MENTAL DISEASE IN AFRICANS: RACIAL DETERMINISM

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THERE has grown up in the past 30 years in East Africa a school of medical psychologists which sets out to interpret African thought processes, personality traits and mental disorders in terms of a racially genetic and cultural disposition. A correlation is assumed or suggested between a specific brain structure, social behaviour, psychology and psycho-pathology. Explanations are couched in terms of a racial determinism, and involve an assertion of inferiority as compared with the White race.

Those of us who are acquainted with the corresponding efforts of Wilhelm Wundt and his folk psychologists, or with the disastrous myth of Nordic superiority produced by Gobineau and Houston Chamberlain, will be familiar with the difficulties that must be overcome by the thinker who seeks to establish a causal relationship between race, culture and mental development. These entities cannot be satisfactorily described in empirical terms, there is much doubt as to the bearing of race on individual characters, including body ones, and we have as yet no means of distinguishing inherited from environmental factors in social behaviour.

In so far as the race determinist tries to substantiate his theory by objective observations of a scientific kind, he relies mainly on comparative studies in anatomy and intelligence testing. The East African school, having a strong bias towards medicine rather than psychology, has drawn its evidence almost wholly from anatomical studies, particularly of the African's brain as contrasted with the brain of Europeans.

Indeed, the school's hypotheses may be said to have originated in measurements of African brains. These were said to be smaller, simpler and therefore likely to be inferior in reasoning power and other significant functions as compared with European brains. Much of the theory rested on a conception of the evolution and operation of the different parts of the human brain which is now largely discredited. Le Gros Clark (1952) has pointed out that intellect and emotions are closely interlocked in mental activity and that the allegedly "primitive" regions of the brain play an integral part in this process.

Gordon (1935–36) asserted that the "frontal brain", having evolved last, was normally less stable and durable than other parts of the brain. He claimed to have demonstrated the "frontal inferiority of the Native brain" and adduced this inferiority as the reason for another alleged phenomenon: the "unprecedented stress and strain to the Native frontal brain" caused by scholastic education. This, he implied, was the reason why cases of adolescent psychosis in his series occurred only in educated persons.

An evolutionary approach is also evident in Vint's (1932–33) comparison between the frontal cortex in Africans and Europeans, leading to the conclusion (Sequeira, 1932) that in relation to the corresponding parts of the European's brain, represented by 100, the depth of the East African's "infragranular"

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layer is 106, the "granular" 98·7, and the "supragranular" 92. He describes the infragranular layer as the seat or physical basis of the "animal instincts", the granular layer as that of "perception", and the supragranular as being concerned with the "higher" functions of the will and intellect.

"In the East African therefore", claimed Sequeira (1932) commenting on these findings of Vint, "animal instincts are provided with six per cent. more physical basis than in the European, but the physical basis of 'mind' shows a preponderance in favour of the European of 9·3 per cent." There follows a plea for racial discrimination, which underlies and indeed seems to be the main purpose of much writing of this kind.

> "If it is proved that the physical basis of 'mind' in the East African differs from that of the European, it seems quite possible that efforts to educate these backward races on European lines will prove ineffective and possibly disastrous. It has long been recognized among highly civilized races that the educational methods applied to the normal child cannot be applied to the backward or defective."

I am not in a position to assess the value of these anatomical observations. It would seem, however, that the mere assertion of a structural difference as here outlined would not demonstrate a qualitative difference of intellect or psychical traits. The somatic types compared may have different standards of physical normality.

This objection also applies to the comparison made by Vint between the brain of an adult African and that of a European boy aged 7 or 8 years. The latter, he says, is 84 per cent. of the fully developed adult European brain. The "supragranular cortex" of the adult African is similarly 84 per cent. of the European's. Therefore, concludes Vint, "the stage of cerebral development reached by the average Native is that of the average European boy of between 7 and 8 years". This statement is, of course, incorrect and misleading. The one brain is that of a child, the other that of a man; and the two differ in terms of the whole range of qualities that distinguish the child's immature and unrealized potential from the adult personality.

Dart (1956) has recently drawn attention to the fallacy of comparing brain sizes unrelated to body volume, an aspect that the East Africans appear to have overlooked. His masterly survey suggests that the conclusions drawn by the East Africans as to the relation between brain size and intelligence are untenable in the light of present knowledge.

Later adherents of this school, though more discreet than its founders, still rely on their findings to support an assumption of African inferiority. Carothers (1953) cites Vint to the effect that the African's brain is about the same as a European boy's, and regrets that "this fine piece of pioneer research did not inspire something more than criticism". Smartt (1956), even more restrained, suggests only "the possibility of actual structural differences in the brains of Africans—particularly in the diencephalic frontal system—which may produce psychopathic tendencies. If these differences exist we have no way of making them good."

Cultural Traits

Unable to fire enthusiasm in scientific circles for its anatomical speculations, the school has shifted its emphasis from the plane of physical anthropology to that of social anthropology. Here the race determinist treads on even more dangerous ground, and usually does so with less training and experience than he possesses for his hazardous ventures in comparative human physiology. The

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study of tribal society has become a highly specialized field of research and follows approved scientific methods. Persons not equipped for the exacting field work required and without the necessary theoretical insight are hardly in a position either to make more than haphazard, isolated observations or to add significantly to the interpretations of social anthropologists.

Consistent with their notion of an "African brain", members of the school assume the existence of an "African culture". Carothers, in a monograph (1953) prepared for the World Health Organization, claims to have extracted "the fundamental and distinctive features of African culture" south of the Sahara.

Carothers does not give a definition of "fundamental", but seems to exclude law, government, economic activity, and kinship. His own comments on the results of his efforts suggest that the phrase "fundamental and distinctive" conveys to his mind the idea of something exotic—"odd" as he puts it—in comparison with the standards of an urban, industrialized community in Western Europe.

> "The subsequent description may give the impression that African culture is entirely odd, alien to anything one knows in the Western world. Such an impression would be false, for much of African life is just like life elsewhere. But in a monograph of this nature, it is relevant to describe only peculiarities and it must in general be assumed that life is otherwise much like that in rural Europe. Indeed, some of the peculiarities themselves would not be regarded as alien by certain elements in Europe" (p. 42).*

Data selected according to these criteria are bound to yield a distorted and misleading account of African societies. The margin of error has been further widened by Carothers's tendency to generalize from inadequate or unrepresentative data. His descriptions of alleged "African" customs are not sufficiently documented and cannot be accepted without more ado as being true of all or most African societies. Indeed, it is doubtful if the general run of his statements, of which a few typical examples are quoted below, can be regarded as true without much explanation and qualification of even particular societies.

> "Weaning is abrupt, the more so in that there was previously no constraint in feeding" (p. 97).
>
> The child "meets no restraint, his wants are met at all times, and his developing functions are encouraged at all times" (p. 52).
>
> "Whereas, prior to initiation, masturbation was considered right and proper (at least for boys), thereafter it is regarded as childish and intercourse between the sexes is correct" (p. 47).
>
> "Illegitimacy has little meaning for the child in Africa" (p. 48).
>
> "Certainly there is little link in Africa between ethics and religion, and morality is simply a question of the application or contravention of the traditionally correct rules of social behaviour" (p. 51).

Some of these statements are patently improbable, ambiguous and inconsistent, but only by consulting the relevant literature could one decide how far they are true of, for instance, the Islamic Hausa, the pigmy Batwa, the aristocratic Watuzi, the supercilious Masai, the highly organized Baganda, or the thrifty Xhosa. Special mention should however be made of two persistent errors, long ago exposed by social anthropologists, but still recurring in popular, unscientific writing. According to the one error, people at the tribal stage are illogical or "pre-logical"; according to the other, they are identical robots.

In "African culture", writes Carothers, "logic is distorted, cause and effect are confused, and the question 'Why?' must always be answered in magical and animistic terms which do not permit of further speculation . . . Logic, speculation, and the search for true causes are supplanted by magic and animism,

* All page references shown in the text relate to Carothers (1953).

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which supply the answers and the lines of action" (p. 53). Smartt (1956) adds: "the average rural native of Tanganyika . . . is filled with superstitious beliefs and his thinking is animistic, concrete, and often illogical."

So it probably is, like the thinking of all people on occasion. But one must protest against the claim that metaphysical thought is necessarily illogical. It is essentially pre-scientific—perhaps embodies truths about the unconscious that elude the attention of European materialist science—but magical beliefs are inherently consistent. They are deduced as logically from the underlying premises as are the dogmas of any other religious system. Indeed, a case could be made out for tribal thought as being the more unified and consistent, since it is not conscious of the dichotomy between supernatural faith and scientific empiricism that plagues Western man. Nor is it true to say that magic rules out speculation or even experimentation. The diviner and herbalist try both, looking for new techniques and remedies or applying old ones to new situations. Their adaptability is one important reason for their survival in a crumbling tribalism.

The claim that Africans conform habitually and spontaneously to rules is linked to an assertion of physical sameness. Carothers (1951) and Smartt (1956) believe that a rigid social organization is universal in Africa, demands meticulous obedience, and makes every member of the group think and act like the rest. No African is ever in a position when he does not know how to behave or what to do. This being so, writes Smartt, the personality of one African should be much like the rest; even "his physique shows little variation. There are differences in stature between various tribes but the types of physique described by Kretschmer are not often found in Africa."

This uniformity is traced back to the dawn of the Mesolithic age in East Africa! "During an estimated 10,000 years the rural African has remained almost unchanged."

10,000 years ago on the archaeological scale was the time of the Upper Pleistocene geological stage, the end of the Gamblian pluvial climatic stage, and the start of the Middle Stone cultural stage. It was the divide between Paleolithic and Neolithic man, or, in Gordon Childe's terminology, between Savagery and Barbarism. It was within this span that Homo Sapiens accomplished his greatest and most revolutionary advance: the transition from hunting and food collecting to the growing of crops, the rearing of domesticated animals, and the formation of relatively big, stable communities. The Neolithic revolution is thought to have begun in the Fertile Crescent of the Middle East, between 6000 and 5000 B.C. It is certainly after this time that the great changes associated with the introduction of food production and stock breeding spread southward into East Africa.

We must reject with equal emphasis the notion of a changeless East African man during the historical period. Starting from about 700 B.C. when Arabs are known to have traded along the coast, we have to take note of the occupation of large parts of East Africa by advanced peoples of Hamitic origin at the beginning of this era, the spread of Christianity into Abyssinia about 1,600 years ago, the coming of iron before about 1,000 years ago, the ravages of the slave trade in the modern period, and the coming of the White man. Our knowledge of East Africa's past is negligible, but it is enough to establish the presence and interaction of peoples of different physical and cultural types during the past 2,000 years.

We must conclude that traces of these divergent strains still occur in East African populations and that the assumption of complete uniformity is un-

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founded. Should the absence of Kretschmer's types be established, an empirical classification of African physiques may show the existence of other somatic categories.

A Synthetic Psychology

If we agree that the many ethnic groups south of the Sahara do not have the same practices, beliefs, ideas and sentiments, we must necessarily reject the notion that they share a common psychology.

This corollary has evidently been grasped by Diedrich Westermann, whose book *The African Today and Tomorrow* is one of Carothers's main sources on the nature of African psychical traits. In the first English edition, published in 1934, the chapter on "The Negro's Mind" begins with the observation:

> "If the Negroes are one race, it is permissible to inquire into the characteristic traits of this race."

The sentence was changed in the second edition of 1939 to read:

> "Although the peoples whom we call Negroes do not form one race in the strict sense of this term, and in spite of the fact that they have evolved widely differing cultures, they share so many essential physical and cultural features that (with the necessary reservations) they can be called a unit, into the characteristic traits of which it is permissible to inquire."

The whole chapter has been omitted from the latest edition, published in 1949. Carothers took his extracts from the second edition.

Most physical anthropologists regard the Negro as being among the most varied racial types. Even if Africans did form a single race—a proposition to which Westermann never subscribed—we should be chary of believing that they have a social or collective consciousness, or a "racial" psychology. There is no evidence to support an assumption that the evolutionary process presumed to have produced the African's peculiar bodily characteristics also produced a set of racial psychical characteristics. Would not selection and heredity have favoured a diversity of mental qualities, or at any rate the higher grades of intelligence? It is surely not in dispute that Africans differ in intelligence, temperament and personality. Anyone wishing to discover an African psychology would have to find a satisfactory method of observing and recording these traits and their distribution in the population at large.

Carothers, Smartt, and other members of the school do not claim to have used a measuring-rod of psychic quantities. They rely on general, unverified impressions and popular conceptions current among colonists and officials, and similar in kind to the 17th century encyclopaedist's description of the Cape of Good Hope's inhabitants: "They have Sense in their Looks, but none in their Brains." Carothers says that these impressions "represent the truth", but they could be more accurately described as a social stereotype.

The social stereotype is a conventional image current in a group and generally accepted by its members as a fair portrayal of the essential qualities of persons belonging to another group. Originating in the idle tattle and common chat of gossips, it represents a crude and popular form of sociological inquiry and discourse. To borrow a phrase of Jung's, it is a "calculus of subjective prejudices", and tells one more about the attitude of the person applying the stereotype than about the person to whom it is applied. In a colonial-type society, stereotypes are used to support the assumption of intrinsic superiority in the White group, and so justify racial discrimination and privilege.

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Stereotypes are products of ignorance as well as of prejudice. A person is less likely to make facile generalizations about members of his family, firm or class, whom he knows well and whose distinctive traits he recognizes. It is when the observer stands outside the group, feels little sympathy with it, and sees its individual members in the mass, that he ventures to apply to them collectively the terminology evolved for the analysis of individual personalities.

The reader will judge for himself whether the following passage constitutes a stereotype. It is Carothers's notion of "African mentality" as seen by "most" White observers.

"The African accordingly has been described as conventional; highly dependent on physical and emotional stimulation, lacking in spontaneity, foresight, tenacity, judgment and humility; inapt for sound abstraction and for logic; given to phantasy and fabrication; and, in general, as unstable, impulsive, unreliable, irresponsible, and living in the present without reflection or ambition, or regard for the rights of people outside his own circle" (p. 87).

Such phrases do no doubt circulate among settlers and officials, but cannot for that reason alone be regarded as "representing the truth". Indeed, they are not convincing. Are we not all "highly dependent on physical and emotional stimulation"? "Conventional" people may be "given to phantasy and fabrication" in an inner, concealed life, but they are not usually "unreliable and irresponsible". Nor is an "absence of spontaneity" associated with "instability and impulsiveness". People who lack "humility" are presumably self-assured, perhaps aggressive. Are not these qualities often attached to tenacity and ambition? Does an African "live in the present without reflection or ambition" when he sets out to acquire cattle, obtain a wife, buy a bicycle, or send his children to school?

Mental Disorders

The speculations of the East African medical school are used to provide a theory of African mental disorders. These are described in conventional Kraepelinian terms; their incidence is assessed largely by an examination of admissions to mental hospitals; and they are compared with mental disorders in Europeans and at times in American Negroes. The differences are attributed to the alleged cultural, anatomical, or psychological peculiarities in Africans.

The survey of known mental cases leads to the conclusion that the incidence of "insanity" in Africans is very low: "probably very much lower than that in Europe or America" (Carothers, 1953). This applies to nearly all kinds of insanity. As regards the organic types, both general paralysis and arterio-sclerotic dementia are rarely recorded. Paranoia, paraphrenia and depressive psychoses are seldom seen. Obsessional neurosis is almost unknown. Overt anxiety symptoms are not prominent in psychoses and are almost absent in depressive states. Schizophrenia is the most common psychiatric disorder, but its recorded incidence is far lower than in Europeans.

This is the picture drawn by the East African medical school on admittedly scanty information. As will be shown later, there is reason to doubt whether the picture is altogether a true reflection of reality. But in the form presented, it reveals a people far freer than Europeans from most if not all kinds of mental ailment. The difference may well be significant and require an explanation.

Psychiatrists are not able to account for the difference. Conjecture has to take the place of established theory, and there is room for surmise and supposition. One might, for example, draw the inference that unstable types have been

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discouraged by some untutored process of eugenics, and that Africans are more balanced, healthier in mind, than the European stock, and therefore better equipped for great social change and stress.

Such hypothesis would discredit the conventional stereotype of African inferiority. The East African school has preferred other explanations. One, which may be called the sociological, is consistent with its notions of tribal society, and is expressed by Carothers (1947) as follows:

"the very low general incidence of insanity among Africans living in their natural environment is due to an absence of problems in the social, sexual and economic spheres."

The proposition includes two assertions of fact and an assumed association. The first assertion has not been satisfactorily demonstrated; the second is incorrect; and the alleged association is inconsistent with psychiatric theory concerning the unconscious and its relation to psychosis.

In general, it should be pointed out that we know of no people who are free of the cares associated with death, birth, nutrition, reproduction and security. Further, that the low incidence of mental diseases is supposed to occur in present-day Africa, which is not free of other problems. Carothers's statement appeared in print in 1947. At this time thousands of Africans from Kenya and Tanganyika, who had been enlisted, trained and employed to fight a ruthless war with modern weapons, were undergoing the difficult, painful process of adjustment to civilian life. The society to which they returned was in a state of disorganization, and stood poised on the verge of a long, brutal civil war, explicable only in terms of acute, critical social conflict.

Carothers has laid himself open to the reproach of having created an imaginary society, less ingenious than but as unreal as the worlds that his patients create in their phantasies. They wish to escape from reality; his aim is to support a preconceived notion of African inferiority.

His second line of approach proceeds from certain psychological and anatomical speculations and leads to the startling conclusion that "*all* primitive Africans are psychopathic by European standards" (1951). Here "primitive" presumably means tribal, but they are not the only ones held to be abnormal in their normality, for, says Carothers, the mentality of "the partially detribalized African"—that is the great majority—resembles to an even greater degree "a certain type of aberrant European mentality commonly included under the title psychopathic".

The psychiatrist will decide if "psychopathic" is a specific condition capable of precise definition. The sociologist must however enter a protest against the stratagem of assessing "abnormal" conduct in one society by the norms current in another, very different society. It is common observation that foreigners usually seem eccentric to the vulgar mind. There is much in European behaviour patterns—their strongly developed acquisitive drives, excessive stimulation of eroticism, and aggressiveness in inter-group relationships—that many Africans find inexplicable and "abnormal". But who would accept the African's judgment as a correct diagnosis of European mental health?

The anatomical reference in the Carothers theory (1951) can be summarized in the following propositions: the main function of the frontal lobes is to integrate stimuli from the thalamus and cortex; Africans make little use of their frontal lobes except for verbal synthesis; this idleness is the cause of "all the observed African peculiarities" and the "complete" resemblance between leucotomized Europeans and "primitive Africans". The first two of these

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assertions raise issues that concern the anatomist, physiologist and psychiatrist; the third proposition falls within the domain of the sociologist.

The objections raised to broad, impressionistic, unsubstantiated accounts of African personality traits apply also to the comparison between leucotomized Europeans and normal Africans. The whole approach seems ill-conceived and unfortunate. It is not improved by the failure to give chapter and verse. Indeed, we are given even less to go on than in the assessment of African psychology. Carothers (1951) explains:

> "It would have been possible to write the analysis of the leucotomized European's mentality in words that echoed the analysis of the African's; but it would have been wearisome reading."

Some of us would willingly pay in tedium for precision and proof. The feat suggested might be possible, but would the words reflect reality? The samples given are not encouraging. The opinions of (three) unrepresentative employers are not the best source of information on the reliability of their servants. An alleged irresistible impulse in Africans to laugh uproariously at blind men slipping on bananas, or to jolly a condemned murderer about his fate, is surely insufficient evidence of a deficiency in "social sense". The fondness shown by a single leucotomized European for the company of Africans can be attributed to reasons other than a mental affinity between them.

There is real danger in such writing. It is liable to pass into technical literature, and become an "authority" for subsequent writers. Carothers quotes Carothers, and is quoted in turn by Smartt (1956) as in the following passage:

> "It is difficult to deny the similarity of the bush African's mentality to frontal lobe defect syndrome, or the 'frontal lobe idleness' postulated by Carothers. Many Africans tend to be apathetic and lack interest in everything except their immediate environment. Initiative is usually blunted and may be limited to finding enough to eat and a shady tree under which to rest. In his work with Europeans he is often found to be irresponsible and unreliable. Under the least mental or physical stress he shows a tendency to uninhibited conduct."

It should not be necessary to point out the dangers of sweeping and immoderate statements on important issues. "Many" may mean most, half, or perhaps less than half; "tendencies" are inclinations or trends, and these may be restrained, obstructed by contra-tendencies; the African's need of nutrition and sleep is satisfied by a wide range of activities requiring the display of energy and effort; the smallest degree of stress may be insignificant, and persons who are uninhibited to this extent are likely to be regarded in law as insane.

The Incidence of Mental Disorders

It is doubtful if we know enough about African mental illness to make useful comparisons with the European pattern. Medical scientists generally have some difficulty in defining mental disorders, and their notions are not the same as the African's. Methods of treatment also differ in the two societies. Facilities for modern types of treatment are not available for a great many Africans who, by approved European standards, need psychiatric therapy. Indeed, Africans are often reluctant to seek and accept such care. Consequently, the incidence, distribution and pattern of mental diseases in the African is imperfectly understood.

The approach to the illness known in South Africa as *thwasa* illustrates the difference in conception and treatment. The verb *ukuthwasa* means in Zulu and Xhosa to come out, renew—as said of the new moon, or start of a new season

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—and also to initiate a person into the mysteries of divination, from which process he is said to emerge as a new being. *Thwasa* also describes a state, a condition marked by pains in the limbs and "all over" the body, nausea, loss of appetite, hallucinations, wild talk, nervousness and excitability. Dreams figure largely in the symptoms of *thwasa.*

The indicated course of treatment is a period of training, perhaps for a year or more, under the guidance of a leading diviner. This culminates in an initiation ceremony, after the novice has experienced a dream or series of dreams, which, as described, follows a set pattern involving such objects as cattle, snakes, birds, stones, spears.* These are symbolically interpreted as communications from the ancestral spirits, believed to urge and guide the afflicted person through the initiation. Africans say that if a person so "called" fails to undergo the training prescribed, he will surely be punished by loss of reason.

Laubscher (1937), an experienced psychiatrist with special knowledge of certain aspects of tribal society, considers that the condition of a *thwasa* patient just prior to being "called" resembles closely a catatonic or depressive phase in schizophrenic or manic-depressive or epileptic psychosis.

It will be seen from this short account that a particular psychological condition can be viewed in very different ways. What a European considers to be a symptom of acute psychosis is to the African a certain sign of rare mediumistic or other undefined psychic qualities. The European certifies the afflicted person as "insane"; the African regards him as a suitable candidate for a highly valued and honourable profession.

For these and other reasons Africans are often reluctant to undergo treatment in mental hospitals. This statement is confirmed by Laubscher, whose observations carry weight by reason of his psychiatric experience and field-work. This started from a point of view different from the one adopted by the East African school. He, like Tooth (1950, p. 26) thought that an investigator into mental abnormalities should have knowledge of the normal.

> "I realized at the very outset that it would be futile to enquire for evidence of mental disorder by employing our conceptions of mental disease, so the first study was devoted to ascertaining the native's conception of mental disorder, and as a result of these findings a method of approach was developed, based entirely on his conceptions. The enquiry hence entered a sphere of his thinking and concerned itself with his beliefs without disputing the reality of his beliefs."

The inquiry showed that mental disorders are not rare among tribal Africans, but are assumed to be so by people who "lack intimate contact and comprehension of the culture of these peoples". The European's ignorance of African beliefs, language and behaviour, is intensified by the secrecy surrounding the treatment of *thwasa* patients, who are carefully guarded in isolation, perhaps for years, while under the care of the diviner. The administration usually discovers the existence of the patient and takes steps to have him certified only when he commits a crime, or becomes a nuisance to traders, farmers and other Europeans in the neighbourhood, or becomes so violent and uncontrollable that his own relatives and friends ask officials to intervene.

We should not jump to the conclusion that East Africans also try to keep their mentally sick away from the attention of the White administration. Indeed, Carothers (1947, 1953), who used government chiefs to make a census of insane persons, suggests that the possibility of obtaining tax exemptions on ground of disability probably worked in the opposite direction. It is not however

* For an account of *thwasa* dreams and initiation see Kohler (1941) and Tooke (1955).

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clear from his account what benefit the chiefs would derive from exemptions granted to individual tribesmen, or what criteria they used in diagnosing insanity. He concedes that they might have missed some simple cases of disorder, but thinks that the objection to a layman's diagnosis is less valid in mental than in most physical disorders. The South African material clearly indicates the contrary view.

It seems that no satisfactory survey has yet been made of mental disorders in any African community. The bulk of the statistical evidence comes from the records of mental hospitals. To assess their value, we could hardly do better than to consider the position in South Africa, which has probably the best medical and hospital services on the continent.

The annual reports of the Commissioner of Mental Hygiene show a tendency over the past 15 years for the relative number of registered European mental patients to decline and the number of non-European patients to increase.

ADMISSIONS AND REGISTERED PATIENTS ADMITTED TO MENTAL HOSPITALS PER 100,000 OF POPULATION

	Direct Admissions		*Registered Patients on 31 December*	
	1940	1955	1940	1955
Non-European ..	21·3	20·4	101·9	111·4
European	50·1	53·1	238·6	188·0

The table suggests that Europeans are more prone to mental disease, and secondly, that their greater susceptibility is diminishing. The statistics are not however a reliable guide, for there is a chronic and critical scarcity of accommodation, especially for African and Coloured mental patients. "The admission rate", stated the Commissioner (1947), "is entirely controlled by the discharge rate." The number of patients in hospital is likewise determined by the amount of accommodation available and the extent to which the administration allows overcrowding. The rated capacity of mental hospitals was 14,122 at the end of 1954; the excess of patients over maximum rated capacity was 3,060 (Cluver, 1951); and the estimated additional number of "insane" persons requiring accommodation was between 3,000 and 4,000 (1956 *Senate Debates*).

The accommodation is so inadequate that 1,628 non-European and 144 European patients were kept in police cells and gaols until a place could be found for them in hospital. In most instances they were locked up because they were regarded as a public danger or nuisance.

This criterion also largely regulates the admission of non-Europeans into mental hospitals. Indeed, it is probably true to say that throughout the continent African mental patients are being admitted to institutions only when violent, uncontrollable, criminal or destitute (Shelley and Watson, 1936; Tooth, 1950). The "protection of society", not the treatment of the sick, is the main concern. The same principle applies to non-European mental defectives, senile and arteriosclerotic cases. There are no special State institutions for them; they are certified only if very troublesome, and admitted to a mental hospital only if vacancies occur.

The non-European mental hospital population is therefore a highly selected group. The African section particularly rarely includes cases of simple senile dementia, uncomplicated mental defect, alcoholic dementia, paranoia, or schizophrenia simplex (Lamont and Blignaut, 1953). In comparison with

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European mental patients, for whom accommodation is usually available, the proportion of African schizophrenics is high (Moffson, 1954). This has led some observers to assume that there is a significant racial difference in the pattern of mental disorders. It seems however that the difference is due not to an African or European idiosyncrasy but to social and administrative policies.

There are other consequences of inadequate treatment that bear upon our problem. Patients who would recover quickly if treated early might, when left untreated for a long time, develop an incurable illness. They then become certifiable and eligible for admission to hospital. A bad organization for the rehabilitation of remitted psychotics may similarly result in a poor prognosis. Such defects are far more common in the treatment of non-Europeans and therefore contribute to the observed difference between them and European mental patients.

Administrative arrangements also partly account for the predominance of African mental patients from towns and other areas in close proximity to European communities. It is in these regions that the African disordered person is likely to be brought to the attention of the administration as a "troublesome person". Little initiative is shown in discovering sick persons in tribal areas who are a burden and nuisance only to relatives and neighbours.

One must assume that, as the absorption of Africans in a modern type of social organization proceeds, and as the standard of health and administrative services improves, the number of mentally sick Africans discovered and treated will increase, while the difference between observed African and European patterns of disorder will diminish.

Both early and contemporary observers have found reason to doubt whether there is an increase in the actual incidence of mental illness among educated, civilized Africans as compared with the tribesmen (Greenlees, 1905; Tooth, 1950). It is too early, however, to draw hard and fast conclusions. The hazards and frustrations of civilization in the form encountered by Africans are not conducive to the growth of harmoniously balanced personalities.

The relative weight of the contributory factors cannot be assessed by examining hospital patients alone. Field work is needed in different kinds of African communities—tribes, urban "locations", farm workers, mining compounds—to discover the incidence of mental illness and social attitudes towards sick persons. The employment of African psychiatrists for this purpose would be invaluable, if not indispensable. They would combine, as few other practitioners can do, the required knowledge of medicine and psychiatry with an intimate knowledge of the people's physiognomy, language, and traits.

Summary

Theories of certain East African medical writers, concerning mental illness in Africans are reviewed. Doubts are raised as to the soundness of certain speculations about African anatomical, cultural, and psychological traits and their relation to mental disorders. Reasons are given for supposing that the incidence and pattern of these disorders are largely unknown or imperfectly understood. Systematic field work by African psychiatrists is suggested.

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