11.—Finally, such results as I have given cannot fail to make an impression on those who have the responsibility of treating the insane, and are anxious to use every method to help in furthering their cure. I believe that in thyroid feeding we possess a valuable addition to our armamentarium in the treatment of certain cases of insanity.

Insanity among the Natives of South Africa. By T. Duncan Greenlees, M.B. Edin., Medical Superintendent, Grahamstown Asylum, South Africa.

Perhaps one of the most difficult investigations possible is the study of the mental characteristics of savage and semi-savage races, and, before formulating any theories regarding their psychic history, it is necessary that a careful study should be made of their mode of life, their normal mental state, and such folk lore as is accessible to us.

Unfortunately the material at our disposal with regard to the normal mental condition of the inhabitants of South Africa is extremely limited. While numerous works on travel and exploration have been published, few refer to the customs of the natives of the present day, and a perusal of works from Livingstone down to the recently-published "Travels of Selous" fails to throw much light on this important subject.

The history of South Africa is one full of interest, and reads almost like a novel. Perhaps in no other country has the influence of the white man been more apparent, and the devastating effects of modern civilization on the native races been more felt. At the present day, however, the Kafir, of all the native tribes, seems to thrive in spite of this civilizing influence, and, although the time is sure to come when the influence of intoxicants will exterminate him, yet so far he stands out as a member of a flourishing race; and, when uninfluenced by civilization, he is still one of the noblest types of mankind.

Further, strict classification is well-nigh impossible, the races have become so mixed. Thus in the Western Province the coloured inhabitants are mainly descended from the old slaves held by the Dutch settlers; while in the Eastern Province the Kafir and Hottentot still hold their own, intermixed to a certain extent with other tribes, and even with white people in many cases. Indeed, the Bastard—a

mixture of white and black blood—morally seems to present all the worst characteristics of both races, and so degraded is the position he occupies that he is compelled to associate still with his coloured half-brothers.

In this paper, as the statistics referring to the coloured races of the Western Province are most meagre and unsatisfactory, the natives inhabiting the Eastern Province and the Northern portions of Cape Colony will be chiefly dealt with. These comprise the Kafir races and Hottentots who may be considered as most civilized, for they have been longest in contact with the white man. The Kafir races, except near the towns, still maintain their original dress and customs.

Thus we may classify the Kafirs under two headings:—

I. Those living close to centres of civilization.

II. Those who still lead a simple and savage existence, and who are rarely brought into contact with the white man.

For the purposes of a statistical inquiry I have gone over all the cases admitted to the Grahamstown Asylum since its opening in 1875, and appended to this paper are certain tables which explain themselves.

From 1875 up to 1894—a period of 19 years—473 natives were admitted, viz., 319 males and 154 females.

1. *Age of Patients Admitted.*—A reference to Table I. will show the ages of those admitted, and it is noted that for the males, the most prevalent age at which insanity occurs is between 25 and 30, while for the females it is a little later, viz., between 30 and 35. These ages, I should imagine, are very similar to those found among the white races, and go to prove that it is while the individual is in the prime of life he is most liable to a mental breakdown.

2. *The Form of Insanity.*—In this table a curious fact makes itself apparent, and that is the enormous excess of cases of mania over other forms of insanity, 321 cases out of 473, or a percentage of nearly 67 of the total. This bears itself out in fact, for by far the larger proportion of patients admitted suffer from the simpler forms of mania. If we consider the theories of those who maintain that while mania represents a loss of the lower developed strata of the mental organism, melancholia indicates an absence of the higher and latest developed strata, then this prevalence of mania among natives of low developed brain-functions goes far to prove this theory.

Examples of melancholia are rare among natives; I only possess the records of 21 cases, and, with one exception, I have never found this condition so acute as is found among

white patients. The exception I refer to was that of a woman who attempted to drown herself and her illegitimate child in a well, and who ultimately died simply from pure mental exhaustion.

In another paper * I have attempted to prove that epilepsy and its insanity is not unknown among native races, especially those cases brought under the influence of civilization. A certain number of our cases suffer from traumatic epilepsy —the result of injuries sustained in mines, etc., but the idiopathic form is likewise found to exist, and presents no characteristics differing from the form as met with among white patients.

General paralysis, on the other hand, is so rare that amongst the pure uncontaminated natives it may be considered as practically unknown. Of the two cases recorded, one was an Africander male—a person in whom a certain amount of white blood circulated—and the other was a Kafir female regarding whom we have no information. This absence of general paralysis is not an extraordinary fact when we consider the simple mode of life of these natives; no cares and no struggle for existence such as is found in European cities. Living a life in the open air, in a perfect climate, with plenty of simple and natural food, it is not to be expected that diseases originating in mental worry and anxiety should make themselves evident.

While a fair proportion of all cases recover, yet it is to be noted that a large number had passed on to the condition of secondary dementia before they were admitted, no less than 87 being classified as such, 18·4 per cent. of the total number.

3. *The History of the Cases Admitted.*—Of the 473 cases 133 (102 males and 31 females) were discharged recovered. This represents a percentage of 28·1 (31·9 per cent. for males, and 20·1 per cent. for females), a somewhat lower rate than is presented by the entire statistics—including whites—of the asylum.

A large proportion of our non-recoveries, viz., about 146 cases, have been transferred to other institutions, and of the remainder 114 have died in the asylum, being a percentage of 24·1 on the total admissions extending over a period of 19 years.

4. *The Causes of Insanity.*—When we consider that little is known of the history of native patients it can be under-

* "Statistics of Insanity in South Africa," "American Journal of Insanity," April, 1894.

https://doi.org/10.1192/bjp.41.172.71 Published online by Cambridge University Press

stood how difficult it is to arrive at any specific conclusions regarding the cause of the attack. In a large proportion of our cases this is totally unknown, and the medical man signing the certificate takes no trouble in endeavouring to ascertain the influences at work in any one case.

There are two causes known which are prominent and worthy of note; these are excessive drinking, and the smoking of dagga, a plant almost identical with cannabis indica, and which produces temporary intoxication, ending in some cases in an acute outburst of maniacal excitement.

Whether masturbation plays an important part in the causation of insanity, I cannot say; but this I know, that natives are addicted to this habit, and this is a well-marked symptom of insanity among the natives while in confinement.

The terrible curse of drink I have already referred to, and, as found among the natives of South Africa, I believe it to be most prolific in causing insanity, which, in the most acute cases, occurs as simple dipsomania.

5. *The Causes of Death.*—I have drawn up an interesting table showing the causes of death in these 114 cases. The only points I would direct attention to are the comparative rarity of deaths from cerebral disease, and the frequency with which chest disease causes death among the native races of South Africa. The former statement is explained by the fact that the average native rarely is subjected to such extraneous influences as are likely to produce cerebral disease, while the latter fact goes to prove that as soon as he is brought under the artificial influences of civilization and compelled to clothe himself, he is peculiarly liable to chest troubles; he gets cold or wet, neglects himself, allows his clothing to dry on him, and such diseases as pneumonia, phthisis, and pleurisy result.

Further, in confinement and while insane, the natives are extremely filthy in habits, and are accustomed to eat all manner of injurious articles, and abdominal diseases, especially those affecting the mucous membrane of the intestinal tract, are very common, and I frequently find large numbers of the large round worm in the intestines of patients dying from acute peritoneal trouble. We do occasionally come across patients living to a good old age in asylums, although my experience is such as to induce me to believe that the white insane has a better chance of a long life in confinement than his black brother.

6. *The Nationality of those Admitted.*—From the table, herewith appended, it will be noted that I derive my patients

from many races of the coloured tribes of South Africa, and these cases are obtained from nearly every part of the country, including Pondoland, and even as far north as British Bechuanaland, and I shall not be surprised if I am shortly asked to provide accommodation for cases even from Matabeleland and Mashonaland.

While these tribes present many traits in common, still they differ in many of their habits and customs, and some are much higher in the scale of civilization than others. Thus the Hottentots have been for the past 300 years in intimate contact with the whites, first with the Dutch, latterly with the English, and it is not unreasonable to suppose that they are becoming liable to such mental and physical diseases as affect the African emigrant; and, again, the Kafir is slowly but surely bringing himself under similar influences; in this case we may likewise expect the same results.

With regard to the other tribes they, for the most part, still hold themselves aloof from civilization, but the time will soon come when civilization will overshadow them with its baneful pall, bringing innumerable diseases in its train, and ultimately exterminating all races that oppose its progress.

In conclusion, I would point out the great advantages of studying such a disease as insanity among primitive people. We are thereby enabled by such a study to grapple many of the facts of the onset, progress, and cause of a condition which is yet to most of us obscure. The native brain has its analogue in the European child's cerebrum; in many respects his mental attributes are similar to those of a child, and in the breakdown of this infantile brain we can investigate the condition from an aspect not obtainable in any other way.

Such an investigation should be aided by pathological research, and, with this object in view, we at Grahamstown Asylum are carrying out a series of observations on the naked-eye appearances and the microscopical characters of the native brain. This investigation, when complete, should prove of some benefit to comparative anatomy, especially when this study is viewed from the standpoint of, on the one hand evolution, and on the other devolution. Investigations of this nature, with carefully compiled statistical information bearing upon mental diseases as met with among savage tribes, are of value, even although the information at our disposal may be meagre in quantity and rather inferior in quality.

TABLE I.—Showing the Ages of Patients on Admission.

	Males.	Females.	Total.
10 years and under 15	3	3	6
15 „ „ 20	26	10	36
20 „ „ 25	58	16	74
25 „ „ 30	60	19	79
30 „ „ 35	39	27	66
35 „ „ 40	33	19	52
40 „ „ 45	27	18	45
45 „ „ 50	15	9	24
50 „ „ 55	20	14	34
55 „ „ 60	9	6	15
60 „ „ 65	9	3	12
65 „ „ 70	1	1	2
70 „ „ 80	5	2	7
Unknown	14	7	21
Totals	319	154	473

TABLE II.—Showing the Form of Insanity on Admission.

	Males.	Females.	Total.
Mania—Acute	114	63	177
Chronic	11	12	23
Recurrent	10	5	15
Puerperal	—	6	6
Melancholia	21	10	31
Dementia—Secondary	60	27	87
Senile	11	6	17
General Paralysis	1	1	2
Epilepsy—Acquired	18	7	25
Idiocy	10	3	13
Imbecility	53	11	64
„ with Epilepsy	10	3	13
Totals	319	154	473

NOTE.—Under General Paralysis a Male Africander and Female Kafir are classified, but no records of a post-mortem examination exist.

https://doi.org/10.1192/bjp.41.172.71 Published online by Cambridge University Press

Table III.—Showing the Results in Cases Admitted. Of 473 cases admitted—

	Males.	Females.	Total.
Recovered	102	31	133
Relieved	55	21	76
Not improved	49	21	70
Died	72	42	114
Still in residence	41	39	80
Totals	319	154	473

Table IV.—Showing the Nationality of Cases Admitted.

	Males.	Females.	Total.
Kafirs	81	32	113
Hottentots	63	41	104
Bastards	26	27	53
Fingos	38	8	46
Gaikas and Gelekas	20	8	28
Basutos	17	6	23
Zulus	18	3	21
Tambookies	9	5	14
Other Races, consisting of Malays, Hindoos, Bushmen, Griquas, Koumnas, Bacas, Batlapin, Makatese, Pondosete	47	24	71
Totals	319	154	473

https://doi.org/10.1192/bjp.41.172.71 Published online by Cambridge University Press

TABLE V.—Showing the Causes of Death in Patients Admitted.

	Males.	Females.	Total.
Cerebral and Spinal Diseases:			
1. Apoplexy	1	—	1
2. Cerebral Softening	5	1	6
3. „ Tumours	1	—	1
4. „ from Epilepsy	10	3	13
5. „ „ Mania	4	—	4
6. „ „ Melancholia ...	—	1	1
7. General Paralysis	1	1	2
8. Paralysis	1	—	1
9. Locomotor Ataxia	—	1	1
Thoracic Diseases:			
10. Heart Disease	3	4	7
11. Bronchitis	2	—	2
12. Phthisis	7	12	19
13. Pleurisy	1	1	2
14. Pneumonia	4	2	6
Abdominal Diseases:			
15. Ascites	3	1	4
16. Cancer of Pylorus	1	—	1
17. Dysentery and Diarrhœa ...	7	3	10
18. Enteritis	1	3	4
19. Peritonitis	2	1	3
General Diseases:			
20. Injury (to head)	1	—	1
21. Leprosy	4	—	4
22. Marasmus	8	3	11
23. Pernicious Anæmia	1	—	1
24. Pyæmia	1	—	1
25. Senile Decay	3	5	8
Totals	72	42	114

Current Opinion on Medico-Psychological Questions in Germany, as represented by Professor Ludwig Meyer, of Göttingen. By A. R. URQUHART, M.D.

(*Continued from Vol.* XL., *p. 213.*)

II. *Criminal lunatics.*—A brief note as to this class of patients will be of interest. Professor Meyer has very decided opinions as to their care and treatment. He fears that the practical outcome of advanced theories would be to change asylums into prisons—a change that would by no means possess the charm of novelty. According to some authorities the term "criminal lunatic" should be limited to such persons as were criminal before they became insane;