that he would give up either of his arms away to have the collie back and that he thought of the dog all the time: "No dog was ever loved as Donnie was, and I love him now and shall love him for ever."⁵⁴ (original underlining)

Alston's dedication to Don's grave drove him to clash with a fellow officer in Zomba, Edwards, who "dared" to ask why Alston had buried his dog in such a manner. Alston lost his temper and had "devil of a row" with Edwards: "I felt inclined to absolutely knock him down and kick him when he taunted me with being womanish about Donald". Despite feeling violent rage, Alston found the most effective weapon with which to frighten his opponent "and to bring him to his senses" was to speak of the Foreign Office (suggesting Alston had potential connections there). When he left Zomba on a posting elsewhere, Alston was reluctant to leave the grave and made a fellow officer promise to look after it faithfully. Later, while feeling slightly feverish, Alston had one particularly detailed dream in which he was travelling in Europe and discovered that his beloved collie was safe and well.⁵⁵

It seems that Edwards may have sought revenge on Alston: he planned the establishment of a rifle range over Don's grave. When Alston received a note detailing Edwards' plans, he was "so upset and annoyed that I can hardly write". While he had to agree to Don's bones being dug up and buried elsewhere, Alston emphasised in his reply to Edwards that these remains were "perfectly sacred" to him and he pleaded for them to be treated with due respect.⁵⁶ Alston's dedication to Don's memory, body and grave seemed to have developed almost cultish features.

Recent studies have connected colonial violence to colonialists' fears and weaknesses, as well as physical and mental illness.⁵⁷ In addition to notes on illness, suffering, anguish and fear, Alston's diary contains important and illuminating references to violence, both real and imagined. Whilst he contained his urge to assault Edwards and to shoot some of his Sikh subordinates (over their complaints about food), Alston clearly beat his African workers on

⁵⁴ Ibid. Entries for 2, 8 and 9 August 1895.

⁵⁵ Ibid., entries for 10 August, 20–22 August, 26 September 1895.

⁵⁶ Ibid, entries for 16-17 October 1895.

⁵⁷ Fabian, *Out of Our Minds*: 144–150; Jock McCulloch, "Empire and Violence, 1900–1939", in P. Levine (ed.), *Gender and Empire* (Oxford: Oxford University Press, 2005); Jackson, *Madness and Marginality*.

occasions. On that same happy day that Don was found alive Alston administered 20 strokes to an Atonga man, noting “Hated it, but he was such a humbug.”⁵⁸

In addition, Alston delivered “a dozen” (it is unclear whether these were whip lashes or cane strokes) upon a station worker for his “idleness”. That day, when suffering from “prickly heat”, Alston described himself as being “very sulky and angry”, but also claimed that he had laid the strokes “very gently”.⁵⁹ Alston resorted to violence rather casually seemingly on good and bad days alike, but there was some evidence of reluctance and guilt.

Alston also witnessed an extreme example of violence inflicted on African bodies. He was shocked to discover that a big game hunter, Gordon Cumming, whom he had earlier described as “the very best fellow I have ever known” had “a hobby for skulls”. Cumming had apparently severed and collected the heads of Mlozi (the leader of Swahili traders who had fought the British) and a man who had tried to kill Cumming on a battlefield. Alston was horrified to learn that Cumming kept the skulls in the box the two men used as a dining table. Alston felt a “nasty aroma” in the room and finally persuaded Cumming to move the box outside.⁶⁰ Whilst Alston did not declare Cumming mad, he was clearly eager to get away from him and his morbid “hobby”, which, as John McCracken notes, was not atypical among Victorian colonialists.⁶¹

For our inquiry, however, the key question is what if any label we should assign to Alston and Cumming’s states. Was either or both of them “mad”, mentally unstable, eccentric, or something else? In Alston’s case we have his diary, whereas for Cumming we merely have Alston’s evidence.

Alston’s unease about Cumming and his skulls suggests that on the colonial frontier the limits of what was acceptable, normal or sane, were at times blurred and that this could exacerbate a fear of loss of control. Was the man Alston earlier described as “the very best fellow” beyond the boundaries of propriety? Alston’s diary does, in my mind, raise this question and the implicit question of Cumming’s state of mind, but leaves them open.

Finally, did Alston “go mad” or “out of his mind”, particularly during and after Don’s illness and death? He himself seemed to think that this had briefly been the case. In writing “I know I

⁵⁸ Ibid., entry for 19 July 1895.

⁵⁹ Ibid., entry for 5 October 1895.

⁶⁰ Alston diary, entries for 18-21 January 1896.

⁶¹ John McCracken, *A History of Malawi* (Woodbridge: James Currey, 2012): 23n120.

was off my head” in his diary, Alston reflected retrospectively on a recognised personal state of momentary madness. In Alston’s text, madness was a state that was either in the past or a future threat, not something experienced at the present moment of writing. But can we say more in our interpretations? Overall, Alston’s expressions and accounts of his actions seem clearly marked by strong emotions of fear, grief, and anger, and it is tempting to call some of his thoughts and actions obsessive and erratic. I would argue that Alston’s mental state suffered a crisis during which the strong emotional bond and identification with his dog (whose health seemed to be threatened by the same tropical dangers that Alston himself faced) is noteworthy. In my mind, Alston’s account of this relationship reveals certain colonial fears and weaknesses more directly than many self-reflective accounts. It seems that for a Victorian officer instilled with a strong sense of masculine strength and self-control,⁶² affection towards a loyal animal companion enabled a particular expression of personal emotional fragility in the forms of love, fear, sadness and grief. In the colonial culture of holistic hygiene, as Fabian notes, such fragilities were deemed dangerous, leaving men vulnerable to malarial fevers.⁶³ Edwards’ jibe that Alston was being “womanish” about his dog hit a raw nerve: it called into question Alston’s manliness in his state of grief, and possibly also questioned his mental health, as over-emotionalism was commonly seen as symptom of hysteria (a mental illness attributed particularly to women).

Alston certainly did not at times seem fully rational, but I would hesitate to interpret his mental state in medical terms. This approach I share with Fabian: the attempt to make sense of the unusual and the irrational, in tandem with the argument that the unusual and irrational can be important. However, I diverge from Fabian in my belief that colonial “madness” needs to be considered more directly. Ultimately, my reading of Alston’s diary is, to an important extent, based on attempts to exercise empathy and imagination, whilst simultaneously recognising the limits of these attempts. Alston’s thoughts and actions seem to me at the same time strange and, to an extent, understandable.

In his useful discussion of methodology in histories of psychiatry, Frank Huisman has emphasised the need to distance ourselves for our subjects’ perceptions and values, arguing

⁶² On ideals of masculinity and discipline in Victorian culture, see, for example, Peter Gay, *The Cultivation of Hatred: The bourgeois experience Victoria to Freud Vol. III*, (New York: W.W. Norton, 1993); J.A. Mangan, *The Games Ethic and Imperialism: Aspects of the Diffusion of an Ideal* (Reading: Frank Cass, 1998).

⁶³Fabian, *Time and the Work of Anthropology*: 158–160.

that a degree of irony and aloofness should be employed.⁶⁴ This is particularly true when studying historical agents who shaped psychiatric discourse, but it is also valuable in the study of lay perceptions of “madness”. However, if we move beyond perceptions and attempt to understand experiences such as Alston’s mental state, an ironic and aloof stance is surely less fruitful. Perhaps we sometimes need to “step out” of aloofness towards a more empathetic understanding of our subjects. Having tried to do so, we must then re-establish critical distance from our subjects, sources and ourselves, a crucial condition for writing a nuanced interpretation. These steps are fraught with difficulties, as practising historians are well aware, and it must be stressed that my reading of Alston’s diary is just one among a range of possibilities.⁶⁵ The choice not to describe Alston as depressed, or manic, or mad, is ultimately mine. Warnings raised about the language used by historians of madness are useful here,⁶⁶ but it is probably easier to avoid medical vocabulary or loaded terms such as “mad” when considering subjects who are laypeople rather than psychiatrists or inmates of an asylum.⁶⁷

“Mad” is a powerful word with multiple meanings that is hard to ignore, yet our craft as historians may require sidestepping it in attempts to understand the crises of past minds. Recourse to a vocabulary of emotions, particularly anguish, grief and fear, may in many cases be more fruitful. And in colonial contexts, attention to control, loss of control and fears of such a loss are recurrent, significant issues that connect crises of mind with both histories of emotions and those of violence.

Primary sources

Society of Malawi Library, Blantyre. Typescript copy of diary of Edward Alston, 1894–1896.

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⁶⁴ Frank Huisman, “From Exploration to Synthesis: Making New Sense of Psychiatry and Mental Health Care in the Twentieth Century”, in M. Gizswijt-Hofstra (ed.), *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches* (Amsterdam: Amsterdam University Press, 2006): 418–419.

⁶⁵ As Huisman has pointed out, in the present day, almost everybody has become a potential mental health patient. Huisman, “From Exploration to Synthesis”: 416. This arguably raises the risks of anachronistic diagnosis projected into the past.

⁶⁶ Toni Gomory, David Cohen and Stuart A. Kirk, “Madness or Mental Illness? Revisiting Historians of Psychiatry”, *Current Psychology* 32 (2), 2013.

⁶⁷ For an emphatic reading of colonial asylum case records, see Jackson, *Madness and Marginality*.

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