Aberration of Mind

Sommerville, Diane Miller

Published by The University of North Carolina Press

Sommerville, Diane Miller.
Aberration of Mind: Suicide and Suffering in the Civil War–Era South.
Chapter 4  
Somethin’ Went Hard agin Her Mind  
*Suffering, Suicide, and Emancipation*

The negro mind does not dwell upon unpleasant subjects; he is irresponsible, unthinking, easily aroused to happiness, and his unhappiness is transitory, disappearing as a child’s. . . . He is happy-go-lucky not philosophical. His peculiar mental attitude is not the result of a knowledge that his poverty, his social position, his unhealthy and cheerless surroundings cannot be bettered, therefore are to be borne cheerfully. . . . Depression is rarely encountered even under circumstances in which a white person would be overwhelmed by it. The expression of suicidal ideas is seldom heard, and suicide is an extremely rare occurrence in the negro race.

—E. M. Green, clinical director, Georgia State Asylum, 1914

In early September 1869, Joe, a “negro man” living with Mrs. Polly Taylor, was found hanging “by the neck” in the stable, “quite dead.” Joe had been a “faithful servant, the main stay of Mrs. T. and was generally cheerful,” a Virginia newspaper reported. About four years earlier—a time roughly corresponding to the end of the war and the abolition of slavery, a coincidence that went unnoticed by the reporter—Joe experienced an attack of “religious melancholy.” The recurrence of “that disease,” it was supposed, accounted for his death by his own hands. “He is a great loss to the good old lady with whom he lived,” concluded the report.¹

Joe’s death must have puzzled white observers and readers. White racialized thought before the Civil War, as outlined in the previous chapter, shaped by self-interest, disavowed notions of slave suffering and suicide. How then would Southern whites react to incidents of suicide among the emancipated? How did one make sense of Joe hanging himself? What was the meaning of Joe’s suicide? How did the meaning of suicide change, if at all, with the end of slavery? The white explanation for Joe’s suicide pointed to a vague “disease” called “religious melancholy,” an obsession or “monomania” fixated on religious themes and linked to religious exertion. But the term had been rarely applied to anyone but whites. With emancipation, however, freedmen and freedwomen now indulged in politics and religion and outside the watchful eye of white supervision. For whites, Joe’s suicide likely augured a predictably dismal future for the region’s blacks: unrestrained and ill-prepared for...
the responsibilities in freedom, former slaves now became susceptible to self-
destruction, until now, a white phenomenon. If freedpeople suffered in the
postwar years, as Joe’s suicide seemed to intimate, it was suffering wrought by freedom.

For historians, Joe’s suicide raises different questions and answers. Why
would a newly freed slave voluntarily choose death after freedom finally had
been won? What of the rapture usually associated with the welcomed end of
the institution of slavery? Where does Joe’s decision to kill himself fit in the
narrative of jubilee? If suicide occurred regularly among the enslaved, and
largely as a consequence of long-standing suffering and abuses withstood by
bondspeople, and the cause of slave suicide had been removed, then Joe’s
death at his own hands makes little sense.

This chapter examines the practice of suicidal behavior among African
American Southerners after the Civil War in the larger context of postwar
conditions, as well as attitudes toward black suicide by whites and non-whites
of the region, and explores the impact of emancipation on those behaviors
and attitudes. Did slavery’s demise affect the nature of suffering among South-
ern blacks? Were incidents of black suicide affected by the war’s end and
with it slavery? Did emancipation remove the impetus that slaves had to en-
gage in suicide? Or, did the experience of freedom create a new set of circum-
stances to which suicide became a common response by freedmen and
women? Finally, how did Southerners, white and black, regard suicidal ac-
tivity among African Americans?

Compared to studies of suicide and slaves, far less attention has been paid
to suicidal activity among freedpeople. David Silkenat’s monograph Moments
of Despair, one of the few scholarly works to do so, touches on the impact of
the war and emancipation on North Carolina’s formerly enslaved population
and their attitudes toward suicide and suggests that a significant change oc-
curred. Suicide among the enslaved in North Carolina, he asserts, had been
endemic. The enslaved viewed self-destruction as a “symbol of resistance,” a
way to exert control over their lives as well as to challenge an owner’s author-
ity; the enslaved naturally accepted self-destruction as a “fundamental as-
pect of slave life.” But following emancipation, Silkenat finds, North Carolina
blacks reformulated their attitudes toward suicide. In freedom, suicide came
to viewed as a violation of a newly constructed code of personal and commu-
nal commitment to life. African Americans, shackles removed, now had an
obligation to live.2

Silkenat’s contention that the formerly enslaved rejected suicide as a reason-
able response to life’s burdens makes sense and appears supported by anecdotal
evidence. As with slave suicides, reports of black suicide in newspapers after
the war are few and terse, suggesting that the rhetoric about “suicide mania”
pervading the South was largely a white phenomenon.\textsuperscript{3} In addition to the paucity of news reports of black suicide, many blacks and whites continued to insist that blacks rarely committed suicide.\textsuperscript{4} Despite the dearth of news reports about cases of African American suicide, many black Southerners did engage in suicidal activity after the war.\textsuperscript{5} While the horrors and brutality of human bondage disappeared after the war, many triggers, some new, some revamped, some familiar, including the similar ones that drove Southern whites to consider self-murder, surfaced in the post-slavery world. Suicide among Southern blacks emerged after the war in response to an entirely new set of conditions that caused considerable suffering. Blacks and whites in the postbellum South also reconfigured their understanding of suicide in light of the changing social, political, and economic climate.

Recent works on the well-being of freed slaves reveal the considerable challenges faced by Southern blacks in the postbellum period and the effects of those challenges on the physical and emotional fitness of African Americans. A reconsideration of the experiences in freedom, one that looks beyond the jubilation framework and takes seriously the extensive suffering of freedmen and freedwomen, provides a foundation for understanding the conditions that (re)shaped both the circumstances and the ideas about black suicide. Despite the welcome news of abolition, questions lingered about how the region’s African American population would negotiate its way in this New South. Lacking capital and land, how would they stake their claims as independent laborers or producers? Where would they live? How would they keep their families intact? How would they secure food and medicine? Works by Jim Downs and Gretchen Long make clear that in the first stage of freedom, fleeing slaves congregated in overcrowded contraband camps lacking adequate sewage, food, and clean water, which quickly became incubators for disease. Thus, in the first moments of emancipation, the health of freedpeople deteriorated. Thousands of former bondsmen, bondswomen, and their children fell ill, constituting a medical calamity of unprecedented proportions, leading Downs to make the point that “emancipation liberated bondspeople from slavery, but they often lacked clean clothing, adequate shelter, proper food, and access to medicine.” Freedpeople faced untold physical and material hardships that tempered the familiar jubilee story. They, alongside white Southerners, now lived in a former war zone and faced war’s aftermath: the physical destruction of homes, crops, livestock, farms, rail lines, and businesses that stalled economic recovery. Former slaves, like their masters, scrounged for basic necessities and shelter and struggled to carve lives out of misery and desti-
tution. Former slaves also faced racial discrimination, harassment, and injustices in their everyday lives as free men and women in their attempts to negotiate labor arrangements with white employers, often former owners. African Americans had freedom, but little else.\(^6\)

Emancipation, as welcomed as it was by African Americans, constituted a path strewn with deprivation and suffering that took its toll on the emotional and psychological well-being of the formerly enslaved. Epidemics, exposure to the elements, hunger and malnutrition, separation from supportive networks, all contributed to a high mortality rate among African Americans in the years after the war. Death enveloped black families and communities in the postwar years.\(^7\) Loss of multiple family members plunged many black Southerners into despair over grief, loss, and worries about survival. Physical dislocation separated loved ones, sometimes permanently.\(^8\) Uncertainty about how to obtain the fundamental means to sustain one’s self and family as well as confusion and frustration with representatives of aid agencies blunted the elation that accompanied the end of slavery. Freedpeople also faced regular acts of individual and mob intimidation, abuse and violence by white Southerners determined to retain racial control over the political, economic, and social arenas of the South. The Freedmen’s Bureau records are replete with cases of horrific beatings, shootings, mutilations, and sexual violence.\(^9\) Emancipated Southerners faced “legal” attempts by whites to “apprentice” their children without their consent, a practice of re-enslavement in everything but name.\(^10\) Freedwomen with children and no husbands perhaps struggled the most, as they faced poor job prospects, little support, and abject poverty. Freedom, as welcomed as it was, ushered in significant trials for freedpeople that taxed the physical and mental health of many. In this climate of hardship and suffering, many African Americans experienced psychological disorders that at times included suicidal behavior.

Establishing causation for post-emancipation incidents of African American suicide is even more problematic than with cases of white suicide. Newspaper accounts of black suicides, as noted earlier, typically contain less information than accounts of white suicides, especially those committed by elite whites. Most freedpeople were illiterate, so they did not record their own feelings or observations in letters and diaries, certainly not to the extent that elite and middle-class whites did. Divining causation and meaning of suicide among post-emancipation blacks is also challenging because virtually all reporting was done by whites, who held racially biased views about the nature of African American temperaments, habits, and mental illness, or who may even have had a hand in contributing to the emotional or material suffering of black suicides, and so may have censored self-incriminating details. Special attention has to be paid to how race shaped the interpretation and
presentation of that information. Despite these caveats and limitations of the historical record, sources intimate that many of the apparent reasons African Americans resorted to suicidal activity after the war were the same as before the war: a desire to end physical or emotional suffering, an effort to avoid punishment, disappointment in love, and mental illness. Some of the triggers, though, were uniquely linked to conditions in freedom or were exacerbated by the struggles African Americans faced negotiating the difficult terrain of freedom. It is not always easy to tell the difference.

For the newly freed, emancipation meant foremost the ability to reconstitute their families and marriages as they saw fit. When enslaved, men and women faced unique challenges and constraints in their intimate partnerships that whites did not. Masters regularly forced marital partners upon the enslaved, thus depriving them of choice of husband or wife. Enslaved couples also routinely lived apart from one another on different farms or plantations, which limited contact and hindered the ability to more fully co-parent children. Indeed, slave marriages were not even legally sanctioned. Enslaved mothers and fathers were not free to exercise control over their own children. The threat of sale loomed and threatened the stability and integrity of family units in slave communities. Enslaved females, even married ones, were vulnerable to sexual assault by masters and their surrogates. The end of slavery held the promise of greater autonomy for the formerly enslaved to fashion familial relationships and roles as they wished, without white intervention or control and with the protection of law. Freedom, though, despite improving the lot of the formerly enslaved in the domestic sphere, provided no guarantee of connubial or domestic bliss.

As in slavery, intimate relationships between African American men and women in freedom were fundamentally important. The burst of black marriages after the Civil War is testament to the importance of the institution of marriage and its symbol of independence. As one African American soldier declared, “The Marriage Covenant is at the foundation of all our rights.” But as in slavery, newly freed husbands and wives at times struggled in their marital relationships. The burdens borne by former slaves in the tumultuous postwar South no doubt created a climate in which financial and personal struggles added stress to the lives of black Southerners and hindered domestic tranquility. Black men and women asserted themselves in their households and frequently expressed differing, even incompatible notions of how that household should function. Joe and Lou Tripp of Georgia appear to have been a couple in a strained marriage, though we have no inkling of what was at the center of their marital strife. The twenty-four-year-old wheel-
wright from Macon, Georgia, got drunk one day in his shop in 1869 and began playing with a pistol, prompting leery co-workers to implore him to put it down lest he shoot someone and then regret it when he sobered up. He defiantly replied, “I don’t intend to shoot anyone but myself,” and with that, he placed the muzzle under his chin and fired, delivering a serious though not fatal shot. Shop workers attributed the attempt to whiskey, but Joe managed to tell the attending physician that the cause was his wife, Lou, and little else about their conflict. Earlier that same year an African American woman from Georgia, a cook, attempted to kill herself following a falling out with her husband.

The large number of grievances and complaints filed with the Freedmen’s Bureau attests to significant tension permeating African American homes as husbands and wives at times contested their respective roles and the distribution of power within their households. The formerly enslaved did not operate entirely freely in their private spheres, as Freedmen’s Bureau agents at times intervened to mediate marital or familial grievances, usually at the request of freedwomen, who requested assistance when their husbands were unfaithful, beat them, deserted them, or were embroiled with them over child custody issues. In short, freedwomen leveraged the clout of the Freedmen’s Bureau in attempts to force their spouses to comply with their expectations of a husband’s obligations to his family and to fashion their households in the manner they saw fit. African American men resented external intrusion into their personal lives, viewing such overtures as an encroachment on their masculine prerogatives. One Mississippi freedman took exception to the bureau’s interference in his marriage when, after whipping his wife, she threatened to report him. The remorseful husband plied his wife with gifts in an unsuccessful bid to secure her forgiveness and forestall her reporting of him. Saying he would rather go to “h__1” than be subjected to the authority of the bureau, he “deliberately” walked into the bayou and “made a body of himself, refusing all aid or succor.”

On the face of it, this man’s self-murder seems impetuous and disproportionate, but the historical context of slavery is instructive here. Enslaved men and women greatly shaped gender roles and conventions in slavery although they were constrained significantly by the dictates of masters and the condition of bondage. Enslaved men exercised male privileges as best they could, through prowess in hunting, fishing, storytelling, games, and sex, but enslaved fathers and husbands could not wield the authority or fulfill the obligations that white patriarchal heads of household did. Enslaved males also faced many degrading challenges to their manhood by masters, overseers, and slave patrols: their wives and daughters might be sexually assaulted; their children might run to a master to avoid punishment from slave fathers; or an...
enslaved man might see his children or wife stripped away from him and sold. In freedom, former bondsmen sought to exert their masculine privileges without interference. In the Mississippi case, a freedman believed he ought to be free to discipline his wife as he saw fit. The threat of involvement by an outside mediator in his marriage, an affront to his honor, humiliated and shamed him. He was unwilling to abide by a challenge to his manhood and so chose death instead.

Domestic discord and a preoccupation with controlling his wife seemingly led to the psychological instability of Arthur Shampert. His mental illness, the cause of which was believed to have been extreme jealousy of his wife, landed the fifty-four-year-old freedman in the South Carolina asylum in 1877 after threatening to kill his wife, their children, and himself, so that they would all meet in heaven. Marital strife also figured prominently in the suicide attempt by Willis Dozier, who reacted to his wife leaving him by trying to kill himself with an axe and knife. The carpenter in his thirties had been devastated when his wife abandoned him, an act that caretakers believed accounted for his insanity. Eventually, Dozier was institutionalized twice in the 1870s for what caretakers diagnosed as mania. But he also presented with delusions: he heard and saw supernatural things. He believed he had murdered someone. He had also become violent, attacking people without provocation.

Enslaved families and couples were split up regularly before and during the war, which, heroic efforts to locate one another notwithstanding, resulted in permanent separations for many. Occasionally, loved ones from the past appeared long after a spouse had become resigned to a permanent separation and moved on with a new life and family. This may have been the case when, on the eve of Lucy Brown’s wedding to her second husband in 1878, her betrothed’s “wife” unexpectedly appeared, halting the service. Brown, a thirty-year-old house servant from South Carolina, entered the state asylum shortly thereafter. The aborted matrimony was the second of two personal shocks experienced by Brown that physicians believed contributed to her compromised mental condition. The first was the unexpected death of her first husband, who had been killed “on the railroad.” On what was to be her second wedding day, Brown became delusional—she believed herself to be the Virgin Mary and that a doctor wanted to “cut a baby out of her”—as well as suicidal. The shock coupled with profound disappointment destroyed Brown’s mental well-being.

Disappointment in love was frequently cited as the cause of suicidal behavior or insanity among black Southerners, just as it was, on occasion, among whites. “Love and jealousy” reportedly drove Nora Johnson, a twenty-one-year-old Georgia woman of color, to kill herself in 1871. The young laundress
swallowed two ounces of laudanum, apparently in response to a fracas with her beloved, Henry Johnson, a twenty-three-year-old porter. A man of color, a Georgia native living in Charleston, likewise killed himself “for love” on Calhoun Street in August 1883. After reaching the hospital, however, he had a change of heart and begged the surgeons to save him from the self-inflicted gunshot. The stomach wound proved fatal, and the man died a few hours after his arrival at the hospital.

In addition to domestic discord, the nexus of postpartum psychiatric ailments and grief over the loss of young children took a heavy toll on African American women in the post-emancipation period. As with Confederate mothers who suffered psychological distress shortly after childbirth, there is considerable guesswork involved in divining meaning from maternal suicidal behavior. Asylum officials offered several theories for the aberrant behavior of nineteen-year-old Margaret Graham of South Carolina, admitted to the asylum in Columbia in the spring of 1877. An unexplained separation from her family, “constant excitements,” and unspecified “shocks” experienced “during her sojourn” to Charleston were believed responsible for her condition. Her patient history recounts violent behavior toward others and herself. She had inflicted blows on her own body and was prone to throwing herself into fires. Graham destroyed clothing and furniture, which she often threw into fires. At times, she became delirious and vacillated among being restless, loquacious, and violent, but at other times she was perfectly tranquil and rational. Importantly, Graham’s patient history also reveals that she had given birth in January 1876 to one child, who had died several months later. Caregivers, though, made no connection between childbirth or the death of an infant and Graham’s compromised mental condition, even though postpartum psychoses and melancholy from the death of an infant likely contributed to her decline. Southern whites had deeply held views about the enslaved’s inability to develop deep familial affection and so minimized their capacity to mourn for their kin, ideas that probably influenced Graham’s caregivers and shaped their assessment of her condition.

Medical caregivers routinely overlooked a mother’s grief or childbirth as cause of black women’s mental distress, even in cases where one or both seem obviously contributory. Postpartum related-psychoses may explain Jennie Glover’s spiraling mental illness in the 1870s. The mother of five arrived at the South Carolina Insane Asylum after it was determined that she posed a threat to herself, her husband, and her children. She had attempted to kill at least one child to ensure it would go to heaven, but she also intended to do harm to herself. She had climbed trees from which she had jumped in
attempts to end her life. She also had hurled herself headfirst into a deep gully in an effort to break her neck. Caretakers did not identify a cause of her mental lapse, and her patient history offers few clues. Although the physician’s record states nothing about any reproductive-related abnormalities, two nuggets of information suggest a possible postpartum condition. First is the age of her youngest child, a toddler. Onset of symptoms coincided with that child’s birth. The second is the intent to do harm to her children and herself, indicators of postpartum psychoses.29 Like many young women of the nineteenth-century South, Glover’s psychological well-being seems to have been compromised by postpartum complications exacerbated by multiple pregnancies.

The combination of grief and postpartum depression likely contributed to Charlotte Haly’s manic behavior, although these are not listed as relevant factors in her patient history. The twenty-seven-year-old house servant arrived at the asylum in Columbia after having been insane for five years. Lately she had become violent and noisy, taken up cursing, and was prone to disrobing, apparently in inappropriate settings. Once she had tried to drown herself in a well. No one apparently connected the deaths of all four of her children to her insanity. Coincidentally, the birth and death of her last child had occurred five years earlier, which roughly corresponds to her onset of insanity.30 White caregivers, in their recordings, seem to have been oblivious to the impact the loss of four children would have on an African American mother.

Black Southern women, like their white counterparts, unquestionably suffered emotionally when their babies died. But because postbellum infant mortality was higher among Southern blacks than whites, such losses would have been more common among Southern black women than whites. African American child mortality exceeded white child mortality in the South before the war and likely continued after the war, though no data exist to confirm that supposition. Brenda Stevenson’s study of one plantation family in Loudon County, Virginia, reveals a mortality rate for slave children in the 1830s of almost 40 percent, and between the years 1834 and 1854 the slave child mortality rate rose to almost 47 percent.31 Economic historian Richard H. Steckel, citing “exceedingly poor” living standards, estimates slave infant mortality at no less than 30–35 percent.32 Conditions did not improve with freedom. In fact, black families following emancipation lost one important advantage they possessed as slaves that might have caused infant mortality rates to rise: the incentive of a master to do everything in his power to ensure the good health and well-being of an enslaved mother and her infant during childbirth and delivery. Slave owners had not hesitated to call in physicians to assist with the delivery of enslaved babies to protect their valuable
assets, especially when complications arose. After the war, slaveholders refused to supply medical assistance for former slaves. As one Louisiana planter bluntly put it, “When I owned niggers, I used to pay medical bills and take care of them; I do not think I shall trouble myself much now.”

For a time, freedmen’s hospitals were accessible for women with difficult pregnancies or childbirth, but most ex-slaves lived far from bureau doctors and hospitals and so went without adequate medical care, ensuring an even higher rate of infant mortality. In freedom, then, African American parents could face staggeringly high child mortality rates. Most black parents in the South thus stood a good chance of losing multiple children. Charlotte Haly lost all four of her children. Another South Carolina woman, older than Haly, lost six of the sixteen children to which she had given birth. Silva (or Silvia) Mc-Griff, a woman in her forties, experienced no fewer than five bouts of insanity during her lifetime and was institutionalized twice in the 1870s, at least partly for the “many” attempts at suicide. Doctors suspected that the “change of life” played a role in her presentation of mania, which manifested as “vague imaginations, unbearable conduct at home, destroying personal property about [the] premises of husband, denying the same.” She also exhibited “strong suicidal tendencies.” Doctors overlooked, however, as a possible causal link her numerous pregnancies, the possibility of postpartum complications, and the deaths of six of her children.

Older African American women with self-injury tendencies also populated insane asylums in the postbellum period. Flora Campbell was a fifty-eight-year-old widow whom asylum caregivers determined suffered from mania. “Disposed to injure herself,” she also had threatened to kill her children. The purported cause of her insanity was the loss of her husband, Jack. As in white nineteenth-century households, the death of the black male head of household ushered in disruptions and uncertainty. Campbell lost not only her husband and partner but the foodstuffs and income he provided as a farm laborer. It was not the loss of a husband, though, but the death of a favorite grandchild that may have triggered her descent into insanity, or perhaps the two together.

Dido O’Cain, wife of a farmer, suffered from delusional insanity upon arrival at the Columbia asylum in 1879. Her history indicates several aberrational behaviors including maintaining a “sullen silence” when spoken to, refusing to eat or drink, and posing a physical threat to servants. She could be cheerful at times, melancholy on other occasions. She was troubled by fears of her house being blown away and of being an outcast. She sought opportunities for self-destruction. Doctors floated several theories about the origins of her insanity. Heredity was one possibility, dyspepsia another. Still another explanation was that she had been physically and emotionally taxed of late while nursing a very sick grandchild, to whom she was greatly attached.
She had stayed up around the clock for seven straight days.\textsuperscript{38} Grief coupled with the physical and emotional exertion and lack of sleep may have pushed her over the brink.

Physical, not emotional, pain drove some black Southerners to suicide, like the thirteen-year-old African American boy who hanged himself in Alabama in 1867. According to the newspaper report, he had been suffering unbearable abdominal pain. An autopsy revealed an ossified obstruction, probably a tumor, that had blocked the colon.\textsuperscript{39} It is unclear whether the boy received medical attention for his condition, but if he had not, that would have been common. The end of slavery left a vacuum of medical care for former slaves, as masters no longer felt obligated to provide health care for laborers in their employ. New labor contracts in the postwar years typically required workers to subsidize their own medical care, and few African Americans could afford such a luxury. Lucky freedpeople in the several years after the war might have visited a Freedmen’s Bureau hospital, if there was one nearby. Few ex-slaves could afford to pay doctors and so had less access to professional medical care.\textsuperscript{40} Southern blacks had few options when sick, and consequently many suffered horrifically, like the teenager who remedied his own pain through self-inflicted death.

During Reconstruction, as in slavery, some African Americans turned to self-destruction as a way to avoid punishment by the legal system. For example, a Georgia freedman jailed for horse stealing attempted to kill himself, presumably to avoid a guilty verdict and death at the gallows. “Stewart” obtained glass, then pounded and consumed it. An alarmed jailor forced half a dozen emetics treatments on the incarcerated man, but to no avail. An attending physician proclaimed that nothing could be done to save the man and that in six or eight days, after considerable pain, he would be dead. The patient-inmate, hearing this grim prognosis, waited for an opportunity to escape, then sprang past his guard and threw himself out of the third-story window, landing some thirty feet below. He did not die from the fall, however, and presumably was taken back into the jail to await the slow death from broken glass making its way through his gut.\textsuperscript{41}

While some explanations for self-injury of freedpeople remained the same as before emancipation, certain causes emerged anew out of the process of emancipation. Adam Miller was jailed in South Carolina, possibly for vagrancy, in 1878. Vagrancy had become criminalized in the Reconstruction South in order to coerce freedmen into labor arrangements. Violators could be fined or assigned to involuntary labor.\textsuperscript{42} Regardless of the circumstances, the confinement aggravated “an already irritable temper,” language suggest-
ing that Miller struggled with mental illness before his incarceration. After the war, and especially before the issue over the admission of non-white patients into insane asylums was resolved, mentally ill African Americans like Miller were frequently confined in jails, where the conditions were horrid and they received minimal if any care.\textsuperscript{43} The conditions of incarceration, likely in squalid, dank quarters, worsened any underlying emotional or psychological ailment that may have contributed to Miller’s confinement. By the time he arrived at the asylum in Columbia, he was “noisy, violent, restless, sleepless, sullen, obscene and profane in speech.” At times he spoke incoherently and entertained “fanciful” delusions; for example, he spoke of “his great wealth and the high society in which he moves.” Sometimes he refused to eat, claiming the food was poisoned. Although he never expressed a desire to take his own life, he banged his head violently against the door of the room in which he was confined. Doctors pointed to the “physical conformation of the patient’s head,” which they believed reflected defective brain development and accounted for Miller’s aberrant behavior. His life of vagrancy and “rowdyism” confirmed the diagnosis.\textsuperscript{44}

Many African Americans struggled financially, materially, and emotionally after the war, as did Southern whites. Their responses to excessive and prolonged suffering occasionally included attempts at suicide. A Georgia newspaper acknowledged that stressful times were a central cause of the suicide attempt of “Tall Kate,” a black woman residing in Macon. Tall Kate overdosed on laudanum five years after the war ended but was saved when a physician pumped her stomach. The local paper surmised that the “rash” act must have been an attempt to “evade the trials and tribulations incident to her probationary term on this mendane [sic] sphere.” An “old negro” who witnessed the attempt put it a little differently: she tried to kill herself “bekase somethin’ went hard agin her mind.”\textsuperscript{45} The perspective of an African American, not wholly inconsistent with the newspaper account, suggests Kate’s mind was left unsettled by some stressful external event or condition.

Some suicidal African Americans suffered from a form of mental illness that likely explains their attempts at self-injury. Twenty-something Adam Mahaffey of South Carolina entered the state asylum twice, the last time in 1876. Examining physicians declared him insane due to his inability to answer questions intelligibly, “insendiaryism,” [sic] and threats against neighbors and “his own person.” Mahaffey’s medical history yields worrisome behavior that included “rambling from neighborhood to neighborhood and house to house threatening insendiaryism”[sic] and threats to cut his own throat with a razor. The cause of his diminished mental state was believed to have been “self-abuse” and “debility of genital organs.”\textsuperscript{46}
Southern whites had denied that the enslaved committed suicide, so when the occasional story of black suicide came to the attention of white Southerners after the Civil War, they had to reconcile their prewar views with postwar realities. Whites, when presented with incidents of black suicide, blamed emancipation and the removal of the constraints of slavery. Frank Alexander Montgomery recalled years after the war how freedman Jake Jones committed suicide while in jail for murdering a black woman. Montgomery used the anecdote implicitly to highlight how freedom had ruined many a good negro. After the war, the “poor fellow” Jones “fell into bad habits,” including the abuse of alcohol and morphine. Such explanations fed the Southern white narrative that freedom ruined blacks. After slavery, no longer under the master’s watchful eye, freedmen succumbed to vices and temptations denied them under slavery, which sometimes led to anomalous incidents like suicide.

Newspaper accounts of black suicide shortly after the war were highly racialized and often couched in humor, allowing (white) readers to view the acts, not as tragic and not as a response to extreme suffering, as usually was the case in stories of white suicide, but as comedic. The lighthearted stories poked fun at freedpeople engaged in suicidal behavior, belittling the circumstances of the incidents. A “sable love swain” in Memphis attempted to kill himself in 1867, ostensibly because “the mammy of his divinity” opposed a matrimonial alliance. But when he placed the muzzle of the pistol to his forehead and pulled the trigger, the skull proved “impenetrable” and the ball glanced off his forehead, leaving him unharmed but “very much frightened.”

In this telling, the innate incompetence and racial inferiority of African Americans underscored their inability to complete a suicide successfully. That same year, the Atlanta Daily Intelligencer ran the story of a “negro” who attempted to cut his throat with a razor, but at the sight of a “few spoonfuls of colored blood” he ran off for his mother’s house, where the wound was dressed. The story expressed skepticism at the idea of an African American taking his own life: “Who ever heard before of a negro trying to commit suicide?” Here, too, the incredulity of black suicide was couched in racial stereotypes: the African American male’s attempt at suicide was thwarted by his own cowardice and childlike disposition. The Petersburg Index in 1867 delighted in relaying the account of two young North Carolina women of color who ingested laudanum in an unsuccessful bid to kill themselves. “A gay Lothario in the shape of a big buck darkey” was the cause of “all this woe,” mocked a Virginia newspaper. The New Orleans Times attached the headline “Not Dead Yet” to an addendum of a story previously reporting the drowning suicide of George Ellis. Ellis had been seen the next day “prom
nading upper Canal Street, in the very *neglige* in which he entered the river.” Ellis, it would seem, was a “capital swimmer” who had pulled a “very clever trick.” Finding humor in black suicide allowed white Southerners to deny African Americans their humanity in freedom and to withhold empathy for black suffering, while reserving it for white victims of suicide. The humorous portrayals of the four failed suicide attempts of formerly enslaved people underscore their alleged lack of competence and courage, implicitly appropriating successful suicide as a white act while denying sympathy for suicidal Southern blacks.

The increased visibility of black suicide in the post–Civil War South went hand in hand with a reported spike in “insanity” among the region’s black population, which had remained largely hidden before the war. Antebellum white Southerners had claimed that the enslaved rarely went insane. As evidence, they pointed to the small numbers of enslaved housed in insane asylums, implying that a miniscule black asylum population indicated a low rate of insanity, when in fact most Southern institutions did not ordinarily treat non-white patients. Where institutionalizing slaves was an option, slave owners bristled at the high cost of care, which, at $1.50–$2.00 per week, proved too expensive for most. Instead, the enslaved of “unsound mind” remained on plantations or farms, where two families, one white, one black, looked out for them. Masters often treated mentally deranged enslaved people as partial hands, adjusting their workloads and assignments to accommodate diminished mental faculties and allowing such slaves to work to the best of their capabilities. The high cost of institutional care and the willingness to accept reduced labor output from mentally incapacitated slaves together with racially discriminatory admission policies depressed the number of non-white patients in antebellum Southern insane asylums, a flawed measure for gauging insanity among the enslaved.

While rare, some non-white patients do appear as patients in antebellum Southern asylums records. Virginia’s Eastern Lunatic Asylum admitted free blacks when it opened in 1773 and accepted enslaved people after 1846. Its counterpart, the Western Lunatic Asylum, actively resisted accepting non-white patients and admitted only one before the Civil War. Georgia legislators made no provisions for inmates of color when they approved the construction of an insane asylum, but officials regularly discussed the possibility of admitting non-whites. In the late 1850s, the legislature approved a bill that provided for the care of insane blacks. The number of non-white patients before the war, however, remained small. South Carolina, too, admitted some African Americans before the Civil War after its legislature, in a political act, authorized the asylum in 1848 to accept black patients, an acknowledgment, it seems, that the state had a moral obligation to care for
the enslaved who were insane. But between 1850 and 1859, only 30 blacks were admitted compared to 600 whites. At the end of 1858, a mere 7 of 180 patients were non-white. In 1858, however, regents of the facility released all male black patients and refused to admit any more until the state funded a separate structure for them. By 1860, the asylum accepted only black females. Asylums in Maryland, Mississippi, and Kentucky also admitted blacks before the war. Louisiana accepted free blacks and some slaves. North Carolina, the last of the original thirteen states to open an insane asylum, did so in Raleigh in 1856 but refused to admit black patients. Similarly, Kentucky’s Eastern Asylum denied admission to the enslaved. When white Southerners cited the paltry number of black asylum patients before the Civil War as proof blacks did not go insane, they failed to note that quite a few asylums refused to accept them as patients or, if they did, did so in paltry numbers.

After the war, myriad sources documented the ostensible rise of insanity among the region’s black population, measured once again by their numbers in asylums. Indeed, the black population in Southern insane asylums increased sharply in the years after the war. In 1884, the head of North Carolina’s Eastern Insane Asylum offered that in the ten years since 1870 the numbers of the “colored insane” had risen by over 200 percent. Dr. J. W. Babcock, superintendent of the South Carolina Insane Asylum, reported that “brain diseases” among African Americans had risen “from one-fifth as common in 1850 and 1860 to one-half as common in 1880 and 1890.” At the end of the war, the Columbia facility held five non-white patients; by 1871, that number had jumped to seventy-five. The superintendent of the Georgia insane asylum used census data to contrast the rarity of insanity among the enslaved with its frequency in freedpeople; in 1860, only one enslaved person in 10,584 was identified as insane. After emancipation, a much higher figure, one African American in 943 by 1890, was insane. Medical practitioners in the postbellum period unanimously concluded they were witnessing a significant transformation in the mental health of the region’s black population. Insanity, unknown in the enslaved, or so it was believed, had become an epidemic among Southern blacks after the war.

Medical professionals, especially asylum superintendents, debated the causes of the perceived rise of insanity among the African American population after emancipation. Expert consensus centered on the black’s transition into freedom as the impetus for the rise in insanity. In slavery, masters had taken great care of their bondspeople, who wanted for nothing: allocations for clothing, food, and shelter were “substantial and sufficient.” They lived under healthy conditions and, when sick, the master provided medical care. Moreover, slavery constrained sordid impulses among bondsmen and kept vices like sexual indulgence, drinking, and gambling, conditions that contrib-
uted to insanity, in check. In short, thanks to the beneficence and watchful eye of their masters, the enslaved lived healthier, carefree lives as slaves than as freedmen and freedwomen. A physician at the Mississippi asylum explained: “While the negro had a master he had no thought of the morrow; not a single care burdened his mind; there was nothing to disturb his equilibrium, and he was always the same fat, sleek, and contented individual.”66 Few physicians could recall an insane black under slavery. The physician of the Missouri insane asylum recalled that before the Civil War, “a crazed negro was the rarest bird on earth.”67 Experts agreed that freedom had had a harmful effect on the region’s black population. African Americans were ill-prepared to fend for themselves and wholly unprepared to provide for their families. When economic conditions worsened in the years after the Civil War and farm prices and wages fell, the formerly enslaved found it even more difficult to meet “exacting demands” for survival. Southern blacks, in this rendering, had been overwhelmed, “thrust” into freedom without adequate preparation, and so were ignorant of laws and the functions of citizenship as well as the responsibilities and duties required of citizens.68 Self-sustenance and self-reliance, the pillars of individualism in a civilized state, eluded African Americans, many of whom freely indulged in vices like alcohol and licentiousness that served “to unsettle their minds.”69

Pseudoscience informed by racialized thought cemented the explanation for why blacks were no longer immune to insanity and, by extension, suicide. Their environments and ways of life had changed dramatically in freedom, adding unprecedented stress. Blacks were further handicapped because of biological and anatomical differences that rendered them unable to adjust. Their “mental caliber is small,” explained a North Carolina asylum doctor. The “convolutions of their brain are few and superficial; their cranial measurement small.”70 Blacks also possessed inferior, underdeveloped nervous systems that rendered them more susceptible to mental illness when required to assume responsibility.71 Faced with unprecedented demands outside slavery, asserted medical practitioners, African Americans proved intellectually and constitutionally ill-equipped to discharge the newfound duties as freed men and women. Conditions peculiar to the enslaved, then freed slaves, accounted for the presumed rise of mental illness in the post-emancipation black population in the South.

The cultural and medical explanation of black retrogression as the cause of increased insanity among the formerly enslaved coincided within a larger trans-Atlantic narrative arc situating mental instability generally and suicide specifically within the paradigm of “modernity” and “civilization.” Nineteenth-century social scientists posited that “uncivilized” or “primitive” peoples were resistant to psychological ailments. A note in the American Journal of Insanity
136 Chapter Four

in 1847, for example, observed: “Civilization appears to favor the development of madness. The circumstance may be attributed to the restraints imposed upon the indulgence of passions, the diversity of interests, and a thirst of power; long-continued excitement of the mental energies, and disappointment in affections and anticipations. The wants of the savage are circumscribed.” African Americans, having emerged from slavery as a “primitive” people, now were suffering the deleterious effects of maneuvering, ill-prepared, in a civilized state. Insanity was the price of freedom.

Whites in the postbellum South had figured out how to explain black insanity among freedpeople. But they proved resistant to making the leap that suicide, too, was linked to freedom. Instead, white medical professionals continued to deny that blacks experienced melancholy and suicidal impulses. Medical experts, primarily physicians and superintendents affiliated with Southern insane asylums, steadfastly denied that African Americans committed suicide. The clinical director of the Georgia State Asylum, E. M. Green, found that the “negro rate” for melancholia was a mere 0.04 compared to the 1.0 rate for white patients. Of 2,119 subjects, he found only one case of “involution melancholia.” Suicide among African Americans was rare, contended Dr. J. F. Miller, the superintendent of the Eastern Hospital in North Carolina. In nine years, he had observed only one case of suicidal melancholia among black patients. Dr. J. D. Roberts, who preceded Miller as superintendent at the African American asylum, also remarked on the rarity of black suicide. Of the two hundred patients he had in his charge the first year or so, not a single suicide attempt was made. Although he lost one patient to suicide in the following year, he remained resolute in his belief that African Americans only rarely committed suicide.

Alabama asylum records that break down patients by race and diagnosis confirm that few black patients were believed to have suffered from depressive conditions compared to white patients. In 1870, 11 percent of blacks presented with some form of melancholy, compared to 15 percent of whites. The racial disparity in the diagnosis of melancholy grew exponentially over time. Ten years later only 5 percent of black patients appeared in melancholia diagnostic categories compared to about one-quarter of whites. This same pattern of racialized diagnoses can be observed in the Georgia insane asylum after the war. Superintendent Green of the Georgia State Asylum (as it was known later in the century), explained: “The expression of suicidal ideas is seldom heard, and suicide is an extremely rare occurrence in the negro race.” On the face of it, patient case histories from the Georgia asylum support this claim. A survey of the nearly 200 African American inmates of the Georgia insane asylum admitted from August 1867, when the first free African American patient arrived, through October 1878, reveals only one iden-
tified as suicidal. This figure, about 0.5 percent, compares to roughly 18 percent of white patients during the same period who were listed as suicidal.80

White medical experts, relying on racist assumptions and stereotypes about blacks’ “natural” happy, carefree temperament, were able to explain why few blacks, despite the large number who appeared insane after emancipation, suffered from melancholy. One asylum director speculated that perhaps the “Negro’s inherent love of life” shielded him from depression.81 Superintendent E. M. Green of Georgia implied as much when he surmised that the “average negro, in his normal environment, is happy, active, boisterous.”82 Green’s characterization of the “negro” temperament likely explains why so few African American asylum patients received depression-related diagnoses. In this Sambo redux, the (male) African American mind “does not dwell upon unpleasant subjects; he is irresponsible, unthinking, easily aroused to happiness and his unhappiness is transitory. . . . The simplest amusements distract him, and he gains pleasure from occasions which should rather give rise to sadness.”83 By contrast, whites, more cerebral, more acquisitive and possessing more self-awareness about life’s potentials, suffered from depression more often than blacks.84

Racialized understandings of mental illness and temperament played a significant role in shaping caregivers’ evaluations of incoming patients. Believing that non-whites were constitutionally disinclined to be melancholic, physicians interpreted their symptoms differently than those of white patients. Asylum officials charting personal information of incoming black patients may never have even asked about suicidal history, presupposing that African Americans were immune to melancholia. Instead, when ferreting out the “cause” of a black patient’s insanity, caregivers privileged heredity, cerebral malformations, epilepsy, intemperance, or masturbation, etiologies more in line with white ideas about blacks’ nature and lived experiences. Acknowledging that African Americans grieved over the loss of a spouse or child or had become distressed over a spouse’s desertion would have contradicted generations of white racial thought denying that the enslaved suffered emotional loss. To recognize slaves’ humanity and their intimate connections to others would have made it difficult to rationalize splitting up slave families or marriages through sale. No one articulated this rationalization better than Thomas Jefferson, who, in his famous Notes on the State of Virginia, proclaimed that African men were more “ardent” for their females, but denied they loved: “Love seems with them to be more an eager desire, than a tender delicate mixture of sentiment and sensation.” Slaves’ “griefs” were “transient.” The burdens of life, he suggested, “those numberless afflictions” that weigh heavily on white minds, “are less felt, and
sooner forgotten with” blacks. Under slavery, casting bondsmen and bondswomen as unaffected by emotions of personal attachment and incapable of cultivating intimacy, assuaged the guilt of slaveholders whose actions tore slave families apart. In freedom, the denial that African Americans suffered in the same way that whites did, especially in the South during and after the Civil War, put greater distance between whites and blacks in an inchoate world where status was no longer determined by bondage. After the Civil War, it became imperative for white Southerners to continue to deny that African Americans committed suicide, even in the face of evidence to the contrary. At a time when white attitudes toward suicide were relaxing and reflecting greater empathy toward white victims of suicide, Southern whites needed to distinguish further racial differences in a society no longer bounded by slavery. Professing to believe that blacks were immune to suicidal impulses elevated suicide as an attribute of civilized (white) society. In denying that non-whites killed themselves while acknowledging that whites did, Southern whites withheld from African Americans a trait, the ability to suffer, that would have confirmed their humanity.

As Southern insane asylums slowly and begrudgingly integrated and accepted more African American patients, white medical personnel admitting men and women of color with histories of self-injury had to make sense of African Americans who presented with suicidal behavior or ideation and to reconcile these manifestations of mental illness with their own racialized understanding of blacks’ psychological nature. Falling back on decades’ old ideas that blacks were neither suicidal nor depressive, white physicians constructed a pseudo-scientific narrative that simultaneously permitted them to deny that blacks committed suicide, while situating that anomalous black suicide in a racialized clinical and cultural framework. In doing so, the medical community in the South preserved suicide as a white disease borne of a superior intellect and an advanced, more complex lifestyle.

African Americans first began arriving at the doors of Southern asylums shortly after the war in a trickle, then waves. Ailing freedpeople during and after the war became the responsibility of the Medical Division of the Freedmen’s Bureau, which established a number of hospitals throughout the South that serviced the formerly enslaved temporarily until localities and states could take charge. State governments and, especially, superintendents of Southern asylums opposed bureau efforts to transfer mentally ill African Americans to their facilities on the grounds that freedpeople were not citizens. The passage of the Civil Rights Act in 1866 invalidated that claim, though some medical supervisors of asylums continued to resist integrating
their all-white or nearly all-white asylums. Some unreconstructed state governments required proof that “paupers”—the poor insane who relied on counties or the state to fund their stays at the asylum—had lived in a county for a year in order to qualify for support, a stipulation that proved difficult to meet given the mobility of the black population during and after the war. Frustrated bureau officials resorted to playing upon the racist fears of local officials, ironically, by expressing worries about “insane” freedpeople running about neighborhoods uncontrolled and supervised. In response, municipal leaders in some Southern towns forced asylums to admit former slaves. Emancipation thus precipitated a revolutionary shift of responsibility for insane blacks from masters to the state.87

At the Georgia lunatic asylum in Milledgeville, the first patients identified as “colored” arrived in August 1867.88 In 1866, there had been over thirty applications for the admission of blacks to the asylum; some had even been brought to the hospital before their applications had been considered. But the asylum lacked separate quarters for non-whites, as required by law, so the superintendent denied them admission. Eventually, over the superintendent’s protests, General James S. Steedman of the Freedmen’s Bureau forced the asylum to accept African American patients. In 1867, thirty-four blacks had been admitted to the asylum, most of whom were deemed incurable. Superintendent Green pleaded with the chief surgeon of the bureau to exclude these patients, and an order was issued to this effect.89 Green further complained that blacks were left “clandestinely” on the premises.90 African Americans who were incapacitated, either developmentally or psychologically, apparently were being abandoned on asylum grounds. By mid-1868, admission of black patients to the Georgia asylum was still sporadic.

The earliest African American patients at Milledgeville arrived with little or no biographical or personal information, probably for a couple of reasons. Mentally unstable African Americans likely were “dumped” stealthily by their former masters, who seized the opportunity to rid themselves of supernumerary or incapacitated former slaves. Non-lucid, developmentally challenged, aged, and epileptic freedpeople, who likely had been cared for by masters, were abandoned along roadways or in towns and incapable of supplying information about their histories. Annie, an eighteen-year-old girl of color, was admitted in 1868 to the Georgia asylum after found “wandering about the country.”91 Another woman of color going by the name Lucy was left on the premises of the Georgia asylum in April 1868. Other than her name, nothing else was known about her.92

A number of African American asylum patients were transferred from jails where they initially had been incarcerated. Jails were the only facilities adequate to constrain mentally incapacitated patients, other than asylums,
especially the violent ones like Richard Dean. Dean, about age twenty, had worked as a barber in Milledgeville after the war but suddenly became violent. Dean was confined in the local jail, likely caught up in the standoff between Georgia asylum administrators and Freedmen’s Bureau officials, as the asylum had no policy of receiving free blacks. Dean eventually became the first freedman institutionalized in the Georgia asylum in 1867. Like Dean, William Taylor of Savannah had lapsed into insanity and become predisposed to violence, so he was confined in jail for over a year before entering the asylum. Albert Brookins, too, landed in jail for about five weeks after he was deemed insane. Both men entered the Georgia asylum in 1871.

Once the Freedmen’s Bureau successfully forced the integration of the asylum, non-white patients flooded the Georgia facility, the vast majority of whom arrived directly from bureau hospitals throughout the state, suggesting that at the local level the agency had assumed responsibility for the care of mentally ill freedmen and freedwomen as an interim postwar measure. The placement of African American patients at the Georgia asylum also suggests that the integration of that facility was effected at the insistence of bureau officials. This was the case in South Carolina and North Carolina as well. After the war, military authorities, the Freedmen’s Bureau, and former slaveholders directed mentally ill ex-slaves to the asylum in Columbia.

African American asylum patients admitted during Reconstruction, especially early on, differed starkly from the white patients. Notably, medical histories of postbellum black patients contain precious little personal information. A typical entry for a “colored” patient in the Georgia asylum admission log contains a name (though not always, and often just a first name); status as a “pauper”; designation as a lunatic, idiot, or epileptic; and the county from which each came. In most cases, no history is provided, or if one is noted, there are sparse details. The abbreviated case histories likely reflect the fact that those delivering the patients knew very little of their backgrounds. This is especially true if the patients had been abandoned on or near the grounds or elsewhere and brought to the asylum. The superintendent of Virginia’s Central Lunatic Asylum for the Colored Insane—formerly a Confederate soldiers’ hospital retooled as an asylum for “black lunatics” in 1870—complained that many of his patients were committed without any personal histories because they were found “at large” and were “too ignorant or too insane” to supply information themselves.

Even in later years, the case histories for black patients are less detailed than those for white patients. Lack of interest in black patients may explain the spotty patient records, but more than likely African Americans arrived with less paperwork from their family members, many of whom were illiterate. It is also likely that black patients, unlike most whites, had received no medical care before admission, so supporting docu-
mentation from family doctors, which routinely accompanied white patients entering the hospital, and on which staff doctors relied heavily, was non-existent for most African American patients.98

Black asylum patients differed from their white counterparts in another crucial way. Their health tended to be much worse than that of white patients. Southern asylums after the war acted as repositories for all manner of physically and psychologically ailing former slaves. Asylums served as a veritable dumping ground for superannuated slaves in addition to those afflicted with severe mental ailments. Seventy-year-old Stephen Foster of Fulton County arrived in Milledgeville feeble, greatly emaciated, unable to walk without assistance, and suffering from diarrhea in June 1868. He died the next month.99 Juda Webb, believed to be about eighty when she arrived at the asylum in late 1868, was unable to walk and in “an utterly helpless condition.”100 Charlotte Lowther was an insane “colored” woman about age sixty when admitted in November 1867. She died less than a year later.101 Mary Harper and Rose Harris arrived at the asylum together from Pike County in September 1867. Harper was seventy-one, had been insane for at least twelve years, and died several months later. Harris, who had also been insane “some years,” arrived very feeble and unable to walk. She perished before year’s end.102 African American patients commonly died soon after arrival. Simon Dunn perished just three weeks after arriving at the asylum. He was seventy and had been insane for several years.103 Increasingly, black patients populated Southern insane asylums after the war but, unlike white inmates, were not always appropriately placed there for psychiatric rehabilitation and cure. Rather, the eradication of slavery had left a void for the care of all manner of disabled and debilitated emancipated slaves. Asylums thus became the de facto repository of the sickest of the sick. Whereas most white patients were believed to be “curable,” most non-white patients were not.

Many formerly enslaved men and women who were institutionalized in the years immediately following war’s end and who suffered from mental illness were debilitated in other ways as well. Quite a few exhibited symptoms of epilepsy, such as convulsions, which likely made them unemployable in the new world of wage labor. Dorcas Cook, for example, was fifty and had been having convulsions for over ten years. She died about three months after entering the Georgia asylum.104 Charlotte Tuggle experienced convulsions, too, sometimes daily.105 The Georgia asylum admitted thirty-five-year-old Henry Park in 1868 as a lunatic but also as someone who had been “a weak minded person” all of his life.106 Maurina Flournoy, a young Georgia mother, had received a blow to her head by a “negro foreman” as a teenager, prompting the onset of convulsions, which had begun to occur more often. She died about two weeks after entering the asylum.107
Unlike white patients, black patients sometimes were admitted with family members. In one case, a woman about age thirty arrived with her daughter, about age ten. Both were classified as congenital idiots. Those individuals or entities sending patients to the asylum at times seemed at a loss to provide for small children of institutionalized mothers, and so infants or children sometimes arrived with their mentally ill mothers. Betsey, an eighteen-year-old woman of color, was dropped off at the Georgia asylum in 1868 after being found along a road with her three-month-old son. The party that delivered her refused to take the child and so the baby stayed in the asylum with his mother.

Records also suggest that a number of black patients admitted during Reconstruction had been mentally ill for years prior to coming to the asylum. Joseph Trey, for instance, was twenty-seven when admitted to the Georgia asylum but had been “insane” as a child, about twenty years earlier. Curtis Hall, aged eighteen, became “excited” with the change of the moon. He had been insane for five or six years. Lucy Loftley, a fifty-year-old Georgia woman of color, had been insane for fifteen years when she arrived at the asylum. In each of these cases, the patients, according to medical histories, had been mentally ill while enslaved. Freedpeople who arrived at insane asylums soon after the war were, as Superintendent Green observed, largely incurable and hopeless, having arrived physically depleted, ill, and/or malnourished and suffering from mental illness for extended periods of time. Not surprisingly, many died soon after arrival.

A decade after war’s end, the chaos surrounding the first admission wave of post-emancipation African American patients to Southern insane asylums had given way to a more organized, systematic evaluation and admission process. By the mid-1870s, the asylum in Columbia, South Carolina, had introduced more extensive standardized intake forms, further regularizing the admissions process by requesting uniform information from new patients, including African Americans. (See figure 10.) At first blush, information gathered seems to support the widespread belief among white Southerners that blacks tended not to suffer from melancholy or commit suicide. Of the 223 “colored” patients admitted to the South Carolina Insane Asylum from September 1875 through December 1879, only 8, or 3.5 percent, presented as melancholic. Of these eight, all but one was female, suggesting that melancholy was not only a racialized diagnosis but a gendered one as well. Only one of these melancholic patients’ histories, however, mentions suicidal behavior. During that same period, fifty-four white patients (twenty-six men, twenty-eight women) entered the South Carolina facility presenting with suicidal histories or
Figure 10  The South Carolina Lunatic Asylum appears to have begun using standardized admission or patient history intake forms around 1860 that were revised and expanded from time to time. This particular form came into use around the mid-1870s. Courtesy of the South Carolina Department of Archives and History, Columbia, South Carolina.
ideation. An equal number (eleven) of the suicidal white women were diagnosed with mania as with melancholia; mania and melancholia account for 39 percent each of the diagnoses of white female suicidal patients. The same pattern emerges for white male suicidal patients: six received diagnoses of mania and five of melancholia (ten were assigned no diagnosis at all, compared to only three for women). White suicidal patients were diagnosed about equally with mania and melancholia in contrast to black patients, who rarely were diagnosed with melancholy. African American patients, nonetheless, did arrive in Columbia with suicidal histories in the 1870s; they simply were not classified as melancholic. Eighteen non-white patients’ medical histories contain references to suicidal activity or propensity, or attempts at self-injury, but not one of these patients was classified as melancholic, even though quite a few were described as having melancholic temperaments. Most African American patients, including the suicidal ones, were diagnosed with some form of mania; a few were believed afflicted with dementia, and one was believed suffering from delusional insanity.\textsuperscript{115}

The pattern of overwhelming frequency of mania diagnoses coupled with the rare diagnosis of melancholia among black asylum patients at the South Carolina asylum was replicated throughout the South. The superintendent of the Eastern (Colored) North Carolina Insane Asylum reported that of the eighty-one patients admitted in 1884, forty-eight, or 59 percent, presented with mania compared to only fourteen, or 17 percent, diagnosed with melancholia.\textsuperscript{116} A study of the diagnoses of inmates of the Central Lunatic Asylum in Petersburg, Virginia, over a longer period yields even more skewed results. Kirby Ann Randolph examined the annual reports of the Virginia asylum from 1874 to 1881 and for the year 1884–85, during which time the facility admitted 1,570 black patients. Of these, over one thousand, or about 67 percent, were diagnosed with either chronic or acute mania. Only fifty-one, about 3 percent, received the melancholy diagnosis.\textsuperscript{117}

Caregivers rarely diagnosed African American patients as melancholic despite evidence of suicidal activity and/or depression. Take the case of sixty-year-old Robert Gardner of Allendale, South Carolina, normally a man of cheerful disposition. The father of ten became grief-stricken when a daughter, of whom he was quite fond, died, an event that propelled Gardner into a “state of great mental depression.” He began wandering about “in an aimless manner” and, more seriously, attempted to take his own life several times, by hanging, stabbing himself, and cutting his throat, which left him with a scar across his neck. Despite indisputable evidence indicating a history of depression and identifying grief as a trigger of self-injury, Gardner’s diagnosis was determined to be dementia, not melancholia. The dementia diagnosis was likely shaped by several factors: one, his advanced age; two, a report of
delusional behavior; three, acknowledgment that the death of a family member rendered him stricken with disabling grief ran counter to whites’ racialized ideas about blacks’ nature; and finally, four, a diagnosis of melancholia would have challenged widespread beliefs that blacks were invulnerable to melancholy.118

Caregivers exploited a distinction between melancholic temperament and melancholia as a form of insanity to withhold from suicidal African Americans a diagnosis of a depressive disorder. Quite a few black patients manifested melancholy dispositions, but they did not receive a melancholy diagnosis. Even though Stephen “Jockey” Wright, a twenty-two-year-old African American from South Carolina, had become “extremely melancholy” in the previous two years and had attempted to procure poison “repeatedly” for the purpose of “self-destruction,” asylum officials pronounced him suffering from dementia when he was admitted in 1878.119

Asylum physicians privileged certain diagnoses for black males over others. Violent and uncontrollable behavior, even when directed toward the self and in the presence of depressive disorders, led doctors to diagnose African American male patients with a form of mania. Forty-five-year-old Harvey Jackson, a blacksmith from South Carolina, had experienced convulsions for years, which were believed to have been the direct cause of his insanity. In early 1879, he had become “dangerous and annoying to his family and community” and was no longer controllable. Even though he possessed a melancholy disposition and attempted suicide once by cutting his throat, the physician at the asylum diagnosed him, not as melancholic, but as an epileptic maniac.120 Charles Johnson, too, had attempted suicide. He tried to hang himself. He had been showing signs of insanity for a few years, but his symptoms worsened in the two months before institutionalization. He had become violent, dangerous, and delusional, imagining that he had “a good deal of money.” No diagnosis is recorded for Johnson, but one set of patient records failed to even include his suicide attempt, suggesting caretakers were more concerned about his violent and delusional tendencies.121 George McMichael was deemed manic upon admission to the South Carolina asylum in 1877. He had been very violent toward others and himself, jumping into a well in an unsuccessful bid to commit suicide. He further alarmed family members when he tried to locate an axe with which to kill himself. The forty-five-year-old suicidal laborer was diagnosed with mania.122

Of the four most common classifications of insanity at the mid-nineteenth century—mania, melancholia, dementia, and idiocy—mania was considered the most violent and dangerous illness and the least likely to respond to treatment. Mania symptoms could include any of the following: a penchant to destroy things, rage, violent anger, extraordinary strength, sleeplessness,
self-destructive behavior, poor judgment, delusions, excitability, mischievousness, distractibility, flight of ideas, impulsivity, pressured speech, and heightened sexual excitement and activities. Manic symptoms exhibited by mentally ill blacks meshed perfectly with the Southern white narrative of relapse and degeneration of former slaves after emancipation. According to this theory, blacks were unfit and ill-equipped to live without the guidance and protection of their former masters. Throwing off the yoke of slavery, African Americans reverted to savagery and unleashed emotions that manifested in the very behaviors that were landing them in the insane asylums. By nature, blacks were easily aroused and excited by religious, sexual, emotional, and political stimuli; they were inclined to indulge in excess. The ones who found it most difficult to modulate their moods or sufficiently control their base instincts posed a danger to themselves, their families, and their communities and so had to be constrained in asylums.

Even when African American patients were noted to have possessed melancholy dispositions, caregivers avoided assigning diagnoses of melancholia, emphasizing instead the symptoms of mania, namely violent and uncontrollable tendencies. King Sanders, for instance, was a middle-aged farmer who had a sudden, inexplicable onset of aberrant behavior, manifested by significant violence toward others and at least one attempt to cut his own throat. Patient notes include his claim that he had had five hundred bales of cotton stolen from him. While the quantity of bales stolen seems unlikely, theft of even just a few bales may have triggered the mental lapse. Robert DeGraffenreid was a twenty-two-year-old laborer who had become so violent and unmanageable that he had to be restrained with handcuffs or chains. He was delusional, claiming to act “under the commands of God in all that he does.” He proved to be a danger to himself as well when he attempted to hang himself. DeGraffenreid was diagnosed as manic; the cause was uncertain but was possibly “jealous excitement.” Intemperance was believed to have driven Thomas Allston “raving mad” in 1875. The forty-five-year-old carpenter attempted to take his life by drowning. Only one black male, Westley Owens, was labeled as melancholic, but there is no evidence that he was suicidal.

A racialized construction of suffering, mental illness, and suicide emerged out of emancipation and the war. Diagnosing suicidal blacks as manic and whites as melancholic allowed white Southerners to withhold empathy for suffering African Americans (or to deny they suffered, or blame suffering on their emancipation), while extending it to fellow whites. Southern blacks, according to the retrogression theory, devolved into madness and mania after re-
ceiving freedom. They became violent, wielding axes and knives and banging their heads on the wall, threatening their family members and themselves; they were obscene, noisy, and profane. White Southerners (and other white Americans) continued to deny that African Americans took their own lives: they did not form deep enough attachments (like whites did) to be driven to suicide by loss of loved ones. According to an assistant physician at the Government Hospital for the Insane in Washington, D.C., their “sorrows and anxieties are not staying in quality and do not make a sufficiently lasting impression on them to create a desire to end their life.” They also lacked the courage and “steadiness of purpose” necessary to destroy themselves. Freedmen and freedwomen possessed an “inherent horror of death” due to their “gruesome imagination” that served to check suicidal impulses. In this constructed racialized narrative, African Americans were constitutionally incapable of experiencing the same emotions as whites, who had higher expectations and so could be disappointed more readily and who possessed more refined sensibilities, greater sensitivity, and more committed, deeply loving relationships. Depression, remarked a Southern asylum superintendent, “is rarely encountered [among blacks] even under circumstances in which a white person would be overwhelmed by it.” On those rare occasions when black suicide came to the attention of whites, usually in institutions, it was submerged in a diagnosis of mania, a bestial madness borne of freedom. Anxiety and melancholia had thus become markers of whiteness, emblems of progress and civilization. White Southerners who turned to suicide did so because they had suffered loss, not because they were flailing and out of control. Melancholy had become a white diagnosis, as had one of its manifestations, suicide. The mania-melancholy duality furthered white Southerners’ efforts to denote racial difference and, importantly, to deprive freedpeople of their humanity while reworking their own identity.