SOCIAL AND CULTURAL DETERMINANTS OF PSYCHIATRIC ILLNESS PRESENTING IN AN URBAN GENERAL HOSPITAL

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Photograph 1: A group of Non-European patients queueing at the out-patient department where this study was made. (These patients were not psychiatric).

To Blumé

CONTENTS

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SECTION A

Perspective—a review of the literature

INTRODUCTION

> "I will not follow these thoughts further, but one might show how 'das Volk' judges, believes, hopes and works quite otherwise than we do. There is a psychology of the common man which is somewhat different from ours."
>
> - FREUD, 1883.[1]

In spite of these words to Martha Bernays, at that time his fiancée, Freud was for very long preoccupied with the analysis of patients from a Viennese middle-class practice alone. It was out of this experience that he evolved his views of the origin of psychological symptoms from repression of stereotyped instinctual urges of childhood. These instinctual demands arose out of the patriarchal Viennese society.

Psychiatry has since extended its perspectives to include other forms of society and different strata within the same society. Its margins have joined

those of the neighbouring disciplines of sociology, anthropology and social psychology. The psychiatrist has left his engrossment with the single mind and seeks also to study extrinsic pressures modifying the human personality and patterns of sickness as they affect groups of persons.

That social learning enters largely into the formation of normal and abnormal personalities is now generally accepted.[2] Yet Lewis (1958) noted that significant advances in social psychiatry have occurred only in the last two decades.[3] He relates this unawareness of the workings of outside forces as being tradition-bound to the development of psychiatry as an offshoot of organic medicine. "Pathology, whether it be psychopathology or cellular and chemical pathology, has been looked for <u>inside</u>+ the patient's mind and body".

Yet to-day a vast realm of literature confronts the student. Even Freud himself, in his later period, contributed significantly. But Adler had to secede

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+ Present author's italics.

from the Freudians in order to develop his system based on social feeling (Gemeinschaftsgefühl), which connoted a sense of relatedness to the human community as a whole; so that Adlerian psychotherapy was directed at enabling integration of the individual with his group.

So wide are the ramifications of social psychiatry as stated to-day[4] that Wittkower has found it necessary to detach cultural psychiatry from social psychiatry and to treat it as a separate entity.[5] Comprehensive reviews abound both from the social[3, 6, 7, 8] and anthropological[4, 5, 9, 10, 11, 12] aspects; and the preventive view-point has been emphasized by Rennie[13] and Sutherland[14], the former being regarded by many as the founder of modern social psychiatry. The present review will therefore focus on selected aspects relevant to the present study, while at the same time outlining the main conceptual trends.

CHAPTER I.

Earlier Theoretical Approaches

In 'Totem and Taboo' (1912) Freud analysed the conflict between basic human impulses and what could be permitted socially.

"....The fact which is characteristic of the neurosis is the preponderance of the sexual over the social instinctual elements".[15]

Using anthropological examples he argued that primitive societies were organized in order to enforce Oedipal taboos. He recognized that the taboo varied according to the culture; so that while the Viennese young man languished after his mother, in Melanesia it was the mother-in-law who needed social protection from the illicit fantasies of her daughter's husband. In his much later work (1930)[16] he reiterated that civilization was built upon the renunciation of instinctual gratifications and that this "cultural privation" dominated the whole field of social relations between human beings - a sort of blanket super ego.

This pessimistic view, based as it was on a theory of immutable instincts, implied a Darwinian predetermination in the light of which man was not able to change his destiny, nor to plan socially. In shifting the focus from the individual to the community Adler made the latter possible.

Family relationships were seen as broader than an Oedipal battle-scene and sibling interactions were introduced into the picture. The family became a training-ground for "social feeling", giving rise to a "life style" which determined one's feelings and actions in the real world[17]. The difference with Freud was summed up in 'Social Interest: a challenge to mankind' (1938):

> "The child is constantly confronted afresh with ever-varying problems that cannot be solved either by trained (conditioned) reflexes or by innate psychical capacities. It would be a most hazardous venture to expose a child equipped only with trained reflexes or with innate capacities to the tests of a world that is

continually raising new problems".[18]

THE NEO-FREUDIAN OUTLOOK

The heirs to Freud and Adler were Karen Horney and Fromm. Their respective systems of personality "trends" and "orientations" are markedly similar. Fromm[19] has reinterpreted the Oedipal situation, not as a sexual rivalry, but as a necessary struggle of authority versus the child; a taming of the child's free spirit in order to meet the needs of society. The child meets through his parents "the kind of authority which is prevailing in the particular society in which it lives, and this kind of authority tends to break his will, his spontaneity, his independence" i.e. to cause him to give up his true self in exchange for a social self. This new self, depending upon the prevailing patterns, may be a culturally patterned defect self such as the "marketing" personality, whose chief asset is to mirror the roles expected of him, so that he is unable to make any contribution of his own. The necessity to maintain a social front alien from that of one's true self is the root of neurotic conflict in Fromm's view; and successful treatment must free the

individual to relate constructively with others and to share with them the responsibility of building a humanistic community.[20]

Horney[21, 23] regards Western culture as culpable in a similar way; holding out an ideology to the individual in which attitudes of unselfishness, self-effacement and brotherly love are encouraged, while in harsh reality only the aggressive, ruthless and competitive can succeed. Checked by his real world experiences the individual loses confidence, feels fear, insecurity, isolation and hostility. Such feelings of basic anxiety may be defended against by character trends such as moving away from or moving against people.[22] The individual can function in society, but at a tragic price; his shaky adjustment is fertile soil for neurosis.

In a posthumous publication[24] Harry Stack Sullivan (1949) defines personality as the integrative product of experience. Such experience arises in interpersonal situations both externally and internally conditioned. "Mental disorder must be regarded as the result of the personality relating to the demands of the personal situation".

For the present writer Sullivan's great clarification is the concept of parataxic distortion[25], by which the impingements of a culture are individually perceived according to previous interpersonal experiences. The citizen moves in a world of illusory people, and his culture-reflecting contacts with them determine his future distorted conceptions and reactions. While in this Sullivanian world the individual is at the mercy of conjunctive and disjunctive forces which pull him this way and that. Thus while Sullivan's social forces are reminiscent of Horney's and Fromm's character trends and orientations, his implications are of passivity; theirs of active motivation.

Sullivan's parataxic picture is, of course, a modification of Freudian transference theory. But Sullivan takes transference-formation out of the parental living-room and into all the significant daily contacts which are possible. Jung would go further, proposing as he does a dual personal and transpersonal unconscious. The personal unconscious contains lost memories and subliminal perceptions; the collective unconscious the inherited primordial "archetypes" - "the inherited power

of human imagination as it was from time immemorial".[26]

With Horney, Fromm and Sullivan stands Erikson in the group of psychoanalysts increasingly concerned with social factors in mental illness, but still emphasizing intrapsychic processes. Kardiner and his anthropological associates, chiefly Linton, are almost solely concerned with cultural influences.

For Erikson[27, 28] personality growth is indistinguishable from social growth and the child must proceed in stages, at each step learning a new social modality. The human thus undergoes a continuous metamorphosis in which in turn he learns to trust, incorporate, be independent, initiate, produce, identify, pair off, and generate new social beings. As with Freudian libido theory, theindividual is in peril of being blocked at a particular level of social interaction if he fails to master a given step. This then becomes his habitual behaviour form.

Thus the child who fails to learn the quality of industry at school may never make a satisfactory work adjustment; and the boy with no adequate father on

whom to model himself may never develop a proper sense of his sexual identity. Erikson's maturation scheme has been extended to include a stage of senility by Linden and Courtney(1956).[29]

THE ANTHROPOLOGISTS

Ruth Benedict (1953)[30] similarly discusses child training as a continuous conditioning to social participation, while at the same time the tasks that are expected of the child are adapted to its capacity. Ideally the child should progress from status role to status role, learning qualities such as responsibility and dominance on the way. Western culture however (cf. Horney) demands in the adult traits that are interdicted in children. Its conditioning is discontinuous. The child, encouraged to be submissive all its life, finds suddenly in adulthood that it is dominance that is rewarded. "Far from redoubling efforts to help children bridge this gap adults in our culture put all the blame on the child when he fails to manifest spontaneously the new behaviour, or overstepping the mark manifests it with untoward belligerence". In contrast Benedict cites the "joking" relationships current in

primitive Indian cultures between grandchild and grandparent and father and son. Unlike the western "dogma" of respect for elders, the child is encouraged to reciprocate the adult's teasing and practical joking; so that "travellers report wonderingly upon the liberties and pretensions of tiny toddlers in their dealings with family elders".

The individual in the primitive culture is regarded as likely to maintain a particular trait all his life, so that in childhood he is encouraged to assume the particular qualities which he would do well to manifest in adulthood. In Western society on the other hand many individuals fear to use behaviour previously banned and trust instead, at great psychic cost, to attitudes which have been approved in their formative years.

Like the late Dr. Benedict[+], Kardiner and his

+Benedict characterized cultures on a polar scale of Apollonian and Dionysian. According to this scheme the former was characterized by an intellectual approach to life and by low emotional affect. The Dionysian culture on the other hand was characterized by heightened emotion and ecstatic experiences.

collaborators sought after the central values of a culture; but not only were they interested in evaluating the impact of specific cultures upon the individual, but also the circular process by which the individual in turn influenced his culture.

In 'The Individual and His Society'[31] the manner is described[+] in which the basic personality structure derives from primary institutions such as child training practices and subsistence techniques. They postulate a shared core personality with a superstructure of individual differences in all members of a culture typically reared. Deviant rearing is however likely to produce a deviant personality.

Thus in Tanala culture paternal authority is emphasized while in Marquesan no such emphasis on childhood obedience was discovered. Tanala folk-lore therefore showed a typical father-son relationship in which jealousy was repressed and passivity overtly substituted. In Marquesan mythology father-hatred was absent, and in

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+Using techniques based on Freudian psychoanalysis.

its place stood fear and distrust of the woman. Kardiner reasoned that the basic personality had projected itself into folk-lore and religion, and that in turn such projective systems served to reinforce prevailing mores. Additional key integrative systems playing on the individual are unconscious learning situations within the family; conscious reality systems for imparting technical skills; and mimetic systems by which the individual apes the fashions and manners of his group. The latter, however, do not enter into the basic core personality itself.

The Kardiner group set out to test their theoretical constructs by analysis of contrasting cultures. 'The Psychological Frontiers of Society' (1945) records this comparative study of simple yet cohesive Comanche; complex yet degenerate Alorese; and contemporary small-town American Plainsville communities[32]. The affectionless Alorese, product of a culture dependent upon its womenfolk for subsistence, is necessarily deprived of maternal care and is reminiscent of Bowlby's "affectionless character"[33]. Meanwhile Kardiner's hypothesis of differential social aggression has relevance for our

own problems. In Alor

> "the whole system of organized aggression becomes blocked, and the individual has a life-long struggle to contain these impulses .... He thus lives in constant fear that they will spill over and then get completely out of hand. Hence he must avoid all intoxicants which diminish the powers of control .... The only time when overt aggression becomes a form of expression is in the insane".

While there can be no doubt about the great validity of the contribution of this school in concept formation in this difficult area, its uncritical application to contemporary complex societies has been challenged.[34] Linton himself[11] admits that the hypothesis does not hold for societies whose cultures are undergoing rapid change. Nor does he underestimate the influences of heredity in small endogamous groups.+

+ While an adherent of the anti-racist anthropological school, Linton cites differences in the degree of activity between Hopi and neighbouring South-Western United States white children as hereditarily determined.

Kardiner and Linton[36] are, however, able to show how basic personality structure is finally altered in a small culture where a major social change has been consolidated. This happened in Tanala-Betsileo culture with the change from dry to wet rice cultivation, necessitating a shift in the local subsistence economy. Stern competition was introduced into the lives of a previously submissive people, who now became hostile and suspicious towards each other.

What relevance has the theory of basic personality formation for mental illness ? In 'Culture and Mental Disorders' Linton postulates an organic substratum for all psychoses, unhappily based only on Tooth's Gold Coast work[35] since Linton himself was not a psychiatrist. In a more convincing section he shows, however, that no matter what the underlying etiology of hysteria may be its form in a given culture may

be predicted from a knowledge of that culture+.

The danger inherent in such a basic personality system, first pointed out by Linton's disciple, Devereux, is its possible exploitation by racists likely to categorize a "national character" by such terms as "paranoid". Basic personality is not an operational term; it can only be evaluated in the context of the particular culture. Thus if one lived in the Congo one could not be termed paranoid in the Western sense if one took reasonable precautions to assure one's safety. The whole value of the Kardiner-Linton studies lies, in fact, in their exposition of the infinite variety of normal forms of behaviour, according to the culture in which such behaviour is current. Thus the warlike aggression of the Comanche

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+Thus among the Malagasy members of their lowest social order, the childless widows, may end their frustrating treatment at the hands of the community by developing tromba, a form of spirit possession. The community is obliged to supply all the demands of the possessed person during her affliction, and, since it is a form of dancing mania, provide her with relays of drummers and dancing partners whom she rapidly wears out. Naturally, after such an illness, the community will treat a tromba sufferer with care and respect so as not to reinduce the costly illness.

is "normal" for him, though it would be regarded as extreme deviance among the peaceful Zuni or among ourselves.

In fact the whole concept of "normality" has received critical attention[37], and Lewis has pointed out[38] that social norms in themselves are not adequate criteria for defining normality. Redlich has indicated a large borderland where the assessment of mental health is a function of the interaction between patient and psychiatrist[39, 40], while Cohen regards personality maturity not as an absolute concept but as one which is culture-bound. The mature man is not one who has freed himself from the bonds of his culture, but one who has merely moved into another group[41].

Implicit in Kubie's view[42] of universal neurotic potential and neurotic process is a society where no one is "normal", only degrees of abnormality. Kubie (1957) holds that the neurotic illness precipitates out of the neurotic process through the action of subtle trigger-like stimuli which may be culturally determined.

As Sir Geoffrey Vickers has put it[43] "conflict is

endemic; breakdown is still, happily, relatively exceptional .... we need to understand both the noxious nature of a given stress .... and the vulnerability of a given organism to a particular form of stress".

It would appear then that the future of social planning for the prevention of mental ill-health must lie in the analysis of dynamic forces in a particular culture which encourage or retard the crystallization of neurotic illness out of Kubie's inherent neurotic process. This means a detailed study of communities, which was what Lewis called for in the Morrisonian lectures of 1951.[44]

Carstairs (1956) has convincingly shown how high-caste Hindu attitudes to sexuality have produced one form of illness called jiryan, where the complaint is of malaise, wasting and loss of energy such that the Western doctor might have searched for an underlying endogenous depression when he has excluded organic disease. What the sick Hindu is really expressing so symbolically is that his sperms are draining away, and with them his very life-strength; for Hindu sex

fantasies are preoccupied with all-devouring demon-women whose demands are insatiable+.

Carstairs regards the prolonged indulgent breast-feeding practice, with its abrupt weaning, as at fault. This excites in the child the fiercest hostility, which is then projected onto a malevolently transformed mother-figure. Meanwhile the need to deny one's sexuality to one's father overdetermines the illness by inducing great guilt in the sexually mature Hindu male[45].

There are thus societies which are more or less conducive to healthy or unhealthy behaviour and it is essential to be aware of the role of important community institutions such as the family, school and religion, as well as the degree of tolerance shown to different forms of behaviour in any given society.[46]

Lindemann (1960)[47] considers the psycho-social stress of bereavement as an example of the effect of differential cultural practices. Such cessation of

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+ Institutionalized in the form of the goddess Mataji, pictured as slaking her thirst with the gushing blood of a decapitated man.

interaction with an emotionally meaningful person requires a sudden change in one's own role and complete reorganization of one's social programming. The type of family and kinship group to which one belongs may facilitate or impede this role-transition and affect the new adjustments which one has to make.

As a member of society the individual has specific activities to perform in the group of which he is a part. As Simmons and Wolff[48] have indicated, it is important for the person playing a role to live up to the expectations of his peers, so that his efforts are fraught with tension. Each transition of roles - from adolescence to taking up a responsible job, marriage and parenthood, brings extra duties and added stresses. These stresses may be considerably increased in minority groups who are barred from full participation in the dominant culture and yet subject to conflicts arising from both.

Such a group is the subject of the present investigation.

That society provides a means of easing tensions and normalizing behaviour is also clear. Sainsbury's

model study[49] has shown that isolation from the social mainstream may lead to suicide; and Faris that social disorganization is related to increased incidence of mental disorder, particularly schizophrenia:

> "The person who is isolated from primary contacts outside his own family during the years of childhood and youth is too far behind to catch up in his adult years. The direct and frank rebuffs which children give to one another, which enable each to acquire from others a reasonably accurate conception of his own status, are rarely given among adults. The result of years of isolation is a great and socially incapacitating ignorance of how other people think, feel and behave .... . The person who through isolation, has failed to acquire this knowledge .... often fails in many aspects of his social relations. To make his troubles worse he is usually unaware of the reason for his many failures .... .

> "Such a process develops not infrequently among overprotected children and produces one of the typical complexes of the schizophrenic - the paranoid reaction".[50]

The disorganized social system plays a part in producing such marginal and inappropriate personalities and at the same time presents an environment which is utterly unsympathetic and inhospitable to them (Faris, 1956).[51]

In their classic Chicago investigation Faris and Dunham (1939) showed that the highest rates of mental illness are found in "hobohemia" in the centre of the city, often Negro apartment-house areas in the most deteriorated part of the Negro districts.[52] Schizophrenia followed the general distribution rate for mental disorders being highest in the central area, and progressively lessening towards the outlying districts. Rates were high both in the mobile hobo and the rooming-house areas; and in the foreign-born and the Negro districts.

Faris and Dunham were able to counter effectively

some of the criticisms levelled at the interpretation of their findings such as that of Myerson[53], who suggested that schizophrenics "drifted" towards the disorganized areas, rather than that the areas in which they lived were etiological. In their careful New Haven survey Hollingshead and Redlich (1958) support Faris and Dunham. They found that 65 percent of their schizophrenics had been reared in the community where they fell ill. Of the 35 percent who had not, most were concentrated in the upper social classes and so had not "drifted downward".[40]

Hare[54, 55] lends further support in his study of the urban distribution of schizophrenia (1956). He found in 441 cases of schizophrenia that the rates for schizophrenics living out of their family setting were highest in the central districts of Bristol and were significantly correlated with the proportion of single-person households. Among the 64 cases out of family setting, separation from the family was due in one quarter to uncontrollable external circumstances; in one sixth to the patients' own choice; and in one half to personality disorders.

CHAPTER II.

Sociological Aspects

THE FAMILY

The family may be defined as the biological-social unit composed of husband, wife and children.[56] Any individual must be viewed sociologically as having originated from a family of orientation (his parents and siblings), and having founded or potentially founded a family of procreation (spouse and children). Flügel (1931) early applied Freudian interpretations to the family situation; yet even at this early stage he was not unmindful of the influences of the family on the wider social adjustment of the child.[57]

In the constant vital interplay between family members the child's personality takes form; and for a number of years the family remains the agency through which the child contacts his cultural milieu.[58] This

transmission of value-systems may be overtly undertaken by precept and example, sanction and reward; or covertly conveyed by subtle intonations of voice and symbolic gestures.[59] Furthermore these values imparted to a child are consciously and unconsciously selected by the parents as leading towards a meaningful goal which is part of the family pattern and determined by its dominant members.[60]

Orlansky has shown (1949) in his thorough review of studies of parental care that child-rearing practices themselves - breast or bottle feeding, early or late sphincter training - are not so important as the associated parental attitudes.[61] It is these parental attitudes which give the child its notions of its own status and worth[60, 62]; and even determine the composition of the kinship-system in the future.[63]

Maternal rejection, for example, is founded on the mother's own emotional immaturity and has been clearly shown in controlled studies to generate insecurity in the child, showing itself in aggressive, anti-social, as well as over-submissive neurotic symptoms.[64,65] A child growing up in such an atypical household is

exposed to conflicting standards as he compares the way his parents treat him and the way other children's parents treat them, and this may be correlated with increased likelihood to psychiatric illness in later life.[66]

Furthermore, that the effect of the family may outweigh later normative influences has been shown in a follow up study of children with behaviour disorders. O'Neal and Robins (1958) in their 30-year pursual of 150 disturbed children found a high rate of psychiatric disease among them as adults, compared with a matched group of normal controls.[67]

The stable family maintains its integrity and continuity through time and under the pressure of changing life conditions (Ackerman).[68] Conflict may either stimulate growth or disorganize the family-structure.

Spiegel (1957) views the family as a modal system of interacting social roles being exercised in equilibrium. Role conflict is the result of discrepancy in the expectations of any ego and alter and leads to anxiety. Defensive processes come into effect both in the

person and in the family systems. By a process of persuasion ego persuades alter to comply, and equilibrium is restored (role induction). Where the conflict is settled by mutual insight rather than by manipulation the process is termed role modification.

Spiegel regards role modification as more desirable, since role induction does not settle the conflict but internalizes it within the family structure, where it may lead to difficulties in interpersonal relations or actual neurotic symptoms. In comparing the families of disturbed children with normal controls he has found consistent evidence in the former children of being involved in parental conflict. He does not agree with the psychoanalytic view that the child identifies with the unconscious wish of a parent and "acts out" the conflict for the parent. He believes that "something" in the group process itself takes over.[69] Discrepancies in cultural values are associated with incompatible roles (e.g. in mixed marriages). If one partner were to move culturally in the direction of the other, strain would be reduced, but the activity of the dominant partner may prevent such acculturation in the other. When this happens the latter may take revenge

by neurotic behaviour (e.g. seductive relations with an older daughter in the case of the Italian-American family cited).

If family break-down is thus a concomitant of conflict, one might expect high illness rates in divorced persons. Ødegård showed from mental hospital statistics that the incidence of mental disorder is much higher in the single and divorced than the widowed and married, but regarded this as selection by personality rather than due to any protective influence of marriage.[70, 71] Norris (1956) confirmed the much higher first admission rates for single than for married persons, and showed also that they were liable to higher morbidity (longer stay in hospital).[72] She found the rates for widowed and divorced persons in between those for single and married, but closer to the latter in certain age groups. In one or two instances the rate for widowed and divorced persons was paradoxically less than for single and married people.[73]

From a different aspect Gregory (1958) found that size of family had no bearing on predisposition to psychiatric illness, though he cites Malzberg as finding

larger families slightly more prone to manic-depressive psychosis than to schizophrenia. His finding, based on critical analysis of data, chiefly Norton's, is that youngest children in families of four or more are statistically more likely to break-down.[74] This would accord with Myers and Roberts (1959) view that in every neurotic family one child is more exposed than the others and internalizes the family conflicts to a greater degree.[75] Such a child would tend to be the one most subjected to maternal influence, and the youngest falls naturally into such a role.

Surprisingly, however, Gregory could not demonstrate any difference in the rates for only children, though only children were found in excess of expectation in both the 2,500 psychiatric patients and the control group (500 physically-ill patients). Does this suggest that only children are more likely to break down than others, and that whether they do so in the psychic or somatic sphere is determined by factors which we do not as yet understand ? It would have been extremely illuminating to know what percentage of the physically ill controls suffered from psychosomatic disease and disorders of maladaptation, and how much this weighted

Gregory's findings.

A further interesting finding of Gregory's which invites speculation is that of increased maternal age among his psychiatric patients. It is perhaps likely that children from ageing mothers arrive when the family is "finished" and are therefore unwanted. This would communicate itself as maternal rejection (vide supra).[64, 65]

The impact of mental illness on the family was studied by Clausen and Yarrow (1955).[76] Not only does the removal of the sick member threaten, but also the whole family structure has to be revised. Recognition of psychiatric illness by a spouse depends on the accumulation of various kinds of behaviour which are not readily understood or acceptable to her, and may be delayed by her unwillingness to accept the fact. It is as if one has built-in mind-blindness to mental disease in one's own family, and as has been shown[40] this depends on the acceptance of psychiatry by one's own social class. A wife confronted by such deviant behaviour may even stretch the range of normality to include it. Eventually a tolerance threshold is exceeded when the wife comes to the relatively stable

conclusion that the problem is psychiatric, and that she cannot cope alone.

Albert (1960) has further described three stages of breakdown in the relationships and dynamics between the mental patient and his family.[77] In his formulation stage one is uncoupling in which the sick member comes to be viewed as peculiar, less integrated, and unpredictable. During stage two (or dislocation) participants feel helpless and a sense of acute loss. They may react with resignation; may aggressively try to force the ill person to behave "normally"; or may withdraw from the family struggle, e.g. develop psychosomatic complaints themselves. Finally in the last stage of patient-family separation and patient-isolation the last vestiges of trust are withdrawn and the patient reclassified as a problem-centred individual to whom old rights and norms do not apply. Now only is the family ready for the psychotic's removal to hospital.

During treatment the social meaning of his illness becomes clear to the unfortunate patient and his family. In a sense they are now members of a minority

group excluded by the dominant "normal" group. They must face the expected social stigma by attempts to communicate, or accept isolation and retire to the wilderness. The patient's job is endangered, and his wife may regard the marriage as a failure. In fact the greatest concern is expressed by wives attempting to maintain high social status or upwardly mobile in aspiration. In their dealings with others the family becomes hypersensitive and prone to interpret ambiguous social responses as hostility or rejection.

Carstairs et al (1956) have described one aspect of the needed efforts of the doctor to reintegrate the patient into community living[78], but reports such as this are all to few in the literature. In this account of an industrial workshop in which chronic mental patients were paid for their work, it was shown that many long-stay patients are capable of reaching normal levels of productivity at comparatively unskilled tasks.

Brown has shown (1959) that discharged chronic schizophrenic patients were less likely to relapse and maintained higher levels of social adjustment if they returned to the care of siblings and to lodgings;

rather than to parents, wives, or large hostels.[79] One may interpret his findings as showing how very difficult it is for the chronic patient to reintegrate with his family. As has been shown, the family structure is now so altered that the previously-loved individual has become an embarrassment; while on his part the patient is less able to withstand the pressures from his parents or wife which were previously etiological. Gerard and Houston[80] have suggested that the single or divorced schizophrenic's residential instability may be an attempt at protection from disturbing close relationships with his family.

Freeman and Simmons's work (1958) has bearing on Brown's findings. In their study of male functional psychotics remaining in the community[81] they found high level of social and work performance related to conjugal family setting and low level to living with parents. They postulate differential tolerance of family members. Living in a parental setting the psychotic is allowed to regress since other males functioning as breadwinners are more common in such a household, while in a marital setting he is likely to be the only breadwinner. The question of differential tolerance of

deviant behaviour by mothers and wives is also raised.

SOCIAL CLASS

The individual is one with his society as a whole, but subtle differences of outlook are ingrained into him according to the stratum of society in which he has been reared. Ericson[82] in her study of social status and child-rearing practices, found that middle-class mothers were more exacting about feeding-habits, cleanliness, environmental exploration and control, and age- and sex-roles, than were lower-class parents. Middle-class children might have been reared in entirely different worlds from their lower-class peers; were taught ways of living that would prepare them to become financially independent and to assume responsibility in the home and community. Lower-class children, on the other hand, were reared in families in which life was less strictly organized and with fewer demands. Davis and Havighurst (1953) showed not only comparable class but also colour differences in child-rearing practices. Substantially class differences occurred regardless of colour. However

Negroes were found to be more permissive than whites in the feeding and weaning of their children, while on the other hand much more demanding in toilet training[83].

Ericson's conclusion of a less stressful rearing for a lower-class child is open to challenge. Myers and Roberts[75] have more than adequately shown that the lower-class child, while escaping some of the rigours of the middle-class youngster, has more than enough of his own kind of difficulty. While the class III+ boy (whose father is a clerk or small-business operator) strives to live up to his mother's expectations for his "success"; the class V lad (son of an unskilled or semi-skilled labourer) is thrown upon the streets, erratically punished, given little emotional warmth and attention. His parents are both preoccupied with a marginal subsistence economy and in any case he has several more siblings with whom to share what little affection they have time for.

+Refer to footnote page 41.

More class V patients therefore viewed their fathers as stern, distant, punishing persons. They sought substitutes in adolescence with whom they could identify, but authority-figures such as schoolmasters, social workers[84], policemen and ministers of religion were tabooed. Distant, discontinuous, unsatisfying and over-idealized figures - film stars and "rock-'n-roll" crooners - were turned to instead. Elder siblings had to assume the disciplinary duties their mothers were too harassed for, and earned as a result the hostility of their younger sibs. The trend was towards rebellion against authority; and "acting-out" of inner tensions. This violence was encouraged by frayed tempers easily produced by overcrowded squalid living conditions, and anxiety over the satisfaction of basic subsistence needs.

The class lll patient had identification problems of a different sort. In this stratum while nominally father was dominant, in fact mother held the wheel. She scorned the father's inadequacy as compared with the American model of "success"; for husbands in this class were marginal men, neither executives nor workmen.

Mothers made it clear to their sons that material success, such as educational attainment, would be rewarded with affection; failure with rejection. Soon the child had so incorporated his parental standards that his parents were no longer good enough as role-models themselves. Chasing upward mobility this youngster moved on the fringe of the in-group to which he aspired, whose parents were richer and more successful than his own parents. While these children could act spontaneously in social situations, his own reactions were laboured and based on social techniques which he learnt from them as he went along.

Myers and Roberts found that these social presses influenced the lives of patients more than their healthy siblings; and were present more often in schizophrenics than in neurotics.

Meltzer's early study of normal school-children in 1936[85] is thus substantially corroborated. Meltzer found that economic insecurity was closely paralleled by emotional insecurity in the child. But this did not mean that the corollary held true. In this comparative study of rich, middle-class and poor neigh-

bourhoods, the wealthy children were almost as insecure as the poor ones; and Meltzer postulated that middle-class parents were more home-centred than those of higher economic level, "who are looking for the first opportunity to move away and join the richest group living in private streets or in the country".

In this respect conceptions of parenthood have also been compared by Duvall in four social classes and for Negro and white (Jewish and non-Jewish) mothers.[86] She found that mothers at lower-status levels had a more "traditional" ideology than did upper-class mothers, who followed a more "developmental" outlook. Thus the former were more concerned that their children should be physically looked after and taught to keep clean, neat and religious; while the latter were concerned with providing for their children's "mental growth", and inculcating in them ideals of social co-operation and emotional contentment. Negro mothers tended to be more conservative at every level; and Jewish mothers slightly more developmental. Aberle and Naegele[87] in an investigation of middle-class fathers' attitudes discovered that they stressed in their sons' behaviour qualities

of initiative and aggressiveness which would equip them for positions in the middle-class occupational structure+.

INCIDENCE

Future citizens of the same society are thus differentially adapted for differing roles and like sleek passenger coaches and goods-carrying trucks shunted along different rails which seldom cross. Does the track on which one journeys through life carry with it a varying risk of mental disorder ?

Jaffe and Shanas[88] in 1939 showed that in fact it did, and that white males in 'rich' areas of Chicago had a 1 in 21 chance of insanity while the probability in a 'poor' area was 1 in 18++. Tietze,

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+Interestingly enough, the last authors found that middle-class fathers tended to reject academic careers for their sons. Only one father accepted such a possibility, and he said it would be fine for his son who was "shy, irresponsible, bookish and needed a woman to look after him". Clearly it was not simply a matter of meagre financial rewards, but that the academic role did not exemplify appropriate masculine behaviour.

++But Ludwig Stern had already published a pioneer study, not available to this author: Stern, L., "Kulturkreis und Form der geistigen Erkrankung", Carl Marhold, Halle, 1913.

Lemkau and Cooper found two years later[89] a "higher concentration of schizothymes in the 'lower' socio-economic groups, and a higher concentration of cyclothymes in the 'upper' groups". Fuson confirmed this soon after[90]; and in 1944 Hyde and Kingsley showed in a study of army rejectees that the incidence of psychosis increased from 7.3 per cent in the 'best' to 16.6 per cent in the 'poorest' communities. Psychoneurosis was however, found to be evenly distributed, and alcoholism relatively as common in the 'better half'[91]. Clark in two studies[92, 93] shortly reported similar findings and argued that the pre-psychotic was handicapped by his personality traits in the competition for better jobs.

A lapse of a few years was followed by renewed interest mainly from a Yale team of psychiatrists and sociologists led by Hollingshead and the late Dr. F.C. Redlich, their papers on differential incidence[94-98] finally appearing in book form in 1958[40] and 1959[75]. Their contribution has tremendous value and is based on a 5 per cent sample census of the New Haven community covering 3,559 households, and compared with a psych-

iatric census of 1,963 treated cases of psychiatric illness.

An index of social position utilizing ecological areas of residence, occupation and education was constructed by Hollingshead and patients and community classified accordingly into five social classes+. Fifty of the patients were subsequently selected on methodological grounds for fuller study of their family psychodynamics.[75]

The authors found that not only did incidence and prevalence of treated disease vary strikingly between the classes but also attitude to treatment,

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+According to this analysis the classes are constituted as follows:

Class I: Wealthy families whose heads are highly educated important executives or major professionals.

Class II: Families of lesser professionals and "second-line" executives, also college graduates.

Class III: Shopkeepers, white-collar workers or skilled factory employees with high school education.

Class IV: Semi-skilled factory workers with incomplete school education.

Class V: Unskilled hands, labourers, with elementary-level education.

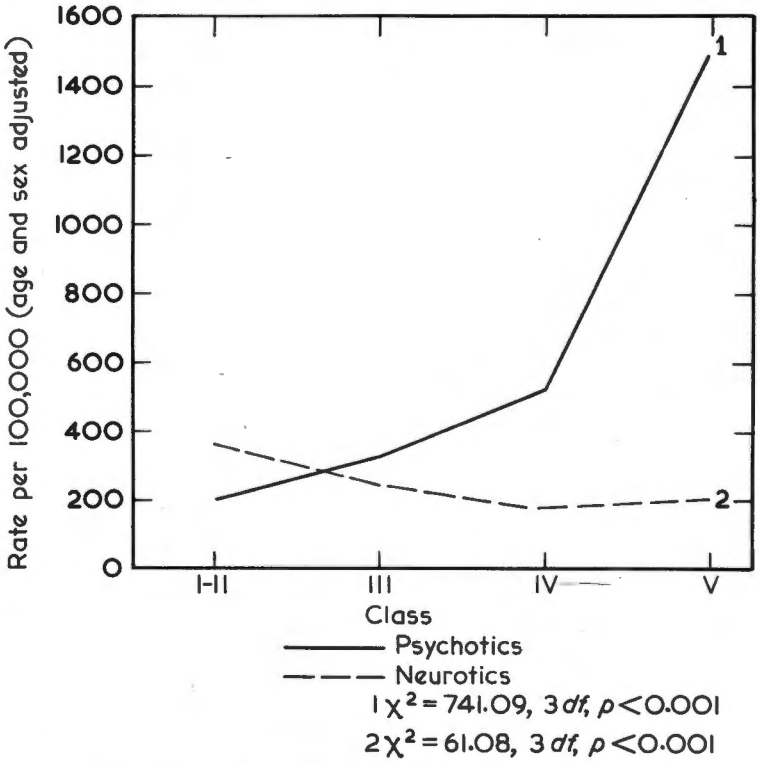

Figure 1. Prevalence of Neurotic and Psychotic Disorders per 100,000 Adjusted for Age and Sex—by Class.

available facilities and even response of the psychiatrist. Insofar as incidence was concerned neurotic illness was commoner in Class 1 and 11 (65%) than in Class V (10%). The reverse held for the psychoses (Fig.1). The authors attributed these sharp differences to variable use of the available psychiatric facilities. For the Class V individual mental disorder was equivalent to spending one's life in the "bughouse", a sentiment only too true. He would visit a psychiatric agency only when forced to, and only under duress of a severe illness. The upper-class individual was, however, more sophisticated and would seek help for a milder illness more readily.

When the authors came to differentiate neurotic disorders they discovered that the "character neuroses" clustered in Class 1-11, and the anti-socials+ and

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+There is however no lack of delinquents from "good" families as Herskovitz et al. show in a recent article.[99] These youths showed "inordinate disdain for authority, with a prominent sadistic element", impulsively stole motor-cars, committed serious traffic offences, and acts of robbery. A history of chronic lying, stealing and defiance was present in 79 per cent. 27 per cent of the group were adopted children and a high proportion (44%) came from broken homes, while in the others lax overprotective mothers figured prominently.

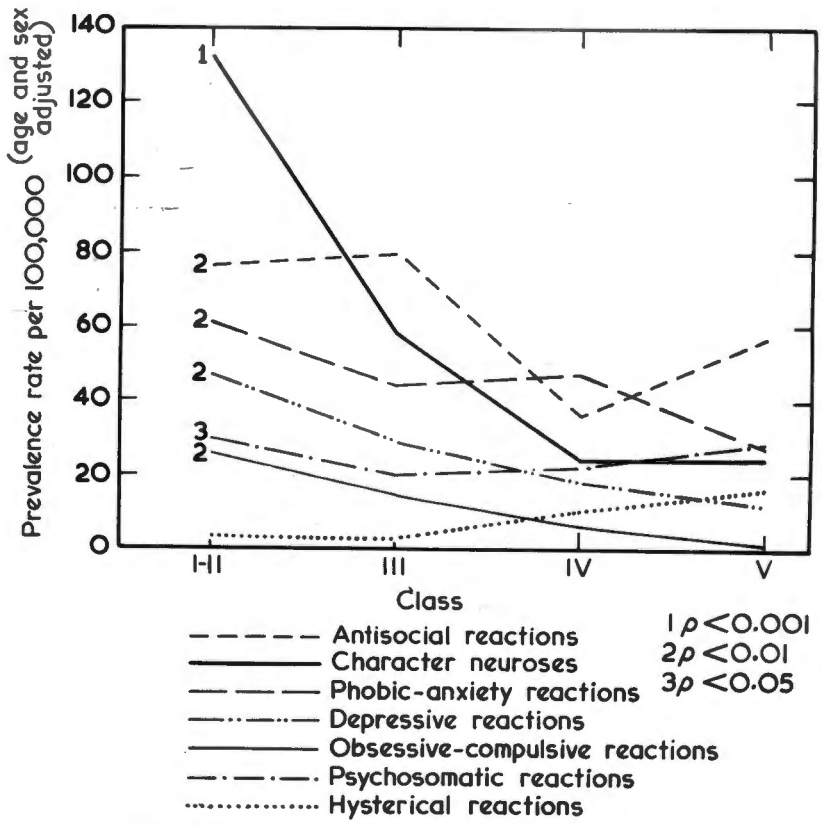

Figure 2. Class Status and Types of Neuroses.

hysterics in the lower classes (Fig. 2). Similar analysis of psychotic disorders showed that schizophrenia, as expected, was the most common psychosis at all levels, followed by the affective psychoses (Table 1).

TABLE 1[40]

Class Status and the Rate of Different Types of Psychoses per 100,000 of Population (Age and Sex Adjusted)

Type of Disorder	Class I-II	III	IV	V
Affective psychoses	40	41	68	105
Psychoses due to alcoholism and drug addiction	15	29	32	116
Organic psychoses	9	24	46	254
Schizophrenic psychoses	111	168	300	895
Senile psychoses	21	32	60	175
n =	53	142	585	672

Organic disorders showed the greatest increase from the high to the lower classes (1:28); affective disorders the least class variation. Alcoholic, schizophrenic and senile psychoses rates were in between, and the curves for these disorders are almost straight (Fig. 3).

Relevant to these striking findings are Malzberg's statistics (1959), showing low incidence of general paresis in 'comfortable' patients (11.1%), greatly increased in marginal patients (63.6%) but again falling to 22.4 per cent in the 'dependent' group.[100] He found that the incidence of all mental disease and general paresis in particular was inversely related to educational and socio-economic levels[101, 102]. General paresis was widely prevalent among Negroes.[103]

Hollingshead and Redlich regard neuroses thus as class-typed. Class V neurotics come forward only when hailed before a psychiatrist by a legal agency because of acting-out behaviour. As Myers and Roberts indicated, the dominant trend in their subculture is towards rebellion against authority. The Class 1-11 neurotic

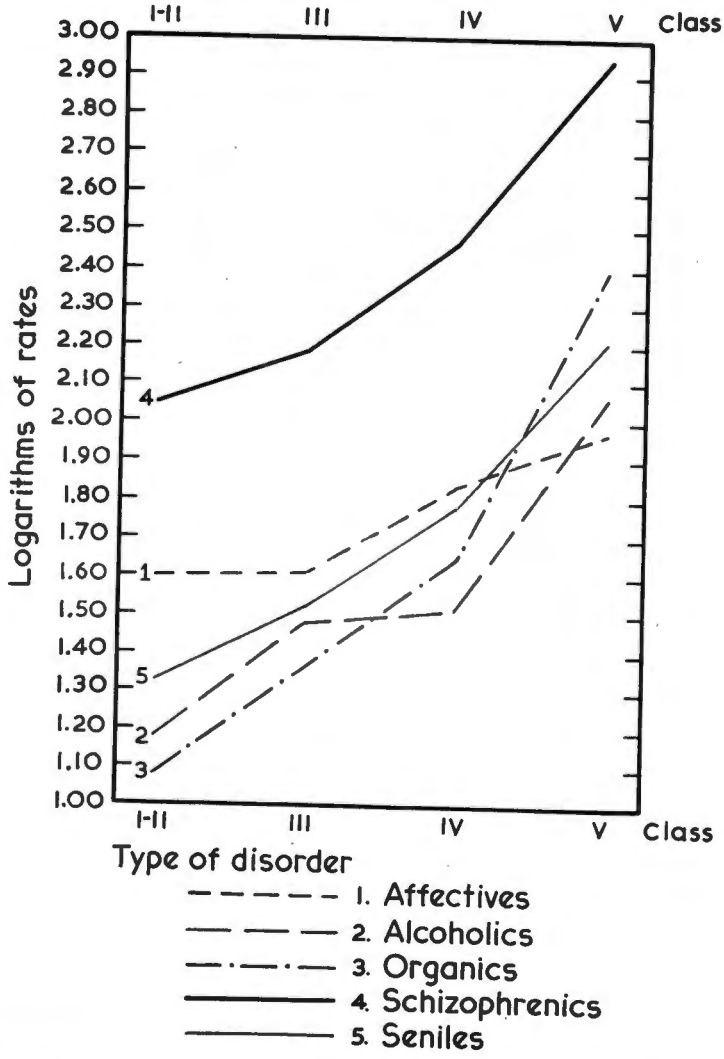

Figure 3. Class Status and the Prevalence of Psychoses.

comes forward voluntarily in response to self-perceived internal anxiety. Thus it may be generalized that the Class V neurotic behaves badly, the Class 1V aches physically, the Class 111 patient defends anxiously, and the Class 1-11 person is dissatisfied with himself and wants to change. As regards psychoses it is clear that lower-class living stimulates the development of psychotic disorders.

Rennie and Srole in a study covering a sample population of 1,900 people found that while all other psychological dimensions were highly correlated with socio-economic status, tension and anxiety was not so related, but was a frequent and generalized phenomenon.[104] Clearly therefore we are not dealing with different depths of feeling and different degrees of human suffering; but only varying modes of expression. Leighton (1955), outlining the theoretical framework of the "Stirling County" study, postulated that status differences in the appearance of mental illness are due to different patterns of interference with striving.

All human beings exist in a state of striving+ and interference with this may lead to disturbance of psychical balance. The individual adopts patterns of response which bring temporary relief, but are self-destructive in the long run to himself and his society. Socio-cultural situations may interfere with the striving patterns at various levels, for instance blocking expression of hostility or love, and preventing sexual satisfaction. Of great relevance to the society under present investigation are those mechanisms which interfere with the orientation of the individual in regard to his place in society; his membership of a human group, and his sense of belonging to a moral order. Leighton further hypothesizes that socio-cultural situations which interfere with the opportunity to interact with a fairly large number of different kinds of other people limit personality development and hence foster psychiatric disorder.[105]

+ Leighton's hypothesis is in agreement with Erikson[27, 28] who postulates that when the individual reaches maturity he ceases to struggle and turns to inner stock-taking. If he is dissatisfied with his life as he has made it he may fall into a melancholia.

Further corroboration of the New Haven findings came from a comparison of Wellesley, an upper-class suburb of Boston, with Whittier Street, Roxbury, a lower and lower-middle-class neighbourhood.[106] Kaplan, Reed and Richardson found incidence rates for hospitalized psychosis significantly higher in the lower-status area than in the upper-level community, but interpreted their findings differently. They suggested that families in the higher strata resisted hospitalization, while those in the lower socio-economic group submitted. These authors do not, however, consider the other factors which apply, including that of private treatment being within the means of a Wellesley resident, while completely beyond the reach of the Whittier Street inhabitant.

Meanwhile in England Hare (1956) was publishing a study of 1,264 male mental hospital patients.[107] In a five-year period he found schizophrenia concentrated in classes 1V and V, while the total incidence of mental illness also showed a social gradient with an excess in the lower classes. Among neurotics there was a deficiency in classes 1-11 but an excess in class 111, but this last result surely reflects

hospitalization versus private treatment rate, rather than true incidence. In Birmingham Lowe and Garratt (1959) carried out a study similar to the Faris and Dunham study. For all psychoses (except affective) rates were highest in the central area correlating with adverse housing conditions. This gradient was much less marked for psychoneuroses and affective psychoses where rates were more equal between central and better-class peripheral areas.[108]

On the other hand Linn (1960) reports in 582 functional psychotics no differences between the types of symptoms shown by patients of differing social background as measured by education, occupation, marital status and religion.[109] This need not surprise one for such conditions, which have etiological organic substrata, but similar studies with neuroses would be most worthwhile.

TREATMENT

Hollingshead and Redlich were concerned with treated prevalence, and therefore not only with the acceptance of psychiatry by the patient but also the acceptance of the patient by the psychiatrist. In

the therapeutic interaction they showed that whether a patient-doctor relationship took root depended on mutual unconscious social prejudices. Chess, Clark and Thomas had already pointed this out from experience at a multi-racial child guidance centre in 1953.[110] These workers showed that significant cultural differences between patient and therapist made appreciable errors of diagnosis and evaluation of therapy likely. Moreover the psychiatrist's own job satisfactions are dependent on his estimation of his status in the professional hierarchy.[111]

Schaffer and Myers showed that in a nominal or non-paying out-patient clinic, allocation for therapy after the initial interview largely followed the social class of the patient.[112] There were no patients in class 1. More than 64% of class II and 55% of class III patients were accepted for individual psychotherapy with senior staff members; but more than 66% of class IV and 97% of class V patients were rejected. These were then passed on to medical students, social workers, and psychology students for treatment. The medical students had no say in patient-selection. It would have been interesting to

speculate on the ultimate fate of their lower-class patients if they had. MacIver and Redlich[113, 114] bring similar evidence to indicate that psychiatrists, while mainly members of social class 1 (95 per cent), fall into two distinct categories. A highly upward-mobile culturally uprooted group is analytically orientated; while those born to their social position are more conservative and directive-organic minded. Intensive analytic psychotherapy is almost absent in the lower classes, and stay in treatment of shorter duration.[40] (But this does not appear to apply to English mental hospitals, for Carstairs et al. have shown in a census that social class was not correlated with length of stay in hospital).[115]

The lower-class individual is thus more likely to have physical treatment if he consults a psychiatrist. This represents a failure of communication between persons of two different classes - the psychiatrist and his patient.[114] In a recent Hillside Hospital study it was found that those patients referred for convulsive therapy were older, more likely to have been foreign-born, and less educated. They

showed higher scores on the Californian F Scale (indicating "stereotyped thinking")[116] In assessing fitness for psychotherapy the psychiatrist judges the capacity of the patient to verbalize his feelings, and terms this "insight potential", but the present writer takes the position that such language barriers necessitate a "coming down" on the part of the psychiatrist. Instead of expecting the patient to acquire his concepts and terminology he should translate them for the patient into his own kind of symbolism.

Selection for psychotherapy is, however, by no means unilateral. Redlich, Hollingshead and Bellis showed in comparing class lll and V patients that both tended to regard their difficulties as somatic, but the class V's were less likely to correct their biases during treatment.[117] Brill and Storrow (1960) similarly correlated "psychological mindedness" with upper-class levels.[118] The former study, however, also showed that therapists were more likely actively to "dislike"their class V patients. They admitted that they did not understand their values, or understand them as people. Many therapists also became discouraged in treating class V patients, especially

when extremely difficult reality situations were added to their other difficulties.

OUTCOME OF TREATMENT

Hollingshead and Redlich[40] postulated that higher-class patients received more active treatment than their lower-class counterparts. Ninety-four per cent of class 1-11 neurotics received interviews lasting the 50-minute hour each but less than half this number of class V patients in psychotherapy did. The lower-class patients were thus "short-timed". In the case of psychotics the position was even more striking. Upper-class schizophrenics might be discharged and re-enter institutions several times. But a class V schizophrenic could expect, if he once returned to hospital after discharge, to remain there forever. Hardt and Feinhandler (1959) supported this finding.[119] The percentage of continuous long-term patients in their study increased consistently from a low 23.6% in class 1 to a high level of 63.6% in their class V1. Freeman and Simmons[120], also, found high post-hospital performance levels (as measured by steady employment and social participation)

correlated with higher-class membership.

These startling indictments are however tempered when one considers other studies such as the London Metropolitan hospital investigation mentioned[115], and even more recent work suggestive that variables other than social class and doctor-patient selection must be considered.

Brown[79] found that the type of living-group one returned to was significant i.e. sibling, marital or parental. Mason et al. (1960) confirmed the relationship of class to length of stay, but when the variables marital status and diagnosis were held constant, this class-linkage disappeared.[121]

Brody and Fishman (1960) from a veterans' hospital report on hospital-dependency and resistance to discharge, such that a veteran may call on his Congressman to support his right to stay in hospital at discharge-time. These authors suggest that patients, irrespective of social-status, may not wish to conform to the doctors' expectations of a two-person treatment relationship and may isolate themselves from the treatment milieu, yet making every attempt to stay

within the hospital.[122]

Tolerance of deviant behaviour is greater in lower than in upper strata, and such patients may therefore arrive later and "sicker" and need more urgent treatment (hence electro-convulsive therapy) than those from upper-class families.[120] Previous levels of adjustment must also be considered, the expectation being that patients of all classes who are better adjusted to work and social relationships before falling ill, will do better.

In their critical review of Hollingshead and Redlich's work Miller and Mishler[123] point out that one of the main conclusions is that the "best" treatments are restricted to the "highest" social group. This is value judgement, say the reviewers, while substantially agreeing with the findings of this model study.

MIGRATION AND MOBILITY

Adler viewed man as having innate feelings of inferiority, which generated in him a deep need to lift himself up. But such needs for upward social

mobility are fraught with danger to the psyche. For when an individual moves from one culture to another the meaning of symbols has to be relearned, behaviour has to be readjusted to the new value-system and old customs and beliefs relinquished. Such transition or acculturation nullifies all the living-techniques the individual has painfully acquired during socialization in his old environment. He lacks appropriate spontaneous responses to meet daily social emergencies, and lives on the fringe of the culture to which he aspires.

Jurgens Ruesch in 1948 described a device for measuring acculturation based upon the concept of culture-distance from the American core-culture. Behaviour patterns are rated in terms of orientation, present status and extent and speed of acculturation, and individuals could be classified on a continuum of core, similar, different, and remoteness. He noted that more than half of the population of the United States was in the process of culture change.[124]

Bossard and Sanger noted next year that scant attention had been given to the implications for the

children of parental needs for mobility. They described the case of a girl, Cynthia[125], who had sudden changes in living scale thrust upon her when her parents moved from a one-room apartment to a fourteen-room mansion and estate. Marked behavioural changes occurred in the little girl, particularly insecurity and fears of losing her mother. Ellis compared mobile with non-mobile women and found that a significantly larger proportion of upward-mobile women had experienced parental rejection in childhood and subsequently by their peer-community. Ellis proposed that the "rags to riches" success story resulted from deep neurotic motives to compensate for disappointing primal group experiences. She discovered, too, that her mobile women suffered from a significantly greater incidence of psychosomatic ailments.[126] Here was suggestive evidence that an individual's movement in the social structure carried a load of psychiatric difficulties, and this was shortly confirmed in a study where patient-groups (neurotics and schizophrenics) were found to be more mobile than "normal" controls.[127] However Lystad reported that schizophrenics as compared with "normal" out-patients were not "status achievers"

or "geographic achievers".[128] But her patients were chronic schizophrenics obtained from a state mental hospital.

Her findings were challenged by Myers and Roberts[75] whose younger, widely-drawn patient population were extremely mobile educationally but broke down before they could consolidate their gains. As has been discussed, these authors view mobile patients as having incorporated the status-needs of their mothers, failing because of their necessarily precarious fringe existence. The same authors found senile and affective illnesses higher in their foreign- than in their native-born subjects, but no excess of psychoneuroses[129]. This agrees with Malzberg's finding that migration from overseas was no longer associated with increased rate of break-down. Migration from other states of the United States into New York was, however, accompanied by a marked excess of hospitalization.[130] Another startling paradox was the finding that immigrant non-whites showed lower rates than did native-born non-whites, which suggested that the Jamaican Negro might be better educated than his U.S. counterpart, or that his struggles for equality had been less bitter,

or that the result was an artefact reflecting immigrant-screening efficiency.

Stainbrook goes as far as to suggest that people who migrate may do so as an attempted adaptation to painful stress, uneasiness and inadequacy. If not already ill at the time of emigration they are likely to be especially vulnerable. Among those who suffer an "acute alien paranoid reaction" during their first year in a new culture are a significant percentage who have had previous psychotic breaks in their native countries.[131] Certainly attempts at "geographic cure" are well-known to those who deal with alcoholic patients.

A syndrome of "psychosomatic disadaptation" has been described by Seguin[132] and Fried[133] in young Indians or <u>mestizos</u> (of mixed blood extraction) who have abandoned small agricultural villages to come to Lima. Similar localized examples abound and will be dealt with in a later section.

Meanwhile Barrabee and Von Mering have described varying ethnic attitudes to mobility. Italian and Irish parents do not encourage their sons to risk the

benefits of a regular income from a steady job for the hazards of a promising but uncertain position. They are satisfied if their boys "get by" at school. The parents of Jewish and Yankee boys have great contrary expectations for their children. Thus the latter undergo stressful parent-son relationships if unable to live up to familial high expectations; while The Italian-Irish group experienee corollary stress when they forsake parental values and attempt to get a better education or job.[134]

In the face of so much gloomy evidence it is reassuring to read Litwak's view (1960) that occupational mobility has not (as Talcott Parsons suggeets elsewhere) led to break-up of the extended family (family anomie) in contemporary society.[135]

STUDY OF A CLOSED COMMUNITY

Thus it would appear on superficial surveillanoe that complex modern living is stressful to the individual and detrimental to his mental health. Yet the famous study of Goldhamer and Marshall showed, firstly, that there has been no overall increase in the frequ-

ency of psychoses during the past one hundred years; and, secondly, that any increased risk in being "stricken by a serious mental illness of either episodic or continuing nature" is related to longer survival rates. Such chance is 1 in 20 by the age of forty-five years; rising to 1 in 15 at sixty-five years.[136] Kramer and Pollack (1958) further established that at the end of 1956 the resident population of the mental hospitals of the United States was lower than should have been expected on the basis of trends during the period 1945-1955.[137] But these authors could not control for the effects of the impact of tranquillizing drugs. Hyde and Kingsley (1944) showed that for army-selectees rejected for psychoneuroses the rates were higher in the semi-rural areas than in a large city, and inculpated the monotony and isolation of such an existence.[138] Hare opined that social communication was essential for mental balance, in his review of the effect of ecology (1952)[139], and the studies of Hebb provide evidence in support of this belief.[140]

Lewis[3] analyses the extreme difficulty of investigating the problem and points to the study of the Hutterite community. This Anabaptist sect lives, on

the surface, an ideal communal life in separationist enclaves in certain provinces of North America. By no means backward, they make use of mechanical advances and agricultural-experimental data and their children attend ordinary-type schools. But "the world" is separated from "our Gemein" by the principle of communal ownership and control of all property; so that the patriarchal government, led by the Wirt or (boss+) buys all clothing, doles out pocket money, and settles all intimate personal problems. Competition and individual striving are discour ged in terms of the slogan, "Do the best you can". "These people (thus) live a simple, rural life, have a harmonious social order, and provide every member with a high level of economic security from the womb to the tomb". Moreover, since intermarriage is regarded as sinful, all of the 8,542 members of the 98 colonies are derived from the original 101 couples. They are peace-lovers, who shut out the dissensions of the outer world by

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+In South Africa white heads of Coloured mission settlements, such as the Moravian Goedverwacht, are referred to as "Die Baas".

outlawing radio, television and the cinema, though they do read daily newspapers.

Eaton and Weil (1955) who investigated this ethnic group[141, 142], were impressed throughout their field work with a prevailing overt atmosphere of relaxation. But when it came to counting figures, far from the expected immunity 199 persons in the year 1951 (one in 43) had either active or recovered forms of mental illness. Of these, 48 were cases of functional psychosis.

At first analysis it would thus appear that a stable cohesive society does not protect its members from mental breakdown, and the Hutterites provide no blueprints for preventive psychiatry. The increased incidence of manic-depressive psychosis and the inversely low rate of schizophrenia among them would appear to support a genetic or constitutional determination rather than a cultural-causal hypothesis.

As Lewis has indicated, striking differences between the incidence among the Hutterite populations intensively studied (13.8 per 1,000), less intensively (7.2 per 1,000) and those only superficially studied (2.7 per 1,000) are unlikely to reflect any real diff-

erence in the incidence of neuroses among them. These are in fact artefacts related to methodology. It would also appear that in offering themselves as an ideal social laboratory to culture-psychiatrists the Hutterites are misleading, in that their endogamy is experimentally vitiating. In spite of this much can be drawn from Eaton and Weil's very careful work. The virtual absence of anti-social and acting-out disorders, of alcoholism and drug addiction are patently cultural. Psychological tests showed that the Hutterites experience the usual aggressive emotions, but that these are repressed in their everyday contacts. Even amoral behaviour disorder was rare, and since 1875 only 5 Hutterite marriages have failed. Hutterite religion is plainly puritanical, "narrow" and ascetic, but non-punitive. It may be argued that anti-social behaviour is thus repressed, and that the absence of punitive attitudes in the environment causes it to stay repressed. There is no pleasure in displaying aggression in an environment where such behaviour will meet with emotional warmth and sympathy. Instead aggressive attitudes are inwardly projected leading to accusations of self-blame, unworthiness and

all the manifestations of a depressive illness.

Comparing the frequency of psychosis in Hutterites with nine similar semi-rural populations, Eaton and Weil rank them third, preceded by an arctic Norwegian village and a north Swedish area. However the available figures for these other regions are based on hospital records - apparent rather than real. Furthermore the effect of genetics is an unknown variable. The authors ask: "Could the true frequency of psychoses among the Hutterites be almost a third more frequent than among the dwellers in the Baltimore Eastern Health District, most of which is a slum area, with all the evidence of social disorganization commonly found in such an urban section ?" They would rather accept the view that the relatively high rank of the Hutterite expectancy ratio is a reflection of thorough investigation on their part, and so it would seem.

Whatever the conclusion we must still await a study such as that of Eaton and Weil applying their exacting methods to a community culturally closed, with known cultural and social variables, yet not too gene-

tically inbred. The alternative is to be able to compute the expectancy by heredity of say, manic-depressive psychosis in the Hutterites, and then to be able to say whether they suffer from an excess or not.

Meanwhile much may be learnt from the comparative study of relatively open communities such as those reviewed in the next chapter, and towards which this investigation is a contributory attempt. It would also be fruitful to relate such social-psychological studies as those of Spinley[143] and the Bethnal Green-Greenleigh investigation[144] to the incidence of different mental disorders.

CHAPTER III.

Transcultural Studies

Alarmed by the expanding psychiatric territory now being included in the term social psychiatry - "so wide that no single person can encompass it" - Wittkower and Fried (1959) decided to detach cultural psychiatry as a separate entity.[5] "As such.... the term denotes a field of research which explores the frequency, etiology, and nosology of mental illness .... within the confines of a cultural unit". Berne meanwhile quarrels with current conceptions of cultural psychiatry as a "romantic movement"; but coins his own term, comparative psychiatry, to cover the same field.[145] Whatever the semantics it would seem that a holistic view of any psychiatric illness must always include its cultural and social backgrounds, and separation of the two is as perilous as lifting a play out of its period and setting, or painting without perspective. For descriptive purposes, however,

it is legitimate to deal separately with anthropological or transcultural[5] aspects of the problem.

In their review, Wittkower and Fried discuss fundamental questions occupying the psychiatrist interested in this area. They appear to accept that in addition to marked differences in the incidence of mental illnesses in different communities, there are certain specific illnesses which occur locally and are not universal.

Windigo, for instance[146, 147], occurs among the Cree, Ojibwa and Salteaux, proud but suspicious Indian tribes who live precarious caribou-hunting existences. A hunter may in winter, when faced with starvation, fall into a melancholic stupor from which he emerges deluded that his family are "luscious beavers .... heavy with fat". One by one the melancholy hunter kills off his helpless family and avidly consumes them. The medical treatment practised by the community is to hunt the patient down, kill him, and in so doing destroy the cruel Windigo ice-spirit which is said to possess him. Latah and its variants (arctic hysteria among the Eskimos, Imu among the Ainus) is prevalent

among middle-aged Malay women who, as the result of an acute emotional experience, develop trance-like states of automatic obedience, echolalia and echopraxia. Yap relates this illness definitely to the "jumping" which occurs among the "Holy Roller" Methodist sect under extreme religious fervour.[148]

Carstairs, however, would not accept that psychotic illness varies in form, but only in content. In his view the gait, posture and expressive movements of a catatonic or manic patient are universal.[2] Berne would agree with this contention, and regards cultural differences as variants only of "dialects of a common language".[145] The amok phenomenon illustrates this view, for in his acute homicidal outburst the mad Malay conjures up for the western doctor familiar patterns of catatonic excitement, post-ictal confusion, or hysterical fugue. The Maori, stricken down by thanatomania and slowly pining away after transgressing tribal custom, would in a western hospital be treated as a manic-depressive psychosis and receive life-saving convulsive therapy. Many cases of amok in any event, if they survive their acute outbreak, settle into recognizable forms of chronic mental ..

illness.[149]

That underlying neurotic preoccupations are universal is shewn in Koro or Su Yang[150], where the hapless Cantonese is seized with the sudden conviction that his penis is shrinking into his abdomen, so that in panic his family rush to clamp the organ into a wooden case or tie it with a red string. The analytically-minded psychiatrist would never hesitate here to diagnose acute castration anxiety presenting in a literal form.

But apart from such localized examples the major psychiatric illnesses do not differ radically in form throughout the world, but only in incidence. Much valuable data has been collected by the University of McGill since May 1956, through the medium of their "Review and Newsletter". As a result we know that suicide rates are high in Denmark, Japan, Switzerland and among white South Africans; but low in Ireland, and among African Negroes and South African Bantu. Schizophrenia is uncommonly frequent in Thailand (72 per cent of all hospital patients) but in Russia relatively uncommon (28 per cent), while in India lay folk

regard the catatonic form as a divine act of grace.[151] Alcoholism is rare on Formosa but common in South Africa and in Peru, where it accounts for 60 per cent of all arrests and one third of all committed crimes.

Meanwhile an attempt to explain the high Danish suicide rate (highest in the world) appears in the "Review" for July 1959.[152] Marayuma compares Danes, Swedes and Americans and finds the Scandinavians introspective, subjective and comparatively isolated from the Western mainstream. Americans are more "other-directed" and therefore less disposed to depression.

Similar international studies intersperse the literature. Comparing out-patient clinic practice in Bombay, India, and Topeka, Kansas, Gaitonde found a high incidence of conversion hysteria in Bombay, where the culture encourages massive repression; in Kansas anxiety and depressive reactions were commoner owing to reality difficulties such as finding satisfactory jobs.[153] Brown compares juvenile delinquency in the Netherlands and in England.[154]

Hitson and Funkenstein report on family patterns and paranoid personality structure in Boston and Burma

(1960). They view aggression as being inwardly directed in depressive illness; outwardly projected in paranoid reactions. In Burma projective cultural trends are seen in general fears of aggressive assaults, robbery and fears of evil spirits. Aggression is thus externally projected - so that the Burmese homicide rate ranks high in the world, and large numbers of paranoids fill the only mental hospital in Burma, but depression is rare. In Boston two types of family pattern are encountered - firstly, where the child is made to feel responsible for his own behaviour; and secondly, where only acquiescence to authority is required. The former leads to introjective thinking with development of depressive personality; the latter leads, as in Burma, to paranoid personality formation.[155]

Yap (1960) has shown that spirit-possession syndrome is not confined to outlandish cultures. In a comparison of findings among French Roman Catholic patients and 66 cases presenting at Hong Kong Mental Hospital, he finds no differences between mediumistic phenomena in the two cultures. The Chinese patients, however, mostly female, suffered from "pseudo-psychotic

hysteria" brought on by real environmental difficulties; while the French cases, mostly male, experienced more highly structured psychoneuroses based on sexual conflicts. Yap tentatively speculates that the difference lies in the belief or absence of belief in possession by a primal satanic figure, the source of all evil.[156]

AFRICA

Africa affords a rich source of cultural material to the psychiatric observer; and Africa in transition the opportunity of studying the effects of the winds of social change. Carothers's survey[157] is commonly quoted, but his views are highly controversial. Opler[4] warns that while his work is recommended "for accurate summarization and intelligent sifting of data .... inept statements of the African mind .... as reflected in the title" detract from its merits.

In "The African Mind in Health and Disease" (1953), Carothers surveys data from 191 sources but makes massive generalizations such as: "There is in all African mentation a high degree of unresolved ambivalence ....".

He makes dangerous neuropsychiatric connections such as "all the peculiarities of African psychiatry can be envisaged in terms of frontal (lobe) idleness".[157] In an earlier report[158] he speaks of "African unreliability", saying "it is a matter of common knowledge to employers of Africans in Kenya that the latter frequently 'let one down' in a variety of ways". Such poorly substantiated generalizations have earned Carothers vehement criticism from such sources as Henry[159] and Simons,[160] who claim that he is racially prejudiced and that his heavy reliance on Vint's physical anthropological work is insecurely grounded. Carothers's description of "frenzied anxiety" resulting in homicide[161] tallies with the earlier description by Shelley and Watson of Nyasaland natives who kill while temporarily insane[162], but both reports seem to have ignored the obvious clinical resemblance to amok.[163] On the other hand no less an authority than Margaret Mead[164, 165] defends Carothers's work as a pioneering ethnopsychiatric study, while pointing out its deficiencies. For oneself one must agree with Opler that Carothers provides a comprehensive literary review and that his own clinical observations are valid,

but his reliance on the diagnoses of tribal chiefs and his sweeping statements unfortunately vitiate many of his conclusions.

The work of Tooth[36] and Field[166] in Ghana, based on their own field studies, appear more reliable. Smartt's paper, speculative like Carothers', also speaks of "the apparent similarity of the African personality to the European psychopath"[167] but Smartt takes good account of different cultural standards in judging behaviour. The widespread nature of Kwashiorkor, a syndrome of malignant malnutrition producing peevishness and mental apathy has been pointed out by Brock and Autret (1952).[168]

More recently Prince (1960) has written of a "brain-fag syndrome" in Nigerian students related to the imposition of European learning techniques upon the Nigerian personality[169]; and of the use of rauwolfia in psychoses by Nigerian witch-doctors.[170] Lambo, as the only African psychiatrist on the continent, has written authoritatively.[171-175] In his view the Nigerian child is reared in "Utopian simplicity" in a permissive culture, but his adult milieu provokes

widespread feelings of anxiety, insecurity, helplessness and resentment. As the Westernized Yoruban approximates the socio-cultural environment of the European he shows the same picture of paranoid schizophrenia; which in the rural Yoruban is adulterated by transient hysterical-confusional symptomatology. Excito-motor syndromes are prevalent in primitive religious groups and do not conform to Western nosological systems. Lambo explodes the notion that endogamous depression is rare among Africans, finding it frequently misdiagnosed; and suicide is relatively common in urban African women, contrary to previous belief.

Farther south Vyncke reports high morbidity rates for Congolese adopting European culture and abandoning their ancestral customs. This is not shared by Barundi and Banyarwanda undergoing the same social changes.[176] Gelfand refers briefly in his book on Mashona medicine to the treatment of insanity by herbalistic means.[177]

Photograph 2: Reproduction of the Izangoma frontispiece of Kohler's book.

SOUTH AFRICA

In spite of the potentialities for research into a multi-racial population at different levels of development thrown together by rapid industrialization, yet separated by rigid statute[178], the psychiatric literature is sparse. Sources of incidence figures are chiefly the mental hospitals, by their nature highly selective; while anthropological studies and descriptions of psychologists afford the only clinical descriptions of non-certifiable conditions.

In his recent review of personality studies of Africans[179], Biesheuvel (1959) emphasizes the cultural diversity of traditional societies. Among the Pedi of Sekukuniland the status of women is low, and boys are educated towards development of aggressive virtues, producing young men who are tough on the surface but basically insecure and affectionless. By contrast the Lovedu of the Northern Drakensberg are peace-loving respecters of women+ and of the dignity

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+So that women may act as kraal heads, own cattle, and even "marry wives" whose children, obtained through a man whose special function it is, will call them "father".

of man. Their personalities are deeper and warmer, and they are basically more secure.

For the urban location masses however, such traditional guidance of personality formation no longer exists. Family and kinship structure, in Western society to be relied upon for imposing conformity, are weakened and disorganized in the location. This means that internalized controls emanating from parental influences are attenuated, and the majority (not including the middle-class) are neither tradition-directed nor inner-directed, but instead are motivated by naked impulse, so that lawlessness and violence are rife in the location, assaults common, sexual morals lax and illegitimacy rates high. In contrast, middle-class urban Africans, predominantly clerks and professional workers, are much closer to the value-systems of the West, and because the rise of this class-level is recent they are peer-directed, learning not from their old-fashioned parents but from their peer-group and their white counterparts. It would thus appear that the African middle-class personality-type has proceeded straight from tradition-to other-direction, and has omitted that historical stage where behaviour is

controlled by internalized parental attitudes producing conformity by means of guilt and shame.

Other workers have probed the influence on personality formation of prolonged breast-feeding followed by abrupt weaning in the African[+], which Carothers had held to result in the development of passive characters. Albino and Thompson (1956) found instead in their semi-rural Zulu population that such weaning accelerated socialization, so that for a time the native child even exceeds social norms laid down for the European of equivalent age.[180] To explain this surprising finding, so different from what might be expected in a Western child, Albino suggests[181] that in Africa maternal rejection does not accompany weaning; whereas in Western Europe sudden weaning is usually preceded by emotional withdrawal of the mother.

[+]In the community studied infants are allowed unlimited access to the breast for periods up to three years with a mean at 18.9 months. The merest whimper is the signal for the breast to be stuffed into the baby's mouth. Then suddenly and without warning by dint of bitter aloes smeared on the nipple and a cockroach charm the breast is withdrawn.

The view that personality differences between Whites and Africans are due to cultural influences, not to fundamental variations in brain functioning, is supported by electroencephalographic studies. In the first published series on the electroencephalograms of African natives, Hurst found no differences between his schizophrenic subjects and the findings reported in the European literature.[182] Mundy-Castle et al. the next year, comparing normal Africans and Europeans found only minor differences of doubtful significance.[183]

PSYCHIATRIC ILLNESS

As elsewhere, in South Africa standardized forms of psychiatric illness prevail among the indigenous peoples. Specific and localized illness-types do occur but are scantily described. Ufufunyana is an anxiety-hysteria occurring among Zulu women which Loudon[184] regards as the expression of social anxieties raised by the inferior status which women occupy in tribal society. In former times these emotions were communally abreacted in Nomkubulwana, an obscene dancing ritual of rebellion in which all the women of a village took part. But this form of preventive

psychiatry has died out with Westernization. The dreams of the Ufufunyana-patient are typically concerned with "flooded water", in the Freudian sense said to indicate conflict centred on the social pressure to bear children (Lee).[185] This worker has also described a form of crying hysteria, hayiza[186], during which, according to Barker, the patient falls grunting and trembling, kicking and screaming to the ground, writhing and tearing off her clothes.[187] The condition occurs also among farm-workers in Zululand, where it is called Mandikkies.[188]

Monica Wilson vividly describes what must be a variant of the same condition among the Pondo: "A girl who is ukuphosela+ becomes hysterical, sobbing wildly and fainting .... In one case I knew of the girl went about for several days cooing like a dove".[189] And along with such dramatic storms occur more prolonged manifestations of hysteria: jaw pains, convulsive shaking of the shoulder-blades, eye-strain, headaches, cardiac pains and pains in the flanks.

+Bewitched by a rejected lover.

The person who is continually ill and troubled by many dreams is regarded as receiving an ancestral call to become an izangoma diviner.+ He besmears himself with white earth and repairs to an established diviner who undertakes to initiate him (ukuthwasa). If the illness continues after thwasa the master is held to have failed; but if he succeeds then his pupil too is entitled to practise as a diviner. That this cure does not always result is indicated by a patient of Kohler's who refused ukuthwasa: "For at our place many people are ill like I am, and they are treated by the izangoma, and now they are diviners who can divine. They are, however, not people who have strong bodies; they are always ill and have no strength to do much work".[190] Subject to somnambulistic wanderings from which he is liable to return in a state of agitation, to trances and fainting fits, the izangoma is himself a sick man.

The cultural patterning of the illness by primitive fears is shown in this description:

+Highly regarded medical consultants.

"I dream about graves and that I walk about them. I dream about a river in flood and see a huge snake going about in a cloud of mist.... All this dreaming made my body weak and tired....I was filled with fear and lay down trembling all over my body....I contemplate suicide to escape from the bad dreams that trouble me so....I also dream about a Tikoloshe, he climbs on top of me and bears down upon me, but says nothing....There is also something always moving about my body....my head shrinks together as though I were about to see a fearful thing....When it thunders this thing which I don't know runs about in my head; it even comes into my eyes and blinds me, but when I feel my head I cannot discover what it is....Sometimes I want to cry...."[190]

There is no doubt that the content of this illness, serious enough to bring its sufferer back from Johannesburg, suggests depression. Wilson's obser-

vation that many women thwasa at the time of the menopause is also suggestive of endogenous depression, its symptoms culturally determined, and rationalised like other psychoses into a treatable system by the diviners, who depend partly for their cure upon a psychotherapeutic personal relationship with their pupil-patients. At the same time the community are able to deal institutionally with their own fears about malignant psychotic illness; fears which Europeans have controlled in themselves by building separate mental hospitals with insurmountable walls.

Generally, however, depression is held to be extremely rare among Africans. Laubscher found only 14 cases of suicide and 4 of attempted suicide in a two-year census of a population of 869,000 people.[191] Walton in an urban general hospital population of 252 cases of attempted suicide saw only 2 Africans.[192] In a later series of 50 the only apparent African was actually a Coloured man who had grown up in the Transkei.[193] Klintworth, however, discovered a much higher proportion of Africans (32 of 141) among those who killed themselves in the Johannesburg area during 1958[194], so that successful suicide in the urban

African is decidedly not rare.

In Laubscher's mental hospital population of 554 only 22 patients suffered from manic-depressive psychoses. This corresponds with other reports (8:258, Lamont and Blignault[195]; and 28:400, Moffson[196]). Schizophrenia on the other hand is extremely common and accounts for 53-58 per cent of total African admissions, including those admitted for epilepsy. Malnourished and pellagrinous patients are also frequent.

Does this tremendous disparity, operating against depressive illness, reflect true incidence or is it merely a function of social influences on selection ? Of Lamont and Blignault's 258 cases 160 were certified because of violently impulsive behaviour such as assault and destruction to property; criminal charges being laid against forty.[195] The 3 cases in the depressive phase were admitted "on account of behaviour disorders with 'lesser social implication'". This would suggest that differential selective factors are militating in favour of admitting socially troublesome schizophrenics, while quieter

but morbidly depressed Africans suffer in comparative silence, and are contained within their community. Whether depressive illness is commoner among Africans than supposed will only be determined by a full psychiatric census of the population. For this we shall have to await great advances in the psychiatric services of this country, releasing many more psychiatrists for diagnostic work among the indigenous peoples.

Meanwhile even less is known and documented about psychiatric illness as it affects the Coloured people of South Africa. In the ensuing pages the reader will find a study which compares mental illness in such a Coloured group with white controls.

SECTION B

The present study

CHAPTER IV.

The Field and Method of Investigation

This study describes two psychiatric patient populations presenting in a large urban general hospital in Cape Town. This hospital provides specialized out-patient, emergency and in-patient consultative psychiatric services. A small in-patient psychiatric unit also exists but, while the hospital's capacity is 882 patient-beds, only seven beds are presently set aside for this purpose, and of these five are reserved for white patients.

Psychiatric in-patients thus tend to be highly selected, and are not representative of those seeking admission. Selection takes place according to criteria which take account chiefly of the limited available bed-space, and also of the functions of the unit as a teaching department in psychiatry. Patients selected

for admission are thus more likely to be white, seriously ill, and to suffer from acute neurotic afflictions likely to be influenced by short-term psychotherapy undertaken by psychiatric trainees. Patients referred from other departments for psychiatric consultation tend also to be selected but in a different way by virtue of their presenting in the medical and surgical wards of a general hospital. Somatic aspects are likely to be emphasized in such a group.

Thus in the methodological consideration which preceded this investigation of social and cultural forces in psychological illness, it became clear that the study would have to exclude the psychiatric in-patients as a group; and also the group referred for consultation from the general wards. The populations under examination are thus:

(i) An EMERGENCY group, comprising all psychiatric patients presenting at the casualty department during the twelve months between October 1st, 1959, and September 30th, 1960.

(ii) An OUT-PATIENT group in which are included all new psychiatric patients attending the hospital psychiatry out-patients' department during the five months between December 1st, 1959, and April 30th, 1960. The individual transactions of this latter group with the hospital are also followed over a 10-15 month period to February 28th, 1961.

The special purpose of this study is to examine certain social and cultural determinants of psychiatric illness presenting in an urban general hospital. The particular emphasis is on a comparison of the main population groups of metropolitan Cape Town - white and Coloured (including Malay), but where the size of the African sample is adequate this group is included in the analysis. In the assessment of the OUT-PATIENT group account is also taken of the cultural differentiation of the two main divisions of the white ("European") group into English- and Afrikaans-speaking persons, and an internal comparison is made.

As far as is known by the writer this is the first attempt to describe the general psychiatry of the Cape Coloured and Malay people and also the first study which compares psychological illness in the two language-determined subcultures of the dominant white group of South Africa.

At this juncture some clarification and definition is indicated. For instance we shall want to know more clearly what is implicit in terms of "race".

RACIAL CATEGORIES

South Africa as a multi-racial composite society is legally divisible into "white","Native", "Coloured" and "Asiatic" according to whether skin colour is white, black, brown or yellow. Whole political philosophies rest upon such distinctions. Unhappily, when for scientific purposes one comes to closer enquiry one discovers that the system, especially as it concerns the Coloured people, is arbitrary and does not lend itself to precise formal definition.

Thus the Coloured people do not constitute a separate physical anthropological race-type, and in

practice skin colour, hair and other physical criteria vary considerably from person to person.+ Nor are they a "community" in the usual sense of a collection of individuals occupying a common territory and held together by some form of local government.[198] One is loathe for scientific purposes to use, for instance, the negative definition of the Population Registration Act which describes a Coloured person as "a person who is not a white person or a native".

The "Report of the Commission of Inquiry regarding the Cape Coloured Population of the Union" (1937)[199] states that "it is not surprising that the difficulty of distinguishing between 'Coloured' and 'European' should have given rise to litigation". Regrettably the Commission makes the situation no clearer with its definition of a <u>typical</u> Cape Coloured as

> "a person living in the Union of South Africa, who does not belong to one of its

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+Thus Ziervogel in "Brown South Africa": "The Coloured people are distinct from the original natives (Bantu). They range from lily-white to nut-brown in colour ....." [197]

> aboriginal races, but in whom the presence of Coloured blood (especially due to descent from non-Europeans brought to the Cape in the 17th and 18th centuries or from aboriginal Hottentot stock, and with or without an admixture of white or Bantu blood) can be established with at least reasonable certainty (a) from a knowledge of the genealogy of the person during the last three or four generations; or/and (b) by ordinary direct recognition of characteristic physical features (such as colour of skin, nature of hair, and facial or bodily form) by an observer familiar with these characteristics".

This definition rests heavily on "the presence of Coloured blood" and is legally as unhelpful as its predecessors. The difficulties of measuring "Coloured blood" are typified in cases arising out of the Population Registration Act and quoted by Mann (1957):[200]

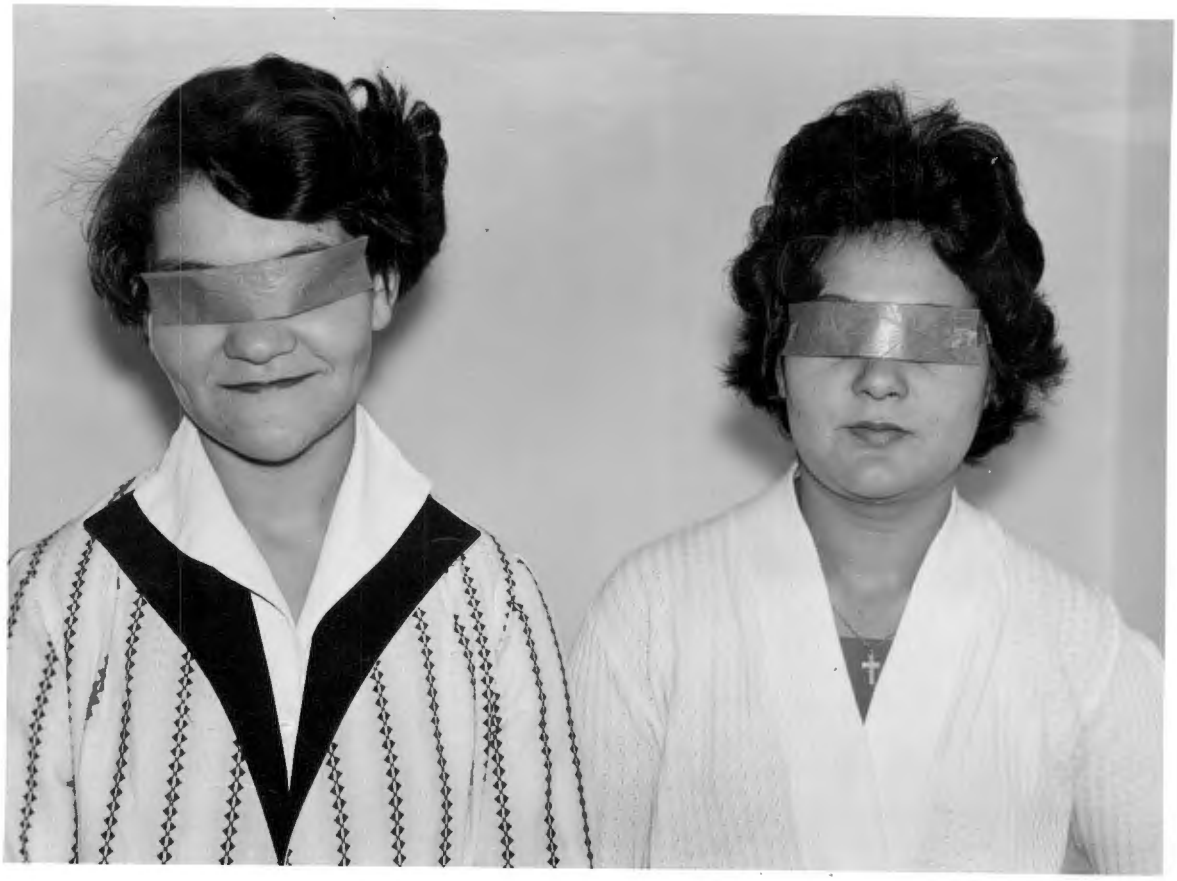
> "Thomas Holyoake....is the son of a white ex-policeman and an African woman. He married

a Coloured woman, his children attended a Coloured school and the Department of Labour have registered him as Coloured. He speaks an African tongue, Sepedi, very well. He was classified as African, but his appeal....was allowed when he produced his father's death certificate....".

Or that of Fred Nicholas who

"passed as white and was so classified. His wife was white and worked as such, while some of his children attended a white school. A neighbour with whom Nicholas quarrelled went to the authorities and had the classification reviewed and changed to Coloured. White neighbours testified that Nicholas was accepted as white by them, but evidence showed the non-white strains in his ancestry."

In our own experience we have witnessed this difficulty manifest in a paradoxical way:



Photograph 3: Myrtle Jones is on the left. At right is her sister married to a white in a foreign country.

Myrtle Jones,+ 19, worked as a domestic servant in a suburban hotel. Her lover was an African waiter. She was dark with coarse hair and broad flat nose and regarded by her associates and employers as Coloured. The patient was admitted to the non-European ward in a twilight state of dissociative hysteria, from which she recovered, revealing in abreactive interviews fears of impregnation. She asked to be protected from her lover until she had sorted out her feelings towards him. Meanwhile he dutifully telephoned and left her parcels of fruit and clothing.

When the patient had been in the ward several days she was one day accidentally encountered by a group of white women passing through the non-European ward on their way to visit a white patient in a neighbouring ward. They stopped in their tracks and with glad exclamations the patient was identified as the daughter of one of them, who had disappeared from her sister's home several months before.

Inquiry revealed that both the parents and grand-parents on both sides were un-

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+ In this report all cases described have been given pseudonyms to guard their identity, necessary enough as the case of Myrtle Jones will show. Where photographs are used they are done with discretion and with the full knowledge and approval of the patient and his family.

> questionably accepted by their associates as white. The mother and several siblings seen "looked white". Under hospital regulations Myrtle had to be shifted to the European ward, and she passed again across the colour line. With her change in status she elected to conceal her life as a domestic servant and the existence of her lover from her family. Heartrending scenes followed when the lover learnt that she no longer wished to see him. In any event he could not be allowed under administrative conventions to visit her in a white ward.

After discharge Myrtle returned to her family. She had repeated hysterical breaks, usually following threats of exposure by figures emerging from her previous incarnation. One day she again encountered George, her African lover. The illicit relationship was resumed, she became pregnant, and sought help (from the writer). The baby was delivered in an institution, its sympathetic senior staff having been acquainted with the special circumstances of the case. While the intention had been to give the child to a Coloured family for foster care, Myrtle now grew fond of it and decided to keep it herself. Its parentage

was, however, concealed from her family, but as the child's complexion began to darken the patient became increasingly fearful of discovery. Yet she refused to give up the child until circumstances became totally impossible for her, expressed by a suicide attempt on the eve of formal adoption papers being signed. Her final decision to part with the child was precipitated by a comment from a relative that the child's hair looked unusually "krissy". She herself has meanwhile confided in an understanding elder sister and has arranged to join her and her family in another country.

The case of Myrtle illustrates the theme of J.S. Marais in a classic work[201] in which he shows the inextricable socio-cultural linkage of the Coloured and parent white peoples such that "the Coloured do not appear to differ from us to-day in anything except their poverty, and that they share with our large army of poor whites". In a footnote he adds "and the reactions engendered by European attitudes to them". In this connection it is conceivable that the attitude of the European to the Coloured must engender considerable

frustration, and the consequent aggression has to be reintegrated into the Coloured personality thus creating special psychological problems for the individual.[202] While referring to Marais's book one may here relevantly state his view of the origins of the Coloured people from four basic elements of "blood" - slave, Hottentot (Khoikhoin), Bushman and white in that order.

Sheila Patterson differentiates between a 'Cape Coloured' and a simply 'Coloured' group.[203] She applies the former term to "those persons of mixed race who are born into, regard themselves as, and are accepted as members of the Cape Coloured group which has its focus in the Western Cape". The latter group comprises Coloured persons living outside the Cape who may be the result of hybridization between different strains, such as between a white and an African or Indian, or between an Indian and an African. Her definition thus lays stress on self-affiliation into the Cape Coloured group, and she makes separate mention of small enclaves who despite similar ancestry regard themselves as distinct from the Coloured group. The Rehoboth 'Bastards', the Griquas, the Buys clan and the

Dunn family are examples of such groups.

Problems also arise with other groups. Thus most of those classified as "Europeans" and "Asiatics" have never been to Europe or Asia, are as much native-born as the Africans who are classified as 'Natives'. Japanese and Syrians are classed as Europeans but Chinese, Siamese and Egyptians are not. The status of a group in the hierarchy moreover alters from time to time.[203]

In the social survey of Cape Town Batson[204] found similar confusion traceable to lack of a clear concept of a 'racial' or 'ethnic' group; crossing of genetic and somatic criteria by religious and cultural criteria, and practical difficulties in classifying individuals. At the time when his social survey of Cape Town was done the Coloured group was included by the official census within a heterogenous 'Non-European' group, out of which their numbers had to be computed. Since then the 1951 and 1960 Population Censuses[205] have categorized a separate 'Coloured' group which could be used in this study.

By its very method of enumeration such a population census is based on data obtained through self-affiliation into and general acceptance by a given group. For the practical purposes of this study similar account has been taken of self-classification and general acceptability and the official hospital categorization has been adopted, whereby a patient places himself in one of four groups. Only in exceptional cases (and these will be described) does this lead to difficulty. The groups adopted are thus 'White', 'Coloured', Asiatic and 'African' and correspond with the official Population Census groupings.

The Cape Malays comprise a special Islamic religious and social subculture within the general Coloured group.[206] Weiss has shown how the different orientations of the two subcultures; the Malays toward Eastern philosophical traditions, the Coloured towards a Western way of life, vitally affect their respective work and social adjustments.[207]

Table 2 shows the numerical distribution of the four main ethnic groups at the last Population census of Metropolitan Cape Town, compared with the distrib-

ution for the whole of the Union of South Africa.[205]

TABLE 2.

Area	Whites	Coloureds	Asiatics	Bantu+	Total
Metropolitan Cape Town	278,555 (38.8%)	365,475 (50.9%)	9,134 (1.3%)	65,025 (9.0%)	718,189
Union of South Africa	3,067,638 (19.4%)	1,488,267 (9.4%)	477,414 (3.0%)	10,807,809 (68.2%)	15,841,128

DIAGNOSTIC CATEGORIES.

As Norris states, at the outset of any study one is immediately plunged into a major controversy over what diagnostic classification is going to be used.

Nosological systems differ geographically and also between psychiatrists of different schools. It has long been argued that even specific semantic terms in the nomenclature are differently applied and interpreted. This was recently investigated for schizo-

+The Bantu or Africans are the Bantu-language speaking aboriginal peoples of South Africa.

phrenia in a survey emanating from the University of McGill.[209] Pasamanick et al. have even asserted that "clinicians may be so committed to a particular psychiatric school of thought as to predetermine the patient's diagnosis and treatment".[210]

Mehlman is so rejecting of existing psychiatric classifications as to suggest that "they have little value for administrative management or for research".[211] Ash found only 20 per cent agreement between three psychiatrists, two of them "nationally known", examining 35 cases in conference interviews.[212] Published evidence with this outlook is, however, in the minority, and even a noteworthy retraction was published by Schmidt and Fonda who in an earlier article had said that "psychiatric diagnosis is too unreliable to permit derivation from our data of substantial conclusions....". These authors had subsequently conducted a study in which each of 426 state hospital patients were independently diagnosed by pairs of psychiatrists, with agreement in major diagnostic categories of 84 per cent, and in the subtypes of 55 per cent.[213] Since the pairs consisted each of a trainee and a qualified psychiatrist, even higher correlations might

have been expected with pairs of experienced psychiatrists.

In the Yale survey, Hollingshead and Redlich[40] found that far fewer cases needed rediagnosis by their team than had been expected. Only 6 per cent of cases gathered from clinics and hospitals were rediagnosed and 17 per cent of those from private practitioners.

In the present study each of the OUT-PATIENTS was seen by at least two doctors, one of whom was a consultant and one the writer, a psychiatric trainee. Disagreement happened less often than had been expected and was usually settled by discussion, recourse to a third doctor only seldom being required. In the EMERGENCY series, however, the writer was often the only psychiatrist to see the patient, even though all cases seen by him in the casualty department were referred to the hospital out-patients' department. (It would have placed too great a load on already inundated doctors to have expected them to see each of these cases in addition to their own). Where cases presenting at the casualty department were not referred

to the psychiatry department at all (figures for these are given in chapter 5) a diagnosis was made on the basis of the information in the records. This was only done if the information was sufficient for a clear and definite diagnosis, and doubtful cases were unhesitatingly excluded. These discards are noted in the relevant section of the report.

The diagnostic classification uniformly used throughout the study was that in practice for teaching purposes at the hospital, based on existing standard systems, and readily assimilable to them (vide Appendix A). Mental deficiency uncomplicated by neurosis or psychosis was not included in the study.

Illnesses were divided into Major (Psychotic) and Minor (neuroses and personality disorders).

1. MAJOR DISORDERS: PSYCHOSES

i. FUNCTIONAL

(a) SCHIZOPHRENIA: Within this subtype were included cases with fundamental disturbance of thinking and conation together with emotional blunting and withdrawal. Incongruity

of thought and affect, primary delusions, hallucinations, and impulsive thoughts and actions might be present. A setting of clear consciousness was essential for the diagnosis. No attempt was made to classify the cases into further sub-categories.

(b) MANIC-DEPRESSIVE DISORDER: This group included cases of endogenous depression, agitated depression, involutional melancholia and mania, where constitutional aspects of the case predominated over environmental factors. Criteria for typical depressed cases were retardation or agitation, melancholic mood, characteristic sleep disturbance with or without delusions of unworthiness and self-blame. Manic cases were required to show elation, overactivity and flight of ideas.

(c) PARANOID STATES: Any case manifesting a delusional system with no other evidence of schizophrenia, i.e. no central mood disorder and no thinking disorder, might be included here. It was expected that the number of these cases would be small. Cases in which

paranoid features were but a part of a global syndrome (e.g. endogenous depression with paranoid symptoms; dementia with paranoid features) would be included under the relevant all-inclusive category.

ii. ORGANIC REACTIONS: Here cases were divided into acute organic reactions with clouding of consciousness, restlessness and delirium (as in the acute drug and alcohol-withdrawal syndromes) and chronic reactions (dementia) comprising cases of gradual intellectual deterioration with dysmnesic syndromes.

2. MINOR: A. NEUROTIC REACTIONS

i. HYSTERIA: Here were included patients with somatic conversion symptoms with no demonstrable organic component, and cases with dissociative episodes. Psychosomatic cases were separately grouped. The diagnosis of conversion hysteria was never made merely by exclusion of organic causes, but on grounds of positively operating psychodynamic mechanisms, whereby the patient was attempting to deal with

anxiety-provoking material by means of repression ar dissociation. Sometimes this mechanism would prove inadequate and the patient might present with conversion symptoms yet manifest considerable overt anxiety. Such cases were called ANXIETY-HYSTERIA and were considered midway between hysterical and anxiety reactions.

ii. ANXIETY-PHOBIC REACTIONS: This group includes acute and chronic states where anxiety is not organized into alternative reactions (hysterical or obsessional) but is overt. Phobic reactions in which anxiety was concentrated on particular situations were included here rather than in the obsessional category. The relationship of phobic conditions to obsessive-compulsive states is however recognized.

iii. OBSESSIONAL NEUROSIS: The subjective sense of compulsion was the criterion for including patients within this category. Patients were expected to have features of underlying obsessional personality and to manifest com-

pulsive thoughts or rituals.

iv. REACTIVE and NEUROTIC DEPRESSION: The criteria here were over-riding environmental and psychological factors in the etiology of the depressive state, with relative absence of constitutional features. Patients in this group were expected not to show retardation, diurnal variation or characteristic sleep disturbance.

v. ADDICTIONS: Patients in whom a consistent pattern of alcohol or drug dependency was established, especially where this interfered with their psychological, occupational or social adjustments.

vi. PSYCHOSOMATIC REACTIONS: Such as bronchial asthma and duodenal ulcer where psychological mechanisms feature prominently in the multiple etiology of physical conditions capable of producing demonstrable pathological changes.

vii. ADOLESCENT REACTIONS: Acute disturbances or "turmoils" in adolescents (15-24 years) occurring as part of the necessary personality readjustments at this phase of life, and

carrying excellent prognosis.

viii. BEHAVIOUR DISTURBANCES: Psychoneurotic conditions of childhood

B. PERSONALITY DISORDERS:

"Pathological personality" - characterological disturbances traceable throughout the patient's life and not comprising a new and superimposed illness with definite onset.

C. SOCIOPATHY and CONDUCT DISORDERS:

Where the pathological personality has a definite antisocial mode of expression. In the personality and character disorders it is the patient himself who suffers internal distress, but in sociopathy individual distress is minimal and the patient externalizes his disturbance in forms of behaviour which cause society to bear the brunt of his disturbed personality. Where this personality trend is found in children it is regarded as a conduct disorder.

OCCUPATIONAL STATUS

In determining an individual's social status for

the purpose of this study the indicators education and occupation have been kept separate and not as in Hollingshead's index of social position[40] where residence, education and occupation were combined to provide a composite rating. This was done advisedly for two reasons. Firstly, the combination of these indicators was criticized by Miller and Mishler[123] on the grounds that they deprived the reader of an evaluation of the effect of the individual variables. Secondly, no published figures are available for the parameters of these variables in the general population from which the sample is drawn.

However a suitable scheme for occupational stratification of households in Cape Town has been devised by Batson (1946).[218] This classification is based in principle on that of the British Registrar-General and the modifications adopted in the Merseyside survey. Its general scheme is:

A : Administrative and independent professional e.g. accountant, managing director, surgeon.

B : Subordinate professional and independent commercial, e.g. artist, assistant manager, druggist.

C : Subordinate commercial e.g. insurance agent, book-keeper, typiste.

D : Skilled manual, e.g. carpenter, plumber, motor mechanic.

E : Predominantly manual but involving special responsibility, e.g. bus inspector, policeman, nurse.

F : Semi-skilled manual, e.g. barman, bus conductor, domestic servant.

G : "Unskilled" manual, e.g. builder's labourer, newspaper seller.

H : Occupations not actively directed towards getting an income, e.g. landowner, pensioner, student.

J : Seeking employment.

From the examples quoted it will be seen that some placements in the hierarchy are arguable. For instance the matron of a hospital might question her position as a nurse in group E, and a bus conductor his social equality with a domestic servant. As Batson remarks, however, the construction of such a scheme is extremely difficult and it is not to be regarded as

hard-and-fast in individual cases but to indicate general trends.

A further methodological difficulty to be considered is the existence of vertical social distinctions based on colour. For instance teachers of different colours while both nominally members of group B might not regard themselves as socially comparable. Moreover the educational requirements for, and the financial remuneration of teachers of different colours varies. A Coloured person may proceed to a training college with only a standard eight education, while a white trainee has first to matriculate. Alternatively, job reservation limits the occupational choice of Coloureds with good education, so that matriculants may be found working in unskilled and semi-skilled positions.

An internal social stratification within the Coloured community independent of education and occupation thus exists. Three social classes were described by the Commission of Inquiry of 1937.[199] Firstly, there was an "undesirable class" of 'skolly-boys', drunkards, dagga smokers and habitual loafers. Sec-

ondly, there was a middle class of farm and factory workers and household servants. Thirdly, there was a relatively well-to-do educated class of teachers, independent workmen and skilled tradesmen.

Van der Merwe (1957) used a panel of Coloured judges to stratify the members of a semi-rural Coloured community. He found that Coloureds themselves stressed morality in status evaluation, and emphasized qualities such as character, drunkenness, birth, family of procreation, ambition and perseverance.[219]

Again for the purposes of a comparative study of this kind we have had to compromise for the sake of practicality. Batson's inclusive scheme was thus adopted, omitting group J (those seeking employment), and combining some groups on account of the smaller numbers in the sample. Where a patient was "seeking employment" his group value was assigned on the basis of his most consistent previous employment. Four classes were thus separated:

"Upper Status" (groups "A" and "B") - Professional and managerial staff.

"Middle" (groups "C" and "D") - Subordinate commercial and skilled artisans.

"Working" (groups "E" and "F") - lesser trained occupations of manual and semi-skilled nature.

"Labouring" (group "G") - Unskilled workers.

Group H (occupations not income-directed) was retained. It was decided to place housewives within this group rather than to assign them the status of their husbands. The reasons for this were: firstly, that status conflict has been shown to be a variable in the sociogenesis of psychological illness, and it would have been unwarranted to assign to wives the occupations of their husbands; secondly, the scheme adopted was derived from a survey of a population mainly male. Similarly students were placed in this group rather than assigned the status of their projected professions. It would not have been accurate to call a student in his first year of architecture an architect when he may never qualify on account of his very illness.

EDUCATIONAL STATUS

The number of years of completed schooling was used to establish ratings for this variable. Unfortuately no reference scheme was available for the local population-at-risk. Census figures are published differentiating only the "literate" from the "non-literate" though full data have to be supplied by the individual completing a census form.

The following educational groups emerged:

"Partial primary school" 0-4 years, completing standard four education or less.

"Primary school" - leaving after standard five or six but before high school.

"Partial high school" - completion of standard seven or eight.

"High school" - completion of standard nine or the matriculation equivalent.

"University A" - having finished up to three years of academic university education.

"University B" - having successfully completed more than three years of university education.

AGE DISTRIBUTION

Age groups used in the Union census[220] were adopted. These, incidentally, are assimilable to overseas studies, such as those of Stengel[221] and Norris.[73] Data were classified as follows:

0-15 years
16-24 "
25-34 "
35-44 "
45-54 "
55-64 "
65-74 "
75-84 "
85-94 "

Because of the numbers of the samples in this study these groups were subsequently combined into

1. "Young people" - 0-24 years.
2. "Mature people" - 25-44 years.
3. "Middle-life and beyond" - 45+ years.

It is felt that these groups are not only convenient

but psychologically meaningful. As Erikson[27, 28] and others have shown, young people are acquiring social and occupational techniques. Their personalities are in a state of constant modification and reorganization. By the age of 25 years the life-course has been relatively determined, the social and occupational life-plan delineated. The next twenty years are spent in creating, as it were, a projection of one's self-image. However at the stage of middle life and beyond the process of self-scrutiny and judgement of one's life-work begins, with its occasional psychological expression in depression if the self-image is rejected, or the potential not realized.

In Appendix B will be found data on the age distribution of the reference population (Metropolitan Cape Town).

MARITAL STATUS

Again the scheme in the Union Population census of 1951 was adopted.[222, 223]

"Never married or single".

"Married or cohabiting".

"Widowed".

"Separated or Divorced". (See Appendix B)

Regrettably these categories are not controlled for age in the case of the Coloured, Asiatic, and Native groups. This means that minors are included in the figures for "never married" and illness rates for this group as evaluated in this study may be expected to be deceptively low.

RELIGIOUS AFFILIATION

The groupings of the Population Census of 1951 (see Appendix B) were combined to give the following categories:[223, 224]

1. Dutch Reformed Church group.
2. Anglican (Church of the Province).
3. Roman Catholic.
4. Major Non-Conformist group consisting of Presbyterians, Methodists, Congregationals and Baptists.
5. Minor Christian group - Lutherans, Apostolics, Moravians etc.
6. Jewish.

7. Islamic

8. Other - including agnostics, atheists, School of Truth, Scientologists, etc.

This is the minimum number of different categories necessary to preserve intact the widely varying cultural continuum of which religious affiliation is the index. Even so it will be argued, for example, that staid and conservative Lutherans are not to be classed with sects of a revivalist persuasion. Regrettably a statistical study of this nature has ruthlessly to limit the number of sub-groups in a table so as to make statistical analysis a possibility.

In the next chapter some of the indicators here defined will be applied to the study of an emergency psychiatric population.

GENERAL HYPOTHESIS

Before surveying the material in the following chapters the general expectation of the study should be formulated in the shape of a basic hypothesis.

This study examines the Coloured people, a group

seeking status within a reference group which keeps it at a social and political distance, yet upon which it is modelled. The Coloured people themselves for the most part reject opportunities of integration within the large inferior-status black group. In fact such contacts between the African and the Coloured groups within the Cape Peninsula have been sociologically analysed by Du Toit (1958), who finds the Coloured group repudiating certain aspects but identifying with others.[225]

It would seem, therefore, that the Coloured group occupies a marginal status and is orientated mainly towards the white in-group (though there are now definite signs of the beginnings of an opposite movement). Stonequist has stated it thus ('The Marginal Man'):

> "....the social isolation of the Cape Coloured is the most significant factor in his present condition. He cannot now find a place in Bantu society - even if he wished it; he is blocked socially from the side of the white man. Compared to the unmixed natives

his status is sufficiently superior to give him some feelings of satisfaction, on the other hand he cannot hope for acceptance as the white man's equal".[226]

Not only is the implication one of an intermediate social status, but of an existence in two separate worlds. The Coloured man wears two faces; he is a duplex personality. When he steps into the white world he is required to act according to the white man's expectation of him. He must conceal his aggression behind a smile conveying feelings of humility and respect for his white superiors. He must "tread on eggs" lest he offend. In the security of his own world he reverts to a different personality. He doffs the assumed cloak of respect for the white man and airs his injured feelings to his family and friends with bitterness and resentment.

The poem of Dunbar quoted by Stonequist is pertinent:

"WE WEAR THE MASK

We wear the mask that grins and lies,
It hides our cheeks and shades our eyes -

This debt we pay to human guile;
With torn and bleeding hearts we smile,
And mouth with myriad subtleties.
Why should the world be over-wise,
In counting all our tears and sighs ?
Nay, let them only see us, while
We wear the mask".[226]

According to Stonequist the marginal situation has its expression in the development of a stereotyped marginal personality characterized by feelings of race and personal inferiority, ambivalence, moodiness, hypersensitivity, withdrawal or overcompensating aggressiveness. Withdrawal may occur into a fantasy world of day-dreaming. On the other hand the desire to overcompensate for inferiority feelings may stir up acute hostility and criticism of the dominant group so that only the contradictions and "hypocrisies" in the dominant culture are seen.

We would expect that this load of cultural tension and conflict over and above the "normal" intrapsychic and social preoccupations shared with the white man will do its work in three ways:

1. There will be increased evidence of mental illness in the Coloured group.
2. The type of mental illness seen will be more serious and more spectacular.
3. The subcategories of mental illness discovered will differ qualitatively from those of the white group, i.e. they will show different form and different response to treatment.

It will be seen in the following pages that only part of this broad preliminary hypothesis is confirmed when we come to examine the facts.

CHAPTER V.

The Emergency Population

Walton's studies of attempted suicides[192, 193] who presented in a Cape Town general hospital pointed to a definite cultural differential at work: attempted suicide occurred less frequently in the Coloured than in the white group and only rarely in the Africans in his series. His population was, however, drawn from patients actually admitted to observation-wards, as was Klintworth's all-white sample in Johannesburg.[194]

The studies of the Yale group under Hollingshead and Redlich had shown convincingly how position in the status hierarchy not only affected the type of illness itself, but also the disposal of the patient. We determined to observe how these forces operated in our local population, and whether the available

figures represented the true proportions presenting or whether some selective process had taken place between the hospital portals and the ward-beds to account for the disparity in numbers between the racial groups. Furthermore, we wished to discover what other groups of patients presented in a psychiatric casualty department, and how cultural factors featured in these.

It was anticipated that:

> Socially selective factors operate in the admission even of an emergency patient to a ward. This selection is based on unspoken interaction between the patient and the casualty doctor, is based on their respective positions in the colour hierarchy and the mutual expectations each has of the other.

METHOD

The registers of all patients presenting at the casualty department of the hospital between October 1st, 1959, and September 30th, 1960 were carefully

scrutinized by the writer. The number of entries thus examined totalled 44,139. A list was made of all cases of a possible psychiatric nature. All poisonings were included and all doubtful cases such as those labelled "cut tendons", "shooting" or "fits". Patients classed as "epilepsy", "headache" and "asthma" were not included. The result was a mixed roster of patients overinclusive of the psychiatric ones and including many who would surely not turn out to be psychiatric at all. Few psychiatric patients are felt to have eluded this net and if some did then their selection out of the study could hardly have been on cultural grounds. At this stage the roster totalled 574 patients (342 white and 232 non-white).

Repeated searches were now made in the records department for all these folders, repeated because some folders might have been in use at the time of the original search. The number of folder records thus obtained was 327 white and 214 non-white; 15 white and 18 non-white folders not being found after repeated searches.

Now the elimination of non-psychiatric patients took place according to the information in the personal folders. In this way 89 non-white and 72 white folders were excluded for the following reasons (Table 3):

TABLE 3

EXCLUSIONS FROM EMERGENCY PSYCHIATRIC POPULATION+

	White	Non-white
Accidental poisoning	17	41
Assaults and accidents	8	6
Epileptics	5	9
Diagnosis: somatic	18	14
Insufficient information and duplicates	24	19
TOTAL EXCLUDED	72	89

+ Of the accidental poisonings 15 were found to have occurred in white children under sixteen and 36 in Coloured. Medical cases included two patients diagnosed as hyperventilation but who subsequently were found to have uraemia and pulmonary pathology respectively. A few patients were found presenting with multiple folders with different numbers. One patient however, an addict and alcoholic had three folders under different aliases.

The residue of 380 comprised the emergency psychiatric population and these records were now subjected to further analysis. The total population was found to consist of 255 whites and 125 non-whites. Table 4.1 shows the respective racial proportions

TABLE 4.1

RACIAL INCIDENCE OF ALL PSYCHIATRIC EMERGENCIES COMPARED WITH THE GENERAL POPULATION-AT-RISK

	Patient Population	Metropolitan Cape Town
Whites	255 (67%)	278,555 (39%)[1]
Coloureds	98 (26%)	365,475 (51%)[2]
Asiatics	- -	9,134 (1%)
Africans	27 (7%)	65,025 (9%)[3]
TOTAL	380	718,189

1p<.001 2p<.001 3p = N.S.

compared with the population of Metropolitan Cape Town (1960 Census).

It will be seen that in relation to the general community white patients present in excess of their

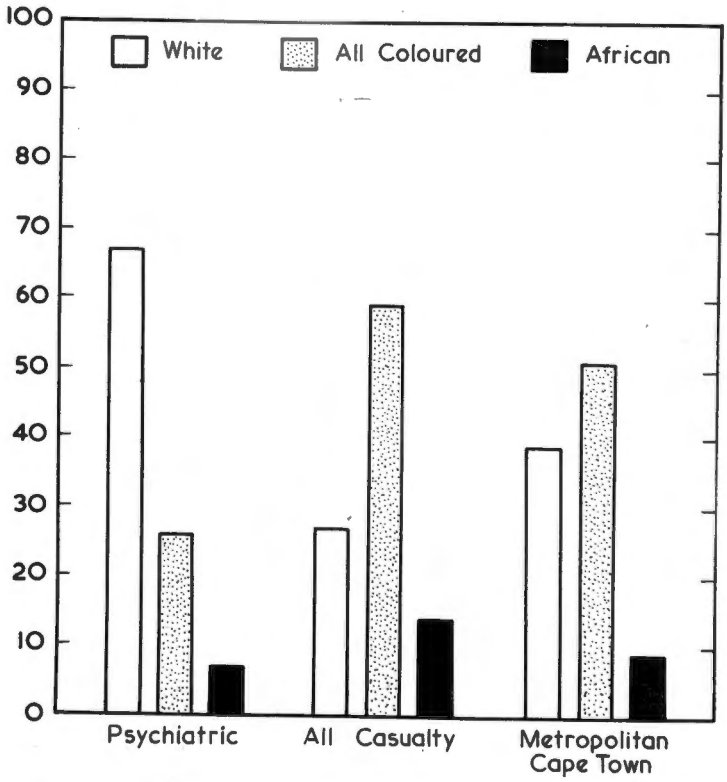

Figure 4. Racial Incidence of Psychiatric Emergencies compared with all Casualties (per cent.)

proportions and Coloured patients are correspondingly under-represented.

That this does not apply to other (non-psychiatric) classes of the casualty population is shown in Table 4.2 and Figure 4.

TABLE 4.2

RACIAL INCIDENCE OF PSYCHIATRIC EMERGENCIES COMPARED WITH OVERALL CASUALTY POPULATION

	Psychiatric	Total Casualties
White	255 (67%)	12,009 (27%)[1]
Coloured	98 (26%)	26,016 (59%)[2]
Asiatics	- -	- -
Africans	27 (7%)	6,114 (14%)[3]
TOTAL	380	44,139

1 $p < .001$ 2 $p < .001$ 3 $p < .001$

The differential racial incidence which Walton found operating in his suicide population may thus be extended to cover all categories of a psychiatric

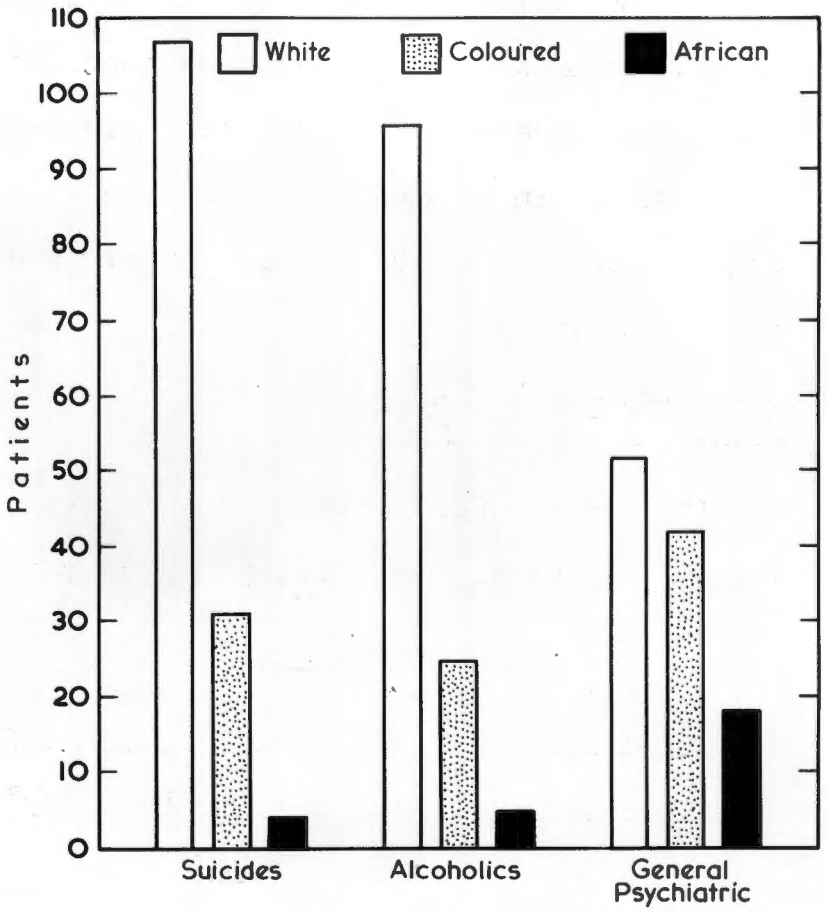

Figure 5. Race Incidence of Emergency Psychiatrics: Sub-groups.

emergency population in the same hospital ten years later. The white and Coloured populations of Metropolitan Cape Town are respectively over- and under-represented in an emergency psychiatric series covering all classes. Does this vary from class of illness to class ?

MAIN PATIENT GROUPS

On examination of the total patient group three large sub-groups were defined - 142 patients presenting

TABLE 5

RACE INCIDENCE OF EMERGENCY PSYCHIATRIC SUB-GROUPS

	White	Coloured	African	Total
Suicides[1]	107	31	4	142
Alcoholics[2]	96	25	5	126
General[3]	52	42	18	112
TOTAL	255	98	27	380

1, 2, 3, analysed separately.

as attempted suicides, 126 as alcoholics and 112 with general psychiatric pictures. Table 5 shows the

numbers of patients who fell into these groups according to race, and Figure 5 their respective proportions (no Asiatics presented).

It will be seen that roughly three-quarters of the attempted suicides and alcoholics were whites, and one-fifth were Coloured. This disparity is less evident in the general psychiatric group. The Africans represent only a very small proportion of the suicide and alcoholic cases, but their numbers increase in the general psychiatric population to a point where they are actually in excess of their proportion in the Metropolitan Cape Town population.

The individual sub-groups will now be examined.

SUICIDES

The series of 142 patients presenting as attempted suicides confirms Walton's main conclusion[192] that Coloured people present relatively infrequently and Africans rarely in this way. It does not necessarily follow that this represents actual incidence in the population. It is well recognized that those patients under psychiatric treatment at any time do not necess-

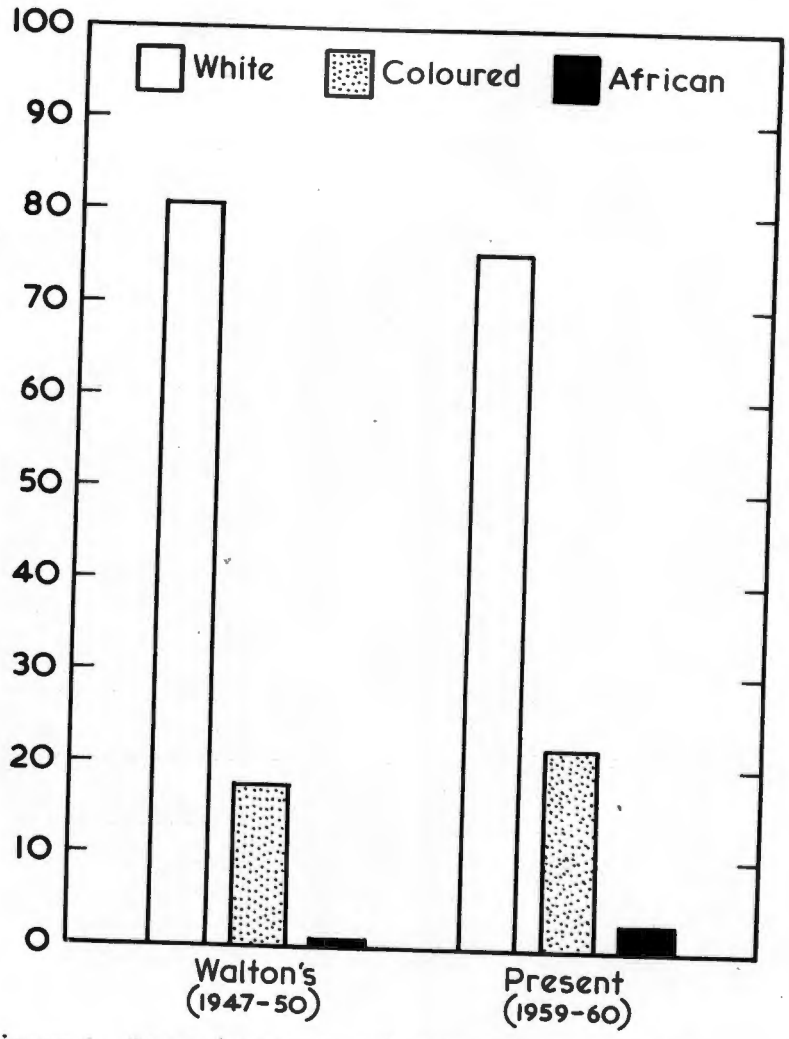

Figure 6. Race Incidence of Attempted Suicides Compared in Two Series. (per cent.) (Admitted and Pre-Admitted.)

arily reflect the actual prevalence of psychiatric illness. Such a conclusion would only be justified by a survey of the general population in the catchment area.

However the present series does confirm that the proportions of attempted suicides do not materially alter between the hospital portal and the hospital bed. Table 6 and Figure 6 compare the proportions

TABLE 6.1

RACE INCIDENCE OF ATTEMPTED SUICIDES COMPARED IN TWO SERIES (ADMITTED AND PRE-ADMITTED)

	White	Coloured	African
Walton's (1947-50)	204 (81%)	46 (18%)	2 (0.8%)
Present (1959-60)	107 (76%)	31 (22%)	4 (3%)

in the present series (pre-admitted over one year) with those of Walton's series (post-admitted over $3\frac{1}{3}$ years). The proportions of the different races have not, therefore, materially altered over the past ten years.

If the hospital accounted for all cases attempting suicide then incidence might be expressed in the usual way as rate per 100,000 of the general population (Table 6.2).

TABLE 6.2

RACE INCIDENCE OF SUICIDES :

RATE per 100,000

White	Coloured	African	Total
38.3	8.5	0.6	19.6

The effect of other social variables on suicide may now be examined, beginning with age (Table 6.3).

TABLE 6.3

AGE DISTRIBUTION OF SUICIDES

	White			Coloured		
	Sample No.	%	Pop.%	Sample No.	%	Pop.%
Young (0-24)	33	31	44	11	35	63
Mature (25-44)	48	45	31	16	52	25
Middle-life (45+)	26	24	24	4	13	13

It will be seen that in our sample the maximal risk is during the "mature" period (25-44 years) for both Coloured and white groups. Young people tended to be under-represented and people in the late age group consonant with their numbers in the general population. There is no difference between this finding and that of other workers. Stengel[221] found the peak period in his several series to be at 24-44 in both sexes, earlier for women than for men within those two decades. In those of his series who committed suicide the peak was 55-64 for both sexes.

In our small sample it would be unjustifiable to draw conclusions for age distribution of the different sexes. However the actual numbers are listed in Table 6.4. It will be seen that females attempted suicide proportionately more often than males in both populations and that the sex ratio is apparently significantly larger for Whites than for Coloureds. However the numbers in the Coloured sample are small and the sex difference there is not signi-

ficant. If both groups are combined the sex ratio becomes **significant.**($I = .05$). Twice as many females

TABLE 6.4

AGE AND SEX DISTRIBUTION OF SUICIDES

Years	White		Coloured	
	M	F	M	F
0-24	8	25	4	7
25-44	17	31	6	10
45+	8	18	3	1
TOTAL	33	74 [1]	13	18 [2]

1, $p < .01$. 2, $p =$ N.S.

as males (92:46) attempted suicide, whereas their proportions in the general population are equal.

Three of the patients in the White group were under 15 years of age, none in the Coloured.

> Susan MacDonald, 14, lived in two worlds ever since her parents were divorced when she was 8 years old. From Monday to Friday she lived in the cramped house of her bus-conductor father in a Woodstock back-street, where she shared a small bed-room

with her four half-siblings. Her step-mother was strict and punished her severely if she came in late from visiting her friends. At her week-ends her mother would fetch her to the luxurious Sea Point beach-front flat which was shared only by a gentleman friend. Here Susan was encouraged to wear make-up and to associate with friends whose values were frankly material and "fast". On Sunday night she would have to take off her fine clothes in case her step-sisters, not as privileged as she would feel hurt.

Secretly Susan preferred to be with her mother but her wish to protect her father from her dominating step-mother caused guilt and a conflict of loyalties. When her mother made a legal move to get full custody of her and her younger sister she attempted suicide by taking several of her step-mother's Noludars.

However the motives of a 20-year-old Coloured girl were not so obviously influenced by socio-cultural reasons as they were frankly Freudian.

Sylvia Saunders had attempted suicide for the second time. She said "I hate my mother; I hate my sister....she says things to me that I will never forget....

Only my father used to stand by me when they used to go on with me in the house. Now he has also turned against me".
The patient was a nursing assistant who had had asthma as a child and complained also of conversion symptoms such as pains in the head and eyes and "weak kidneys". When her boy friend of seven months attempted petting she would tell him "I'm not that kind of girl".

MARITAL STATUS

In both the main comparative groups the heaviest incidence fell on the married group (Table 6.5)

TABLE 6.5

MARITAL STATUS OF SUICIDES

Status	No.	%	Pop.%	No.	%	Pop.%
Never Married	31	29 [1]	48	14	45 [2]	65
Married or Cohab	57	54 [3]	44	13	42 [4]	29
Widowed	8	7	6	2	6	4
Divorced	10	9 [5]	1.6	2	6 [6]	0.6
(One not stated)						

1, $p < .001$. 2, $p < .05$. 3, $p < .01$. 4, $p <$ N.S. 5, $p < .01$. 6, $p < .01$

Fifty-seven whites and 13 Coloureds were married, both numbers in excess of expectations according to general population proportions (the Coloured group not significantly so, the whites highly significant). Never-marrieds were significantly under-represented in both groups. However one has to take account of the fact that the "never-married" group in the general population contains a high proportion of young children.

Widowed persons were not significantly in excess of their parameters, but an excess of divorced persons was signifcantly present in both suicide groups. This is not surprising as the divorced group in the general population probably contains a high proportion of distressed, socially isolated persons.

Sometimes the divorce is, however, merely an expression of a basically unstable prior personality.

> John Martin, a Coloured man, took Sloan's Liniment. He said "I was in a daze, just thinking of finishing myself off. I'm tired of this world, that's all. Everything I do just can't come right....I seem to do the wrong thing....I'm not someone to

> argue. If they tell me something I just keep it to myself. Then it keeps on and on in myself". This patient said that married life "just didn't suit me. I tried to settle down but couldn't stay at home. Every night I would go to dances or bioscopes on my own or with a group of four or five man friends".

Dinah Thomas, the other Coloured divorcee, had similarly shown a disturbed personality before the break-up of her marriage.

Although the widowed group showed no significant statistical excess there is no doubt about the role of social isolation in individual cases:

> Hilda Temple, 60, was depressed, had lived alone since her husband died. Her three sons insisted they wanted to lead separate lives. She said about her flat: "Every time I lock that door there's an awful loneliness....Sort of an eerie feeling. I used to feel when I locked that door I was alone".

REFERRALS AND DISPOSALS

There was no significant difference in the propor-

tion of the two groups coming from private doctors (Table 6.6).

TABLE 6.6

SUICIDE REFERRALS

Source	White	Coloured
Private doctor	73	23
Self or family	34	8

p = N.S.

However when it came to disposal of the patient (Table 6.7) a significantly higher percentage of

TABLE 6.7

SUICIDE DISPOSALS

	White	Coloured
Admitted for observation	86	21
Admitted to other wards	19	3
Sent home	2	5

$p < 0.05$

Coloured suicides was sent home by the Casualty officer after the usual gastric lavage. The practice

in the hospital has long been to admit all suicides for psychiatric assessment after preliminary physical attention. Only 2 of 107 whites were sent home contrary to this practice, but 5 of 29 Coloureds (significance at 5 per cent level)

Although the numbers involved are small the expected corresponding number of white patients to have been sent home would have been a fairly large number (17) whereas in fact only two were.

TABLE 6.8

ATTEMPTED SUICIDE RATE PER ANNUM FOR ADMITTED PATIENTS (PER 100,000)

	White	Coloured	Both
1947-50	25	6	14
1959-60	31	8	16

It would seem that the Casualty officers, usually fearful of potentially suicidal patients, were statistically more prepared to "take a chance" on their Coloured patients.

Comparing Walton's figure for patients admitted to the casualty ward and the corresponding figures

for this series, it would seem that there has been a slight increase in the attempted suicide rate over the last ten years (Table 6.8).

METHOD

Suicide method has always been an index of cultural and social change. Favoured methods in late 19th and early 20th century England were by means of coal gas, wounding (slashed wrists) and hanging. Stengel noted a shift towards the use of narcotic drugs correlating with their easier availability. He even argues that freely obtainable hypnotics, while increasing the attempted suicide rate, help to keep the committed suicide rate within bounds. The patient has available a less dangerous outlet for his self-aggression.

Walton found cultural differences in the choice of method in his series. Most of his white patients (77 of 204) used barbiturates - while carbolic acid (Lysol) was most popular in his Coloured group (13 of 46). Ant poison was second in popularity with both

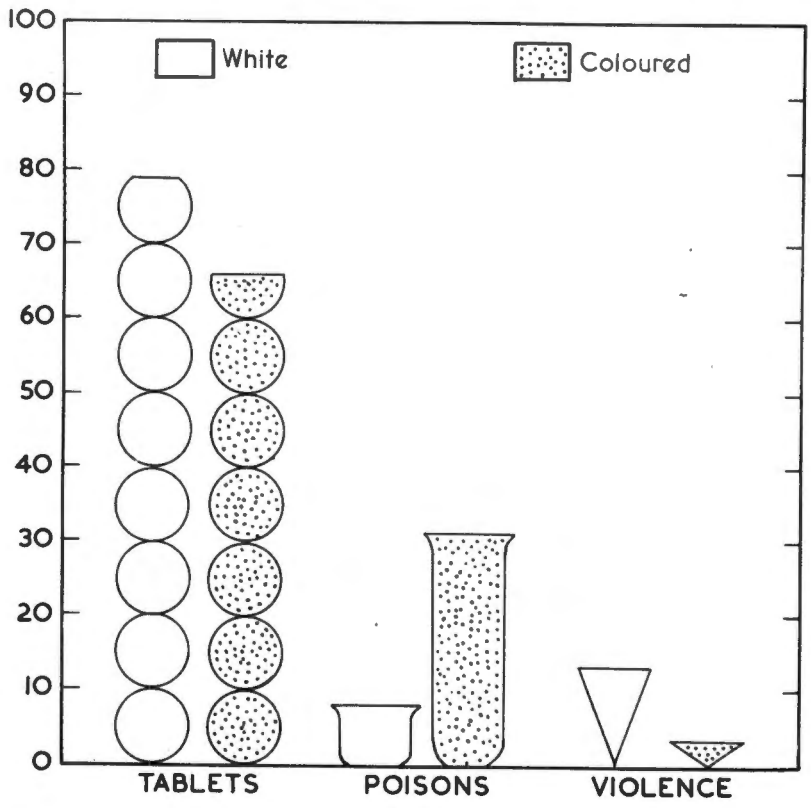

Figure 7. Suicide Method in Different Race Groups.

groups. In the present series the different methods have been combined in Table 6.9 and Figure 7 into three large groups - Tablets, Poisons and Violence.

TABLE 6.9

	SUICIDAL METHOD	
	White	Coloured
Tablets	89	23
Poisons	9	11
Violence	15	1

It will be seen that with both colour groups the means of choice is by tablets and that this method has now supplanted poisons in priority for the Coloured group. Violence occurred in 15 of 113 white attempts but only in 1 of 35 Coloureds. (Note that method totals exceed the number of persons in the sample as some persons combined two methods). The findings are comparable to those of Walton. Violence in the present series took the form of wrist-slashing (8 white males, 3 white females); gunshot (2 white males), attempts to throw oneself under a vehicle (2 white females). The only Coloured person

using violence died of her attempt. All that is known of this unfortunate person is that she was 18, a waitress at a large department store, and that on 4th March, 1960, she leapt from the third floor. She died in the casualty department of her injuries without recovering consciousness.

Of those patients who poisoned themselves, 5 of 9 whites preferred arsenic (ant poison), and 4 of 11 Coloureds. Caustic soda, iodine, Jeye's fluid and carbolic acid were used by the remainder of the Coloured patients. Two whites used camphor and 1 each turpentine and wintergreen.

Total deaths in the series numbered six. Five of these resulted from the use of ant poison, a lethal substance freely obtainable at chemists; the mortality of those using this method was just over one-half. The other death was the young Coloured woman described above. It should be mentioned that 4 of the 5 arsenical deaths occurred in young persons.

One young Coloured male of 18 walked into the casualty department with a disbelieving letter from

his doctor saying he was probably hysterical. Minutes later he suffered acute vascular collapse and died. A Coloured school teacher of 32 years had been seen the previous year, and electroplexy recommended then had been refused. She now felt unable to cope with her unruly class and rather than face her family with yet another failure chose to die.

Of the three whites, one, a 20 year-old, lived with his brother in a flat in the business centre of the city. A week after his brother was killed in a motor accident he too committed suicide. The second was a 30 year-old accountant who impulsively swallowed a whole bottle of ant poison after an argument with his father. The third European was a widow of 50 about whom no detailed information is available.

EDUCATION

No comparative figures are available for the general population so that for this variable only an internal comparison is possible. The numbers are

shown in Table 6.9. Because of the smaller numbers both primary school sub-categories and university A and B categories have been combined (those patients for whom there was insufficient information are excluded).

TABLE 6.9

EDUCATION OF SUICIDES

Attainment	White	Coloured
Primary School	19	12
Std. 7-8	33	5
Std. 9-10	7	1
University	7	-

Most of the white patients (47 of 66) had reached standard 7 or 8, but the bulk of the Coloured patients had attained only primary school levels (12 of 16). There were 7 whites at standard 9 or 10 level, but only 1 Coloured; 7 whites of university level, and no Coloured patients at all.

OCCUPATION

As could be expected from the positions of the two

race-groups in the social hierarchy in Cape Town, more whites came from the professional and managerial class than did Coloureds. Most of the whites came from the "middle" class (37%) and most of the Coloureds from the "working" class (11 of 29). There

TABLE 6.10

OCCUPATIONAL STATUS OF SUICIDES

Status	White	Coloured
Upper (AB)	18	1
Middle (CD)	37	6
Working	16	11
Labouring	1	7
Undirected	28	4

(Exclusions (no information) 7 whites, 2 Coloured)

were proportionately twice as many whites as Coloureds in occupations not earning incomes. Three of the whites were at school and three were university students, but no Coloured patient was either at school or at university (Table 6.10).

Merle Brompton, 17, had done exceptionally well at an exclusive school and was head prefect. She came from a home in a wealthy suburb. At university, however, she joined a fast "modern" clique with loose standards of behaviour. There were frequent promiscuous experiences. Then she developed a vaginal discharge diagnosed as gonorrhoea and in a wave of self-remorse swallowed 30 aspirins.

Henry Nelson's trouble was more deep seated. His home background was disturbed, his father being alcoholic and rather inadequate; his mother more interested in a woman confidante than in her husband. In his first year at the university, miles away from even this feeble parental support, he was homosexually seduced. This reawakened a homosexual struggle of which he had been dimly aware since mutual masturbatory experiences at 16. In acute depression he took 16 Noludars.

The third student-patient was a schizophrenic lad who had been supported through successive breaks during his academic years, the breaks usually coinciding with examinations. An excellent student, he held scholarships which he would forfeit if he failed.

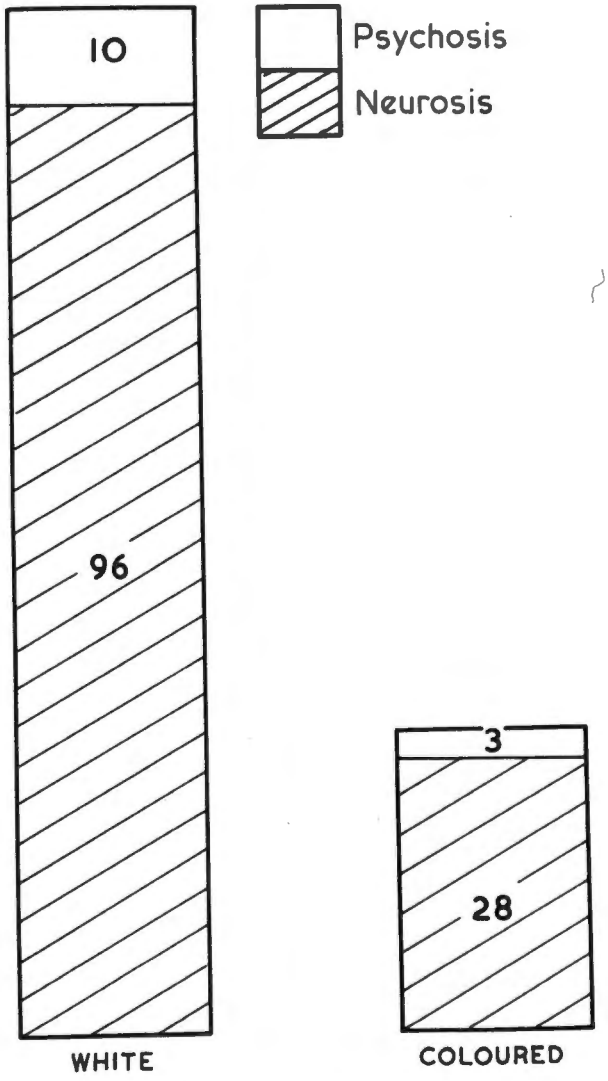

Figure 8. Suicides: Psychosis and Neurosis.

DIAGNOSIS

When one comes to classify the suicide population according to diagnosis one is amazed at the closeness of the similarity between the two groups. Table 6.11 compares the incidence of psychosis and neurosis in the patient population.

TABLE 6.11

SUICIDES: PSYCHOSIS AND NEUROSIS

Diagnosis	White	Coloured
Psychosis	10 (9%)	3 (10%)
Neurosis	96 (91%)	28 (90%)

(1 white excluded - insufficient information)

The psychosis:neurosis ratio is equal in the two groups (1:9).

A breakdown of the psychotic group shows that most of the white psychotics were cases of endogenous depression (Table 6.12)

One man, 54, a commercial traveller, was seriously depressed. He drove into the

Tokai forest, parked his car, put a revolver to his chest and pulled the trigger. As blood trickled down his chest he waited to die. However, when it was apparent after half-an-hour that he was not going to do so, he drove slowly into town and reported to a friend. Only the angle of the revolver, so that the bullet glanced off a rib, saved his life.

TABLE 6.12

BREAKDOWN OF PSYCHOTIC SUICIDES

	White	Coloured
Schizophrenia	1	-
Manic-Depressive	5	1
Organic	4	2
Acute 3		1
Chronic 1		1

A close scrutiny of the neurotic patients shows that, as expected, in both races the largest group were the reactive depressives (56 of 96 whites, and 11 of 24 Coloureds). The next biggest white group were alcoholics (19) but only 4 Coloureds fell into this category. Combined personality and psychosomatic

disorders formed large groups in both races (Table 6.13)

TABLE 6.13

BREAKDOWN OF NEUROTIC SUICIDES

	White	Coloured
Hysteria	4	2
Anxiety	1	1
Depression	56	11
Alcohol and Addictions	19	4
Personality and psychosomatic	11	6
Antisocial	5	-

(Exclusions for insuff. information 11 whites, 4 Coloured)

Alfred Furnace was a Coloured cook of 55 who became depressed when his wife confessed to infidelity with a railway policeman. He had been married 27 years. He himself had been impotent since an ulcer operation in 1955. After his suicide attempt (Nembutal) he relaxed as if a great load had

been taken from his mind. "Van ek nou die ding gedoen het is die ding nou uit my uit".+

The depression of Melanie Kahn, 18, was rooted in culture conflict. Her father was a Jewish country doctor; her mother an Afrikaans nurse. She had come to town to do typing and fallen in love with a Greek university student whose parents opposed their marriage. Her attempt followed a discussion in which they had agreed not to see each other again. Clearly the suicide attempt was her expression of an ambivalent attitude to the parting, and a desperate appeal.

SOCIAL ISOLATION

In view of Sainsbury's finding that social isolation is a potent factor in suicide, we have investigated this in our series (Table 6.14)

There are apparent but not significant differences between the proportions of isolated whites and Col-

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+ Since I've done this thing (the suicide) the thing has left me.

oureds (32 of 92 whites and 5 of 24 Coloureds)

The relative lack of social isolation among the Coloured population would be an expected finding because of their class-status and income. Accommo-

TABLE 6.14

SOCIAL ISOLATION IN SUICIDE POPULATION

	White	Coloured
Isolated	32	5
Not isolated	60	19

p= NS

dation is at a premium and must be shared, hotels are rare and cannot be afforded by the average person earning a low salary as a workman or labourer.

BROKEN HOME IN CHILDHOOD

This factor was investigated where the information was obtainable in the records. No significant differences exist in the two groups (Table 6.15). "Child-

hood" was taken as under 16.

TABLE 6.15

SUICIDES: BROKEN HOMES IN CHILDHOOD

	White	Coloured
Broken	28	9
Not broken	45	12

p = N.S.

RELIGION

Table 6.16 shows the proportions of the suicide-population affiliated to the various religious groupings.

The striking finding was the absence of Malays (Islamic Coloureds) from the series though they account for 17.1 per cent of the Cape Coloured population in the area. On the other hand Roman Catholics were significantly over-represented in both colour groups (20 whites and 5 Coloureds). This finding is contrary to what one might expect from Durkheim's classic view[227] that Roman Catholics and Jews have a

low suicide tendency. In the present series the number of Jews correlated with their proportions in the population.

TABLE 6.16

RELIGIOUS AFFILIATION OF SUICIDES

	Whites			Coloureds		
	No.	%	Pop.%	No.	%	Pop.%
Dutch Ref.	25	27	27	2	7[1]	13
Anglican	15	16[2]	30	13	45[3]	35
Rom. Cath.	20	21[4]	9	5	17	6
Main Non-Conf.	12	13	16	1	3[5]	10
Minor Christ.	9	10	8	5	17	17
Jewish	8	9	8	-	-	-
Islam	-	-	-	-	-	17
Other	4	4	2	3	10[6]	2

1, 3, 6, p = N.S. 5, $p < .05$ 2, 7, $p < .01$ 4, $p < .001$

However it must be remembered that Durkheim wrote of fatal suicides. Of these, in the present series, only one was Roman Catholic and one was Jewish. Stengel, in his series of attempted suicides, found that all religions were represented but was not able

to compare the numbers with the general population.

AFRICAN SUICIDE ATTEMPTS

This series supports the rarity of Africans presenting as attempted suicides in Cape Town, although Klintworth discovered 32 of 141 in his series of completed suicides in Johannesburg.

In the present series there were 4 African attempted suicides, 2 from each sex. All four were married, aged 16-44, and lived in the location at Langa. One female swallowed caustic soda and the other took Noludar tablets. Both males drank paraffin.

Where motivation was known marital disharmony featured prominently. Frank Matembu, a 29 year-old office boy, came from a party and quarrelled with his wife who had allowed the children to play outside when it was raining. The wife of Joseph Gangela had just left him, Martha Kayise's husband was going about with other women. No adequate information on motivation was available in the fourth case.

Although no statistical conclusions may be inferred

it is noteworthy that only one of the four, the woman who swallowed caustic soda, was admitted. One other was referred to the psychiatry out-patient department. The remaining two were discharged after physical treatment without any steps having been taken to obtain psychiatric consultation for them.

ALCOHOLICS

During the year under review it was the practice to recognize alcoholism as an illness and to admit alcoholics to the casualty ward for "drying out" and psychiatric assessment. The Park Road Hospital for alcoholics[228] had been in existence half a year and it was necessary to have available a service outside its premises where patients could recover from the acute effects of their "benders" and receive physical treatment for impending delirium tremens. Their suitability for the special intensive psychotherapeutic atmosphere at Park Road could then be investigated. It is necessary to separate this group of patients from others who might require alternative forms of treatment, such as disulfiram, or who might not benefit

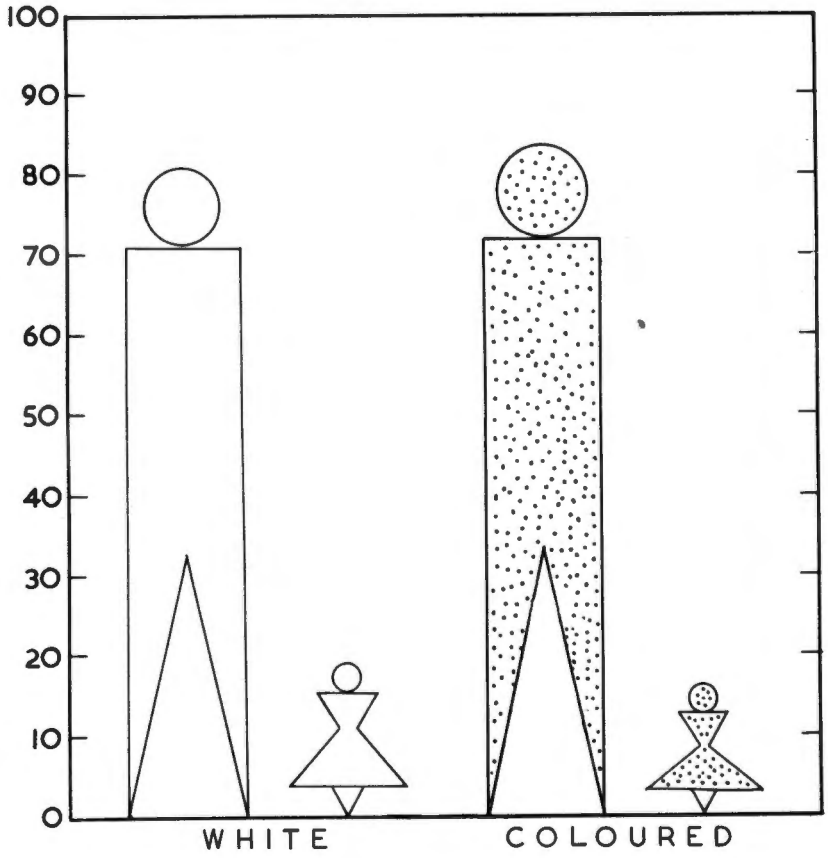

Figure 9. Sex Distribution of Alcoholics. (per cent.)

from, and actually be harmed by, intensive group analysis.

The alcoholics in the series totalled 126, a number almost equal to that of the attempted suicides and even exceeding that of the third (mixed psychiatric) group.

Race and sex distribution are shown in Table 7.1, Fig. 9, from which it will be seen that 82 per cent were males and only 18 per cent females. This is in striking contrast to the suicide group, where females outnumbered males 2:1. It is, however, no surprise finding, for social disgust for women alcoholics is such that few venture into the open and admit their addiction. In any event alcoholics in treatment accounted for only 6 per cent of the estimated 4,589,000 alcoholics of both sexes in the United States in 1953.[229] There was no significant difference between the sex ratios of the individual race groups (the Coloureds and Malays are combined). As observed for the suicides, three-quarters of the patients were white and one-fifth Coloured. Africans in the sample numbered

5 (4 per cent).

A striking finding appears when the mode of presentation is examined. Of the 96 whites 82 presented

TABLE 7.1

RACE AND SEX DISTRIBUTION OF ALCOHOLICS

	Male	Female	Total	
White	78	18	96	(76%)
Coloured	19	4	23	(20%)
Malay	2	-	2	
African	4	1	5	(4%)
TOTAL	103	23	126	

$p < .001$

as openly confessed alcoholics asking for treatment. This proportion was the same for both sexes. However the reverse was true for the 25 Coloured and Malay patients, of whom only five were frank alcoholics, the others presenting with physical complications of their alcoholism such as acute gastritis, inhalation pneumonia, or being run over by motor vehicles (Table

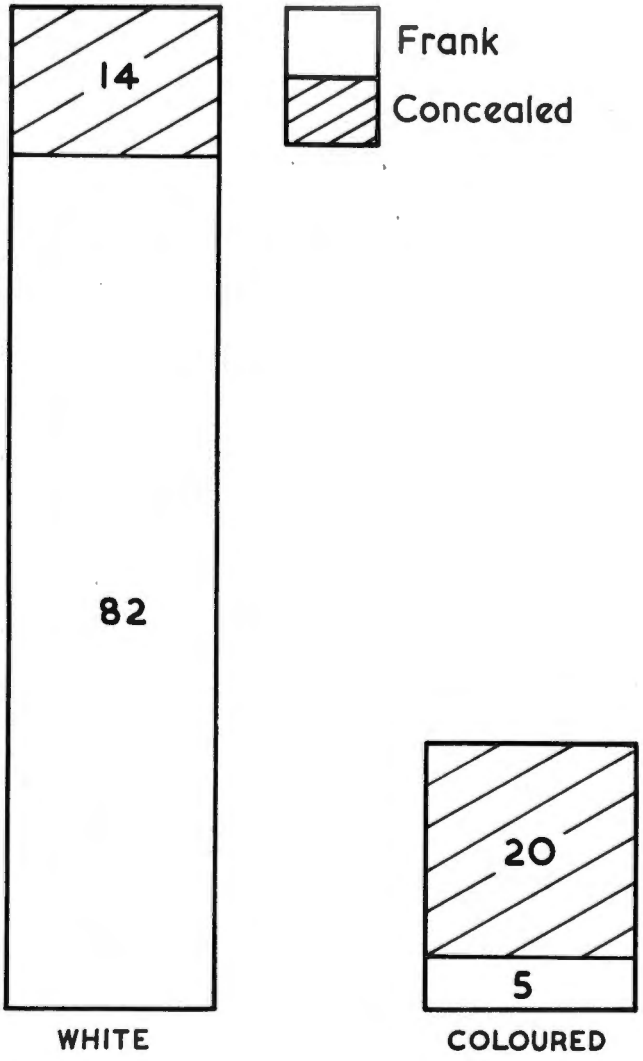

Figure 10. Race Presentation of Alcoholics.

7.2, Figure 10)

This too, is no surprising finding as no in-patient treatment facilities exist as yet for Coloured alcoholics. It has not yet filtered through to any but the small, educated, high-status stratum of Coloured people that alcoholism is an accepted illness and that medical treatment for it may be obtained.

TABLE 7.2

RACE PRESENTATION DIFFERENCES IN ALCOHOLICS

	White			Coloured		
	Male	Fem.	Total	Male	Fem.	Total
Frank Alcoholics	66	16	82	5	-	5
"Concealed" Alcoholics	12	2	14	16	4	20

$p < .001$

Moral judgement meanwhile falls heavily in the Coloured community on those who drink excessively. This critical attitude is not that of lay-folk alone.

> Hassan Davids presented with drinking as his only problem. He was sent home with

the brief note "Drunk - come back when sober".

Norman O'Riley, a 44-year-old carpenter, was sent up by his doctor as an alcoholic who had also swallowed 50 I.N.H tablets. He was hallucinated but his delirious behaviour was interpreted by the casualty doctor as "aggressive and unpleasant". After a stomach wash-out and a paraldehyde injection he was sent home three hours later in the care of his relatives.

This patient illustrates the root cause behind the ambivalent approach of the medical profession to alcoholism. It is difficult to accept disagreeable behaviour as "sick" behaviour. The doctor, moreover, "a product of his culture, may find himself morally disapproving of his alcoholic patient, prepared to treat what illness there is but unable to overlook the 'lack of willpower".[230] It should be noted that the 19 alcoholics who presented in the suicide group are not considered in this section.

AGE

While drinking often started in their teens few

alcoholics presented before the "mature" period and a higher proportion presented in the later period than in the suicide series. The figures are given in Table 7.3. There are no significant sex or

TABLE 7.3

AGE DISTRIBUTION OF ALCOHOLICS

	White			Coloured		
	Male	Fem.	Tot.	Male	Fem.	Tot.
16-24	3	-	3	1	1	2
25-44	43	11	54	10	2	12
45-64	32	7	39	4	1	5

(The age of 6 Coloureds not known)

colour differences in the proportions in the various age groups.

MARITAL STATUS

It is said that there are some women with a need to control weaker men who are unconsciously drawn towards alcoholics, while others are misguidedly attracted by powerful urges to reform them. Nevertheless

chronic alcoholism is an extremely disrupting influence on family life. This is reflected in the proportion of broken marriages in the series, far higher than that observed for the suicide group.

Twenty-one of 91 white patients (Table 7.4) were divorced. The expected number in a corresponding

TABLE 7.4

MARITAL STATUS OF ALCOHOLICS

	White			Coloured
	No.	%	Pop.%	No.
Never married	20	22	48	7
Married or Cohab.	43	47	44	10
Widowed	7	8	6	1
Divorced	21	23	2	-

(Exclusions (no information) 5 whites, 7 Coloureds, all males)

sample of the general population would have been two. None of the 18 Coloured patients where marital information was available was divorced, but the sample of Coloureds is too small to permit of inferences.

Allowing for the fact that the population-at-large of unmarried persons includes a high percentage of children, there are no apparent differences in the other categories.

> The social nature of alcoholism was shown by the Van Rensburgs, a white couple in their forties. Karen and Boetie were alcoholics who had married one another knowing this fact. Whenever Boetie went on a bender Karen stayed sober and fed and nursed him. When Karen "broke out" Boetie went "dry" and cared for her in turn.

REFERRALS AND DISPOSALS

The blind eye of the average doctor to the Coloured alcoholic reflects the lack of facilities for Coloured alcoholics and is shown in the figures for disposal of alcoholics. No Coloured patient taken into the casualty ward was admitted specifically to receive psychiatric attention for his alcoholism, while all white alcoholics who were taken in were admitted precisely for this purpose. Over 80 per cent of the white alcoholics were warded; but only 6 of

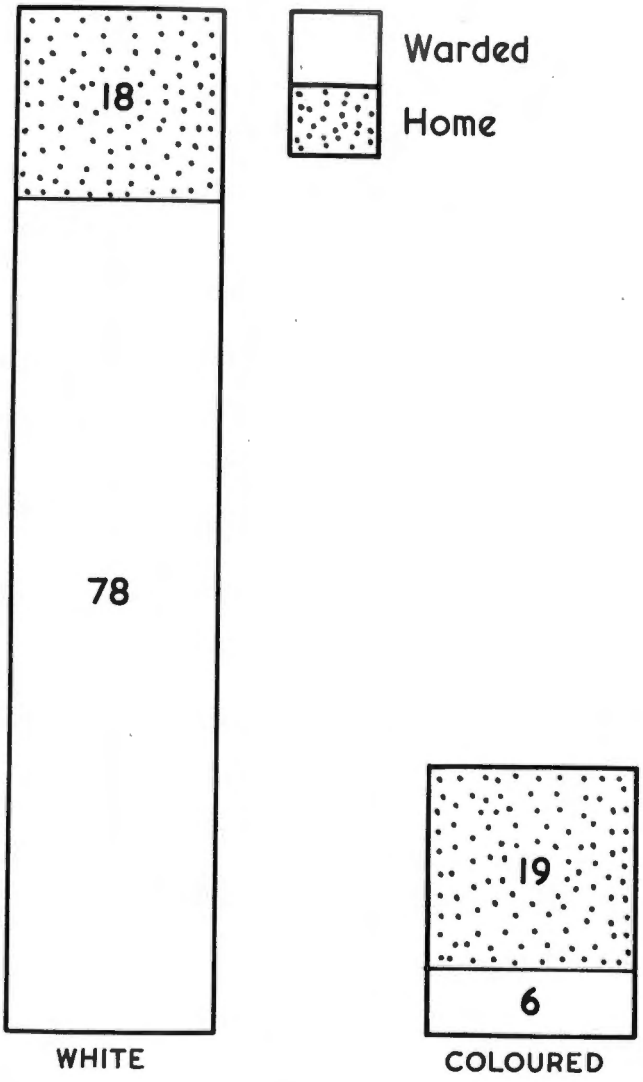

Figure 11. Disposal of Alcoholics.

25 Coloured alcoholics were (Table 7.5, Figure 11) These findings are highly significant statistically.

Of the six Coloured alcoholics admitted one had an acute Antabuse reaction with hypotension and tachycardia. It is recorded that he "could be roused - is quite mad when awake....stinks of alcohol". This

TABLE 7.5

DISPOSAL OF ALCOHOLICS

	White	Coloured
Warded	78	6
Sent home	18	19

$p < .001$

patient was next day referred to the writer at the psychiatry out-patient department where he reported that his wife controlled his Antabuse and gave it to him daily. He had been married twenty years, had seven children and was a wood-and-iron-monger owning his own lorry. One admitted female was a 29 year-old cook-general with epilepsy. She was referred to the out-patient department but did not return for

investigation. A Coloured male was similarly admitted for epileptic confusion. One labourer, 54, cut the tendons of his wrist during a bout but afterwards did not recall the details of the event. The remaining two males were admitted for minor head injuries, one of them being described as an "old gaol bird and dagga lag".

TABLE 7.6

ALCOHOLICS: METHOD OF REFERRAL

	White		Coloured
Private doctor	24	47	5
Park Road Hospital	23		-
Self-referred+	49		20

$p < .05$

Similar colour differences were observable affecting method of referral. Most of the white alcoholics came in an orthodox manner, via their general practi-

+ Self-referred includes patients brought by themselves, their families and friends, or by the police and ambulance drivers.

tioners or the medical staff at Park Road Hospital. Only 5 of 25 Coloured alcoholics were, however, so referred (Table 7.6).

SOCIAL ISOLATION

Where information was known a significant difference at the 5 per cent level was found between the two colour groups (Table 7.7). While 31 of 74 whites

TABLE 7.7

SOCIAL ISOLATION AMONG ALCOHOLICS

	White	Coloured
Isolated	31	1
In family setting	43	14

$p < .05$

lived out of their family setting only 1 of 15 Coloured patients did so.

This is in accord with the living-pattern noted for the suicide series, and there is no significant difference between the proportions of white alcoholics

and white suicides who live in social isolation in the present sample.

BROKEN HOMES IN CHILDHOOD

Insufficient information was available for most of the Coloured alcoholics to determine whether they came from a social background of homes disrupted by death or divorce before they were sixteen. However, this was so for 15 of 62 white alcoholics where data were available.

OCCUPATIONAL STATUS

Again the social pattern discernible in the suicide series was present. Most of the whites (42 of 93) were subordinate commercial workers or artisans, and a fair number (13) came from the professional and managerial class. Most of the Coloured patients, however, (10 of 18 where information was obtainable) were unskilled labourers (Table 7.8)

Statistical analysis was not attempted because of the paucity of numbers in most of the Coloured "cells".

TABLE 7.8

OCCUPATIONS OF ALCOHOLICS

	White	Coloured
"Upper"	13	-
"Middle"	42	3
"Working"	19	4
"Labouring"	7	10
"Undirected"	12	1

(3 whites, 7 Coloureds excluded for lack of information)

RELIGIOUS AFFILIATION

The religious beliefs of alcoholic patients are listed in Table 7.9. There are no significant differences between the various denominations. The excess of Roman Catholics observed in the suicide series is no longer present. Two Moslems, however, now make

their appearance, and this is noteworthy as Islam forbids alcohol to its adherents.

TABLE 7.9

RELIGIOUS AFFILIATION OF ALCOHOLICS[+]

	White			Coloured[++]		
	No.	%	Pop.%	No.	%	Pop.%
Dutch Ref.	15	20	27	2	13	13
Anglican	26	36	30	6	40	34
Rom. Cath.	9	12	9	2	13	6
Non-Conform.	14	19	16	1	7	10
Minor Christ Grps.	5	6	8	2	13	17
Jewish	3	4	8	-	-	-
Islam	-	-	-	2	13	17
Other	1	1	2	-	-	1

(23 white and 10 Coloured excluded for lack of data)

[+] In spite of the small numbers of the Coloured group percentages are included for the purpose of comparison with the general population.

[++] Percentages included despite small numbers of sample for purposes of comparison with the general population.

AFRICAN ALCOHOLICS

Legal restrictions are imposed on the sale of liquor to Coloureds and Africans in South Africa, in an attempt to control the crime and violence rates. Generally speaking Africans may not purchase any alcohol from a bottle store and are not permitted inside public houses. In exceptional cases permits are granted on application to a magistrate. Coloured males are allowed to purchase a maximum of two bottles of liquor per day, and approved persons may purchase more on application to the legal authorities.

This form of modified prohibition is constantly undermined by a network of flourishing illegal "shebeens" where alcohol is sold at high prices to all races.+ White and Coloured "smokkelaars" or runners procure liquor for these illicit houses, often using false identities. In some native locations beer halls are run by the municipal authorities for

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+ Lower-status whites and alcoholics are known to patronize shebeens at week-ends when bottle stores are closed.

the African community, but here too an underworld of "shebeen queens" compete for custom with their own special brews of "skokiaan" to which adulterous materials such as floor polish and pineapple rind may be added.

The present series included only 5 Africans, of whom 4 were males. The female was in her late forties and presented in an acute confusional state for which nutritional changes were partly responsible. Two males admitted in alcoholic stupor were allowed to sober up in the casualty department and were then discharged. One male was involved in a motor accident and entered casualty "raving" but with no serious physical injury, and was discharged.

The remaining African was a chef at a suburban hotel, referred with chronic auditory hallucinosis.

> Johnson Matabele, 52, was a Rhodesian African who complained that "I got nothing with my body...only the tricks is coming to me....Somebody talk to me and I don't see him....They want to attack me and kill me. In the night, I can't sleep, they are also there". Asked about the identity of his persecutors

> he said: "They talk to me between Ama-Xhosa and Zulu....in native languages.... I don't miss much. They started with whistling....whistling....now no whistle, is only voice. When they come I can jump out of this window".

This man had a very good work record with only two jobs in 28 years. He shared the experience of many rurally-reared Africans in that he saw his father (who went away to work in Johannesburg) for the first time when he was ten. The eldest of six siblings, he married at 27 years, paid fifteen pounds (thirty rand) and two cows as lobola (bride-price). He left his wife because she became pregnant by another man while he was away working in the city, and because he blamed the death of their infant daughter on her neglect. Since then he had spent his leisure hours as follows: "Sometime I sleep, sometime I go out....Wherever I go I meet women". A brandy-and-gin alcoholic he would send someone to buy liquor for him at a bottle store for a commission of two shillings and sixpence (25 cents) a bottle.

THE MIXED PSYCHIATRIC GROUP

Those casualty patients who presented neither as suicides nor as alcoholics numbered 112 and were racially divisible into 52 whites, 42 Coloureds and 18 Africans. Thus when compared with the first two presenting groups (Figure 5) the proportion of Coloureds and Africans is significantly higher. Table 8.1 shows the respective numbers and their percentages.

TABLE 8.1

RACIAL INCIDENCE OF SUICIDES AND ALCOHOLICS COMPARED WITH MIXED GROUP

	White	Coloured	African
Suicide and Alcoholic	203	56	9
Mixed Psychiatric	52	42	18

$p < .001$

Sex distribution is shown in Table 8.2, where it will be seen that there is little departure from the sex distribution of the general population for the

white-Coloured samples. Allowing for the small size of the African sample, however, the excess of females over males is greater than is warranted by the respective proportions of the sexes in the general population. These population proportions are shown in parentheses as percentages for comparison.

TABLE 8.2

RACE AND SEX DISTRIBUTION OF MIXED PSYCHIATRIC GROUP

	White		Coloured		African	
	No.	Pop.%	No.	Pop.%	No.	Pop.%
Male	22	48%	16	47%	4	66%
Female	30	52%	26	53%	14	34%
	p. = N.S.		p. = N.S.		p. $<$ .01	

DIAGNOSIS

Roughly one-quarter of the patients in both white and Coloured groups were psychotic, and half the Africans. The numbers are shown in Table 8.3.

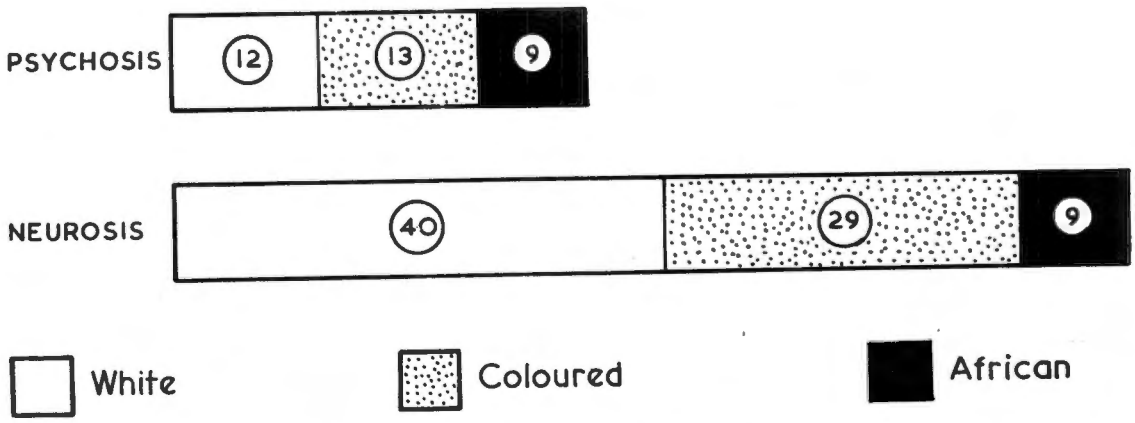

Figure 12. Mixed Diagnostic Group: Psychosis and Neurosis

Within these racial and diagnostic groups there were no significant differences for males and females.

TABLE 8.3

MAIN DIAGNOSTIC GROUPS OF MIXED PSYCHIATRIC POPULATION

	White			Coloured			African		
	M	F	Tot	M	F	Tot	M	F	Tot
Psychosis	8	4	12	5	8	13	2	7	9
Neurosis	16	36	40	11	18	29	2	7	9
	22	30	52	16	26	42	4	14	18

Nor was there any significant difference between the diagnostic presentation of the three racial groups.

Within each race-group schizophrenia was the commonest psychosis (Table 8.4).

The numbers in this sample are too few to permit of statistical analysis. From the individual cases no major clinical differences could be detected in the form of the psychoses in the three race-groups, and this finding is in agreement with the views of

Carstairs[2] and Berne.[145] For instance there was

TABLE 8.4

PSYCHOTIC SUBCATEGORIES OF MIXED PSYCHIATRIC POPULATION

	White	Coloured	African
Schizophrenia	5	8	4
Manic-Depression	3	-	2
Paranoid	1	1	-
Organic	3	4	3

little difference of form between the following two people:

> Johannes Mouton, a white fitter and turner aged 38 who lived alone in a hotel room, complained that people could see what he was thinking. "Sometimes it's coincidence and sometimes I'm not sure....If I'm booked into a room it's always numbers that seem to add up to four". This patient had the delusion that "if I am given the power I can rule the world".

The other was Susan Hendricks, 18, printer's assistant, who

> showed up one night in the psychiatric

ward after visiting hours wearing a doctor's white coat and claiming to be "Popoff, the Princess of Russia". While her manner of seeking treatment at first suggested hysteria, the presence of thought disorder, agitation, and withdrawal convinced two psychiatrists that this was really a schizophreniform condition, and she was admitted to a mental hospital.

The last patient is extremely interesting from a culturally speculative point of view. Her parents and sisters were fair-skinned+ and she was obviously darker than they. She had transformed herself not only into someone of great social significance, a princess, but had selected a country where she believed colour distinctions did not operate.

There were no Coloured manic-depressives in this sample but there were two African females with this condition, one of whom might have stepped from the pages of a 19th century text-book of psychiatry.

+ One was actually married to an Englishman and living in Britain.

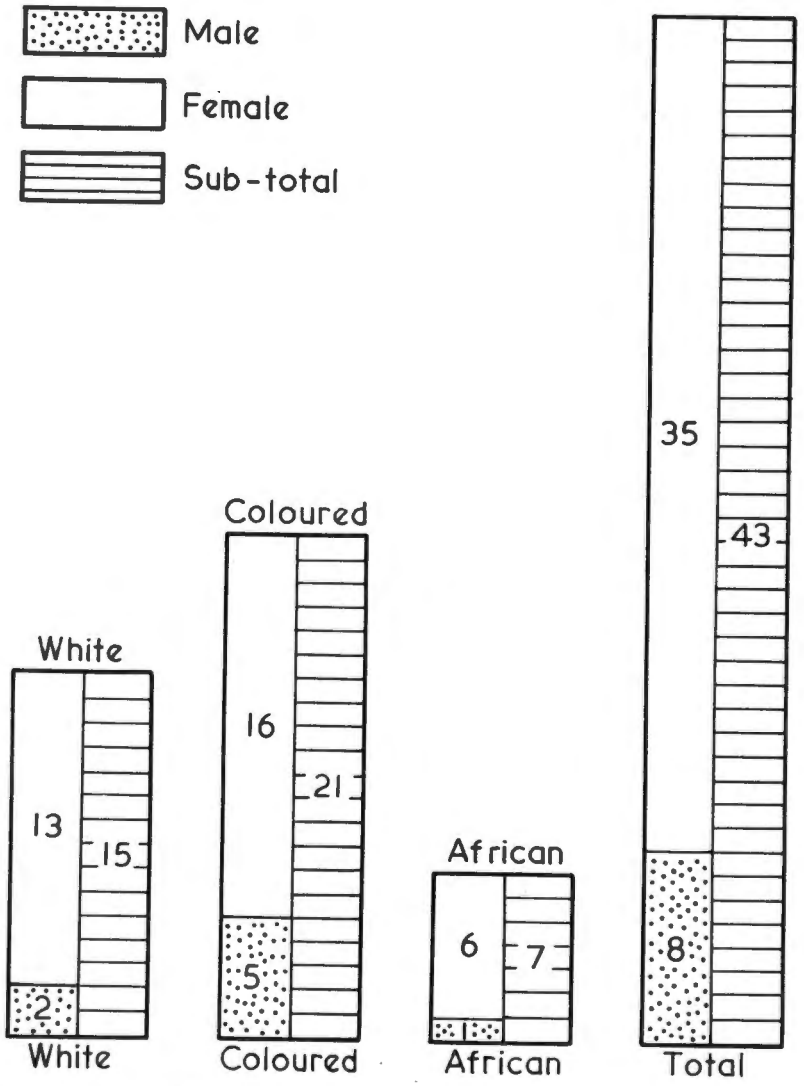

Figure 13. Sex Difference for Mixed Group Hysterics

Ellen Makeza, 60, had had electro-convulsive therapy some years previously. She was extremely depressed, wept and wrung her hands and confessed that she had sinned in 1918 by thinking bad thoughts about people and blaspheming the Deity. She had projected this into a voice which had said, "Your sins will never be forgiven". When she attended a funeral she felt that she was the one who should be buried there. This patient had been a school teacher and interpretress for a number of years.

Of the organic cases one white, a known general paretic, had an acute maniacal reaction, and two presented with amnesia on the basis of senile and arteriosclerotic dementia. There were three acutely disturbed Coloured patients, one with a toxic reaction to dagga (cannabis) and alcohol, one epileptic psychosis, and one transient acute confusional state of obscure cause. One Coloured male had a chronic dementia.

Peter Samuels, 25, unemployed, was referred because he was talking to himself and going

about naked in the streets.[+] Relatives said that his trouble had started after a dagga-alcohol debauche. He was tormented by hallucinatory voices which said "Jy, jy, nie haar nie, jy's honger vir water".[++] However this patient had largely recovered when he was seen, was correctly orientated and made sustained emotional contact.

NEUROSIS

Hysterics present as the most common form of neurosis in this casualty series. Fifteen of the 40 white, 21 of the 29 Coloured and 7 of the 9 African neurotic patients were hysterical.

Of these hysterics most were female (Table 8.5, Fig. 1
This sex ratio for all races combined is highly significant.

+ It is a flagrant contravention of the social code that often causes a patient to be referred to the casualty department, rather than to the out-patient sessions.

++ "You, you, not her .... You are hungry for water".

Among the hysterics one notably disturbed family was discovered in the white group

> Mrs. Van der Merwe, about 40, a known asthmatic, complained of "black-outs". Her husband was an alcoholic who made her life "a misery over week-ends". She already had six children, whom she could not afford, and was terrified of more.

TABLE 8.5

MIXED GROUP HYSTERICS: RACE AND SEX

	White	Coloured	African	Total
Male	2	5	1	8
Female	13	16	6	35
TOTAL	15	21	7	43

$p < .001$

She was advised to persuade her husband to seek psychiatric treatment at the hospital. However, it was her daughter, Johanna, 17, who presented next at the casualty department in July with a "black-out" following a heated argument at home.

When one came to interview the out-patient sample described in the next chapter it was discovered that

a fourth member was involved in the family neurosis.

> This was Pieter, aged 9, who was referred by the paediatric department. His mother said that he had "a pain like he wants to faint" since a minor road accident. His mother was claiming compensation and, repeatedly feeling the boy's head, insisted that the psychiatrist confirm her fears that the boy had a clot of blood on his brain. The family neurosis had, however, already infected Pieter and he was a patient in a special class on account of an incapacitating stutter.

For the writer there could have been no better illustration of the view that the child often enacts the role its mother writes for it. Furthermore, the distortion of the image of other family members by disturbed patients was illustrated when one met the boy's father, who had been conjured up as a violent, enraged, sexually-demanding alcoholic. At interview he was a quiet, soft-spoken man. He said he was "very fond of his kids" but hardly saw them because of his working hours, except at week-ends. It was then that he drank. "If I got a drink in I just goes to my bed....Some week-ends I'm in bed all

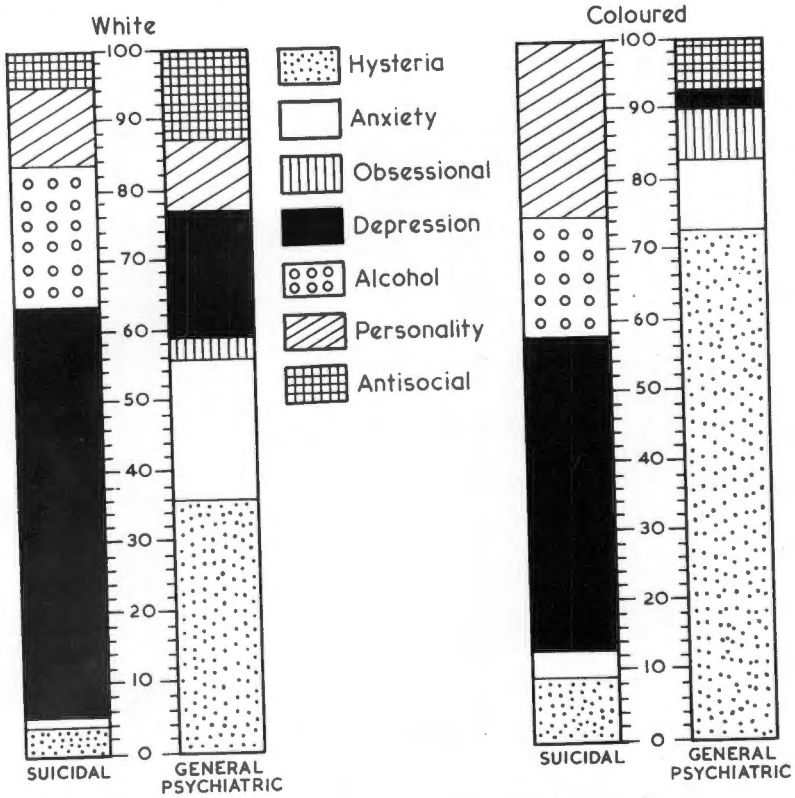

Figure 14. Comparison between Suicidal and Mixed Group Neurotics

the time....I doesn't fight or argue with nobody.... when I got a drink in I just goes to sleep".

Quite a different picture of the family thus presented itself when all the key members had been seen. Here was a hypochondriacal, hysterical, aggressive mother, and a father who was actually the passive one and who chose the path of least resistance when he came home at week-ends to the tense family atmosphere. Here were two children in the family already involved in the mother's neurosis. Psychodynamically the mother, a typical hysteric, had trouble with her aggressive and sexual feelings and periodically would decompensate into a dissociative state. The father chose to obliterate himself rather than face up to his wife's aggression and allow his own feelings to enter the family pool. The daughter was manifesting the same condition as her mother, and even the little boy had a "pain in his head like he wants to faint".

The distribution of the neurotic sub-types is shown in Table 8.6 and figure 14.

It will be seen that in this casualty population

of patients with neurosis, anxiety conditions were next in frequency in all races. Nine white anxiety

TABLE 8.6

NEUROTIC SUBTYPES: MIXED GROUP

	White	Coloured	African
Hysteria	15	21	7
Anxiety	8	3	2
Obsess-Comp.	1	2	-
Depression	7	1	-
Personality disorder	4	-	-
Sociopathy	5	2	-
TOTAL	40	29	9

states and obsessive-compulsive reactions, five Coloured and two Africans thus presented.

In both the Africans the anxiety was adulterated by prominent hysterical symptomatology.

> Milton Ganza, 37, a labourer, complained of pain and tightness in his throat; and Miriam Kumelo, hyperventilating at 28

breaths per minute, presented on account of the pain in her chest which it caused.

In the Coloured patients the anxiety aspects were more marked, though somatic symptoms were also present.

Joan Abrahams, 21, a machinist from a Western Province small town was referred as a case of thyrotoxicosis, but a physician was satisfied that she had no hyperthyroidism. The prominent feature in the case was overt anxiety such that the patient restlessly and repeatedly clasped and unclasped her hands. This patient had been troubled from the age of 9, when her mother became insane. "Ons kinders het geslaap. Vroeg in die oggend toe hoor ons 'n geraas in die kombuis.... toe was dit Mammie. Toe hardloop Mammie weg af in die pad in. Pappie en 'n groot jong het vir Mammie gevang. Toe bring hulle vir haar huis-toe en stuur hulle haar Pinelands toe".+

+ "We children slept. Early in the morning we heard a noise in the kitchen ... it was Mother. Then Mother ran away into the road. Father and a big boy caught her, brought her home, and sent her to Pinelands".

> Since then the patient's home had been broken up. Her father had become blind and lived in a chicken coop in Cape Town, and she went to live as a tolerated member of her aunt's family with its several children and strained economy.

This patient also complained of "lameness", and of sleep troubled by nightmares of "gediertes" (wild animals) which woke her so that she shook and screamed in terror. The present illness had been precipitated by a pregnancy which it was necessary to hide from her aunt and cousins.

The other two patients were males, one complaining of impotence and the other presenting with tension headache and insomnia.

AGE AND MARITAL STATUS

The age and marital distribution of the group showed no marked differences from the general population proportions (Tables 8.7 and 8.8).

The proportion of white divorcees was, however,

significantly higher than in the general population.

TABLE 8.7

AGE DISTRIBUTION OF MIXED GROUP

	White	Coloured	African
0-24	11	22	4
25-44	21	15	12
45-74	19	3	2

TABLE 8.8

MARITAL STATUS OF MIXED GROUP

	White	Coloured	African
Never Married	19	25	5
Married or Cohab.	22	15	10
Widowed	3	-	2
Divorced	8	2	1

OCCUPATION

No differences were demonstrable between the occupational gradings of the patients in this group and that observed for the suicide and alcoholic groups

(Table 8.9)

The usual pattern of colour differences was observable, whites being concentrated in the "middle"

TABLE 8.9

OCCUPATIONAL STATUS OF MIXED GROUP

	White	Coloured	African
"Upper"	6	3	-
"Middle"	18	2	-
"Working"	7	16	-
"Labouring"	-	6	6
"Undirected"	19	13	9

and "upper" strata, Coloureds and Africans in the "working" and "labouring" strata. A large proportion of all three races were not occupationally directed to increasing the family economy.

Educational status was not analysed as the data for this variable were obtainable in relatively few cases.

RELIGIOUS AFFILIATION

No significant differences were statistically observable among the religious denominations adhered to by patients in this group (Table 8.10) except for the Coloured patients in the Minor Christian group.

TABLE 8.10.

RELIGIOUS AFFILIATION OF MIXED GROUP+

	White			Coloured			African
	No.	%	Pop.%	No.	%	Pop.%	No.
Dutch Ref.	16	39	27	1	3	13	-
Anglican	14	34	30	11	34	35	4
Rom. Cath.	5	12	9	1	3	6	-
Non-Conf.	-	-	16	1	3	10	3
Minor Christ.	4	10	8	13	41[1]	17	1
Jewish	2	5	8	-	-	-	-
Islam	-	-	-	5	16	17	-
Other	-	-	1.6	-	-	1.5	1

1, $p < ,001$

+ Percentages are given for the Coloured group despite the small numbers, for purposes of comparison with the general population figures.

Photograph 4: Shirley Tamil and family. The husband was admitted to the surgical wards with acute abdominal pain for which no cause was found.

Of the 13 Coloured patients in the Minor Christian Group 8 were members of the Apostolic Church, 3 were Moravians, 1 Calvinist and 1 a member of the Jehovah's Witness sect. Of the 4 whites in this group 3, the Van der Merwe mother and daughter and one other were members of the Apostolic church.

Cultural and religious influences were strikingly shown in the following patient:

> Shirley Tamil, 23, was a patient previously admitted to the ward for asthma with a prominent psychological background. She now presented with "black-outs" which were undoubtedly hysterical.
> Her father was a white salesman, and her mother a Christian Indian. She was the eldest child with 4 younger brothers, and involved in an emotionally incestuous relationship with her father. She would deliberately provoke him, a man of quick temper, to beat her repeatedly. She said that her mother was despised by her father "because he hates Indians, especially Christian ones". This disturbed man had also stated in interview that he hated all Coloured people. Nevertheless his drinking companions were Coloured men while he worked as a white. When this patient was 16 she

became involved with a young Hindu medical student, at first in order to tease her father. There were repeated angry scenes, her father saying that he wished to choose a light-skinned Coloured man for her. Why had she chosen a dark-skinned Indian of all people ?
At this stage of the patient's life her asthma featured prominently. However, after the patient married her lover, black-outs made their appearance. It was here that there developed a conflict with her mother-in-law which had not previously become apparent. This lady expected her eldest son, in the usual tradition to live with her, and his wife to become a junior member of the Hindu joint-household.[231] Moreover the family, in line with Hindu custom, leaned financially on her husband, an eldest son, who had given up his studies in order to contribute to the economy. There were repeated dissociative experiences during which the patient would, in a "black-out", wander away from home or physically assault her husband or his siblings. Periodically the patient would win out and the couple would move away from the parents, but eventually would return. On one such occasion the husband was admitted as an emergency to the surgical wards for acute

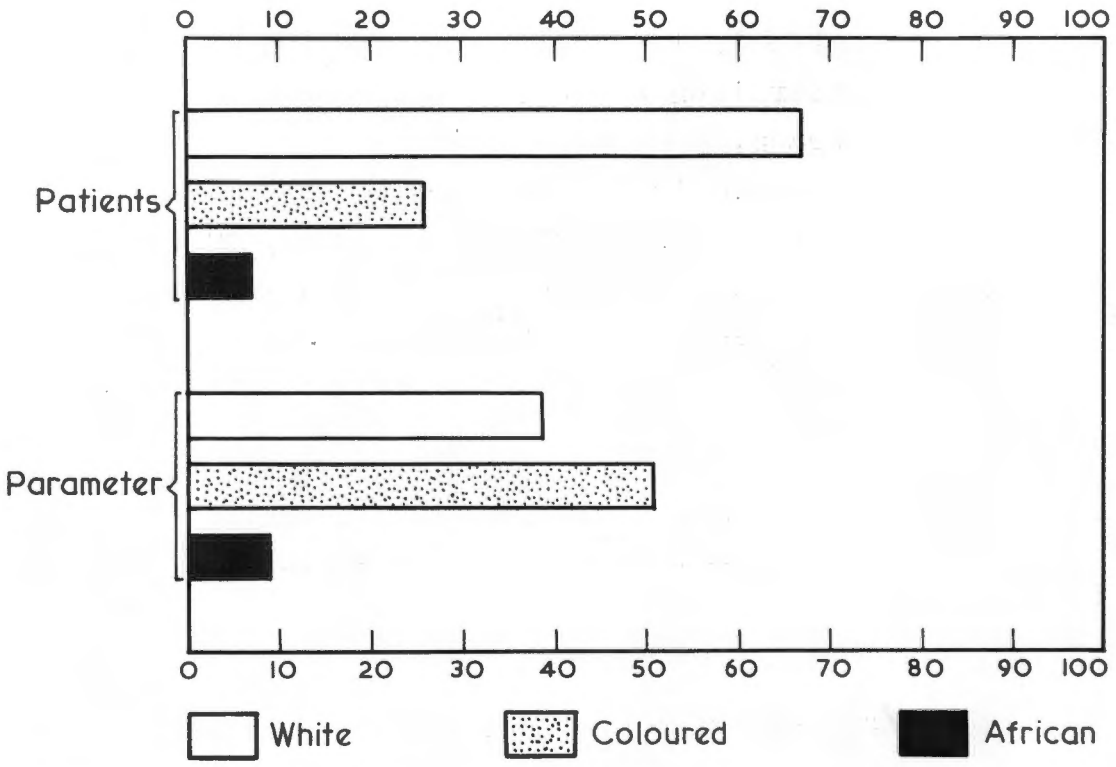

Figure 15. Racial Composition of Combined Groups

abdominal pain but was discharged without operation and a diagnosis of functional spasm.
Remarkably, a peace has now come over this patient since the birth of her first child. Her asthma and her blackouts have ceased for several months. She appears to have accepted her new status in her husband's family.

THE TOTAL CASUALTY SERIES

When all three sub-groups are combined the effect on the considerable prevalence differences found in the suicide and alcoholic groups by the mixed group is felt as a diminution of the white proportions and an increase in the Coloured in respect of their parameters (Figure 15) The numbers in the combined sub-groups are shown in Table 9.1.

Significant over-representation of whites and under-representation of Coloureds is still present at very highly significant statistical levels. There is however no significant difference between the proportion of Africans in the sample and in the general population.

These differences observed in the total population must be viewed as stemming mainly from the numerically-large suicide and alcoholic groups with their

TABLE 9.1

RACIAL COMPOSITION OF COMBINED GROUPS

	White	Coloured	African
Sample	255 (67%)	98 (26%)	27 (7%)
Parameter	278,555 (39%)	365,475 (51%)	65,025 (9%)
	$p < .001$	$p < .001$	p=N.S.

overwhelming differences in white-Coloured proportions. When one isolates the more general group from the other two the statistically significant difference between the white proportion and its general population parameter disappears. The Coloured sample however continues to be under-represented at significant levels ($p < .01$).

SEX

An apparent increased proportion of white and Coloured males over females (Table 9.2) is not significant

in respect of the parameters. African females are over-represented however (17 of 27 patients). This finding is significant and all the more striking as the African population of Metropolitan Cape Town is two-thirds male.

TABLE 9.2

SEX DIFFERENCES IN RACE GROUPS

	White			Coloured			African+		
	No	%	Pop %	No	%	Pop %	No	%	Pop %
Male	133	52	48	50	51	47	10	37	66
Female	122	48	52	48	49	53	17	63	34
	p=N.S.			p=N.S.			p <.01		

DIAGNOSIS

An apparent difference between the ratio of psychosis over neurosis for white and Coloured is not significant when statistically examined, even though 9 per cent of the Whites and 16 per cent of the Coloureds and

+ Percentages given for comparison with parameter despite small numbers.

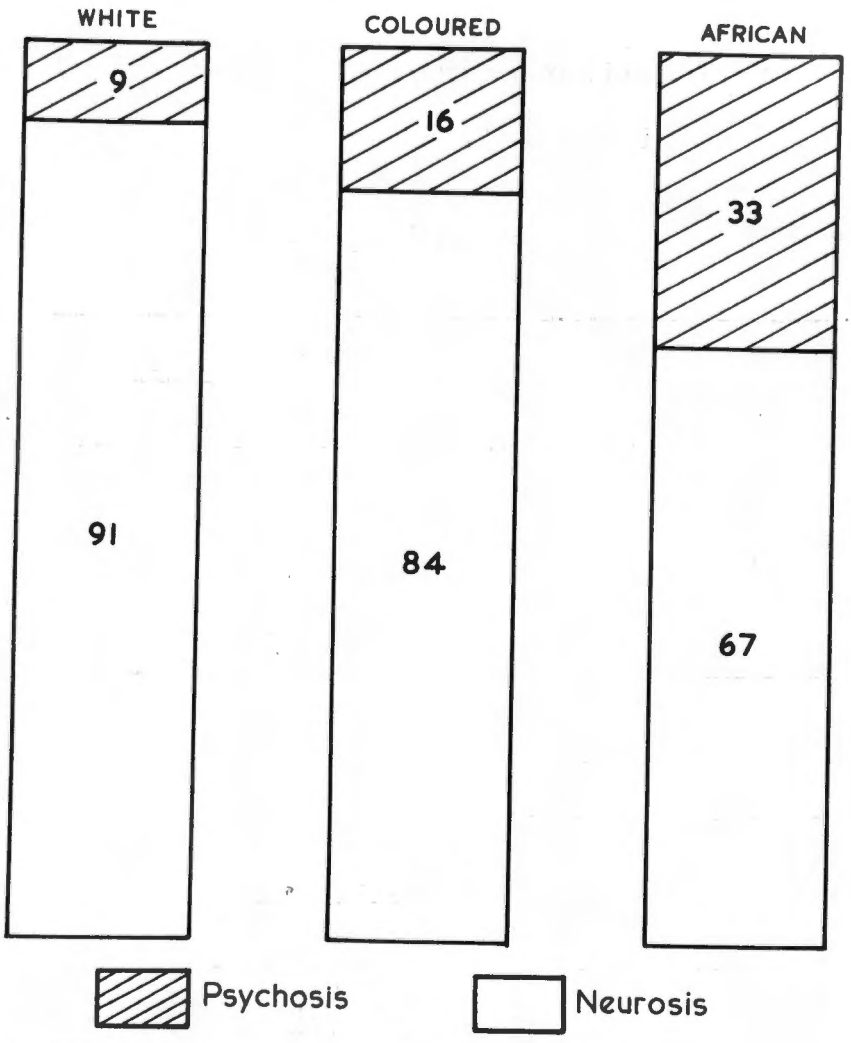

Figure 16. All Casualty Groups Combined.

9 of 27 Africans were psychotic respectively (Table 9.3 and Figure 16).

Table 9.3

MAIN DIAGNOSTIC TYPES			
	White	Coloured	African
Psychosis	22	16	9
Neurosis	232	82	18
		p=N.S.	

Table 9.4 and 9.5 show breakdowns for the psychotic and neurotic groups.

TABLE 9.4

PSYCHOTIC SUBTYPES: COMBINED CASUALTIES			
	White	Coloured	African
Schizophrenia	6	8	4
Manic-dep.	8	1	2
Organic	7	6	6
Paranoid	1	1	-

Half the Coloured psychotics were schizophrenic but only just over a quarter of the whites. On the other

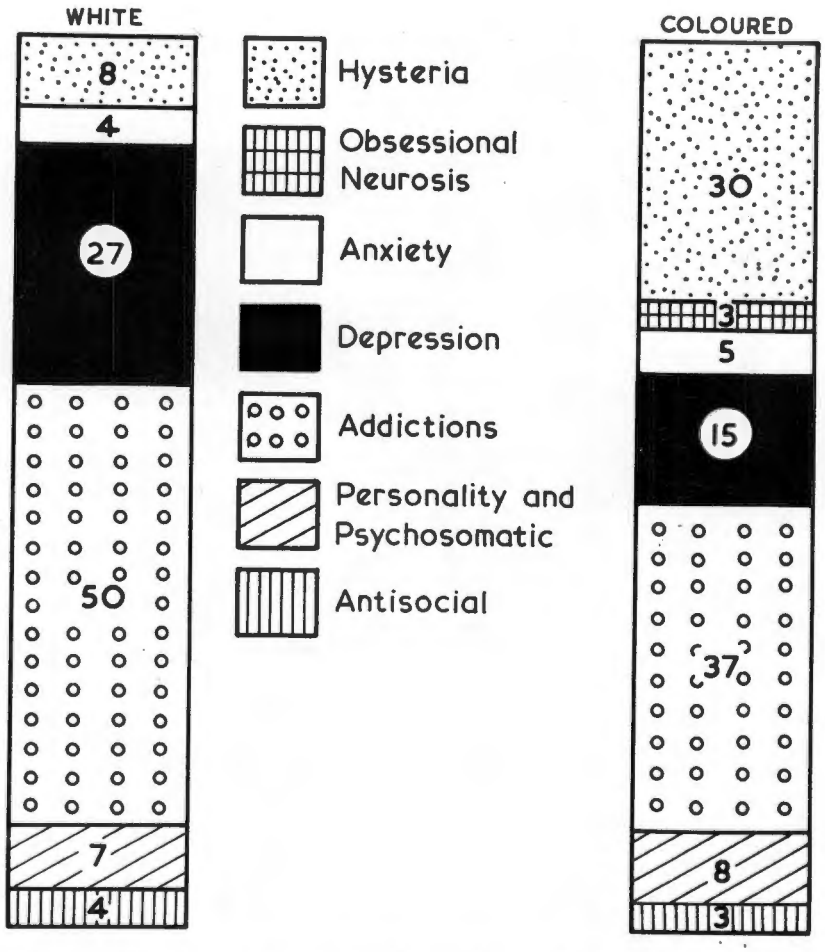

Figure 17. Neurotic Subcategories: Combined Casualty Groups.

hand proportionately six times as many whites were manic-depressives as Coloureds (8 of 22 as opposed to 1 of 16). There were about the same proportions of organic cases and paranoids for each of the two main race groups in the total casualty population.

TABLE 9.5

NEUROTIC SUBTYPES: COMBINED CASUALTIES

	White	Coloured	African
Hysteria	19	25	7
Obsess. N.	1	2	-
Anxiety	9	4	2
Depression	63	14	4
Addictions	115	29	5
Personality	15	6	-
Antisocial	10	2	-

Among the neurotic patients the alcohol-addictives formed the largest single diagnostic grouping for both white and Coloured and were second only to hysteria among the Africans. As a social problem in South Africa transcending all colour bars alcohol looms large. This

is so even when, as we have seen, its magnitude among the Coloured people is camouflaged by an artefact of selection which operates on social premises. Depressives form the second largest white group and the third largest coloured group; and this group is then followed by the hysterics (30 per cent of the Coloureds but only 8 per cent of the whites).

The figures for the different diagnostic sub-types are distorted by the fact that this is a casualty population, selected by the definition that each case is an emergency, spewed up with dramatic suddenness by an environment which can no longer contain it. In the next chapter, which surveys the people of a psychiatric clinic, a different type of patient should theoretically make his appearance, outwardly calmer and less disturbing to his milieu.

REFERRALS AND DISPOSALS

There was no difference between white and Coloured for referral agencies. The same proportions came referred by doctors; and by their families. This is considered to be an important finding, for while it is

the rule in an out-patient clinic for all patients to come with doctors' letters, this practice does not apply to the casualty department. Does it mean that doctors are employed to the same extent by the psychiatrically ill of both colour sections ? If this is so, some of our arguments attempting to explain the disproportiate race incidences are vitiated (see later). (Table 9.6).

TABLE 9.5

REFERRALS OF ALL PSYCHIATRIC EMERGENCIES

	White		Coloured	
Gen. pract.	113	(44%)	43	(44%)
Self and fam.	112	(44%)	53	(54%)
Other depts.	30	(12%)	2	(2%)

There were however valid differences in the disposal of all psychiatric casualties, and a highly significant proportion of white were warded compared with the Coloured patients, who tended to be treated without

being admitted (Table 9.7).

TABLE 9.7

DISPOSAL OF ALL PSYCHIATRIC CASUALTIES		
	White	Coloured
Admitted	210 (82%)	55 (56%)
Not admitted	45 (18%)	43 (44%)
	$p < .001$	

Part of this apparent discrimination may well be due to the fact that with the bigger demand for Coloured beds by physical accident cases, fewer Coloured beds are available to the "less urgent" psychiatric casualties (see Table 4.2 and Figure 4) who consequently have to be sent home. On the other hand the perusal of individual case files suggests that other factors are operating as well, not maliciously, but as a kind of clinical blindness. While attention is given to the physical needs of the dark-skinned patient, his psychological requirements are not given sufficient heed.

One can well see why this could be so, for to enter

into the psychological world of a Coloured patient, as with a European, and this is necessary for treatment, one has to drop one's authoritarian position, and to enter into an emotional relationship which is prohibited by the accepted social code. Moreover, the world of the low-status individual is filled with irremediable social problems so discouraging to the enquiring doctor, that he finds it easier to avoid all contact with it, and to conform to his generally accepted professional role.

RELIGIOUS AFFILIATION

Significant differences were observed in the Roman Catholic, Non-Conformist, Minor Christian and Islamic groups (Table 9.8).

Among the whites Roman Catholics were in excess (16%) and among the Coloureds, members of minor Christian groups. On the other hand Coloured Non-Conformists and Islamics were less evident. This does not mean, however, that these groups are necessarily protected by their cultures, but only that they present less

commonly at the casualty department.

TABLE 9.8

RELIGIOUS AFFILIATION: ALL PSYCHIATRIC CASUALTIES

	White			Coloured		
	No.	%	Pop.%	No.	%	Pop.%
Dutch Ref.	56	27	27	5	7	13[1]
Anglican	55	27	30	30	40	35
Rom. Cath.	34	16	9[2]	8	11	6[3]
Non-Conf.	26	13	16[4]	3	4	10[5]
Min. Christ.	17	8	8	20	26	17[6]
Jewish	13	6	8	-	-	-
Islam	-	-	-	7	9	17[7]
Other	6	3	2	3	4	2

(48 whites excluded and 22 Coloured - no information)

[1,3,4] p=N.S. [2] $p < .001$ [5,6,7] $p < .05$

AGE DISTRIBUTION

This followed the general pattern seen in the three component classes. Young persons were under-represented

and middle-group patients over-represented. Late group whites were in excess but Coloureds equal to their proportion in the general population (Table 9.9).

TABLE 9.9

AGE DISTRIBUTION: ALL PSYCHIATRIC CASUALTIES

	White			Coloured		
Years	No.	%	Pop.%	No.	%	Pop.%
0-24	47	19	44	35	39	63
25-44	123	48	31	43	48	25
45+	84	33	25	12	13	13

However these figures are artificially influenced by the large numbers of infants and young children in the general population not represented in the sample.

OCCUPATIONAL STATUS

The pattern of the component diagnostic classes is not departed from (see Table 9.10). Whites cluster at the "middle" levels and Coloured patients at the

"working" and "labouring" levels.

TABLE 9.10

OCCUPATIONAL STATUS: ALL PSYCHIATRIC CASUALTIES

	White	Coloured
Upper	37 (15%)	4 (5%)
Middle	97 (40%)	11 (13%)
Working	42 (17%)	31 (36%)
Labouring	8 (3%)	23 (26%)
Undirected	59 (24%)	18 (21%)

(12 whites and 11 Coloureds excluded - no information available)

Sixty-five per cent of the whites were in white-collar occupations and 62 per cent of the Coloureds in overalls. There is no reason to suppose that this represents any departure from the occupational hierarchy of the general population although no comparative figures are available.

SOCIAL ISOLATION

Significantly more whites than Coloureds (38% to 19%) were isolated from their families. Again we believe that this is in conformity with general trends, and is governed by socio-economic circumstances.

TABLE 9.11

SOCIAL ISOLATION: ALL PSYCHIATRIC CASUALTIES

	White	Coloured
Isolated	78 (38%)	14 (19%)
With Family	130 (62%)	60 (81%)

(No information: 47 whites, 24 Coloureds)

$p < .01$

In the urban Coloured communities accomodation is at a premium and families cannot afford to split. Hotels, "bachelor" flats and single-person households are virtually non-existent.

The question must be asked: If social isolation is associated with suicide, does the relative absence

of social isolation among Coloured persons correlate with the low attempted suicide rates of Coloured persons presenting at the hospital ? In the section on general discussion (see later) we will take up the tempting questions which here raise themselves.

SUMMARY

This chapter deals with the prevalence of different psychiatric emergencies among the white, Coloured and African race-groups presenting at an urban general hospital in Cape Town. It was found that three large diagnostic groups presented - of roughly equal sizes- attempted suicides, alcoholics and a mixed (general) group. In all the psychiatric casualties as in the individual diagnostic groups the races were disproportionately represented, with an excess of whites and a deficiency of Coloureds and Africans. This was less so for the mixed group than for the two others nor were the Africans significantly under-represented in the total psychiatric casualty population.

Among the suicides race differences were noted for method. Both white and Coloured groups preferred

tablets (a change noted over the preceding decade), but thereafter whites chose violent and Coloureds poisonous means. More Coloured suicides were sent home and more whites admitted to observation wards. However the proportions of psychosis:neurosis in each group was equal (1:9) and of the neurotics most were depressed irrespective of their skin colours. More Roman Catholics attempted suicide in the present series than was expected from perusal of the literature; and no Malays made suicide attempts at all.

In this series cultural differences were noted among the alcoholics. Many more whites than Coloureds presented as alcoholics asking for treatment for their condition and were warded. Coloured alcoholics who entered the series did so on account of physical complications of their alcohol-addiction such as being run over by motor vehicles. The casualty medical officer confronted with the Coloured alcoholic was at a loss, found him aggressive, drunk, and disagreeable, treated his physical condition and discharged him.

In the mixed diagnostic group significantly more Coloureds and Africans presented. Although the Col-

oureds were still less than their parameters the Africans exceeded theirs. Sex differences observed in the other two groups (suicides, 2:1 female; Alcoholics, 4:1 male) disappeared in the mixed group except for the Africans where the general population ratio was reversed. In this diagnostic group psychosis was more common than among the attempted suicides, and of the psychoses schizophrenia was the most prevalent. In the neurotic group hysteria, an acting-out disorder, was the most common, especially among the Coloured patients (72 per cent).

When all three groups were combined the over-representation of whites and under-representation of Coloureds persisted. Nosologically, however, the same proportions of psychosis and neurosis existed although schizophrenia was commoner for the Coloured group and manic-depressive illness for the white group.

Among the neurotics alcoholism was rife in both colour-groups followed by depression in the whites and hysteria in the Coloureds. Though patients from both colour-groups were similarly referred they were differently disposed of, and fewer Coloureds were admitted

for treatment. Roman Catholics and Minor Christian sect followers exceeded their proportions and Islamics and Coloured Non-Conformists presented less commonly.

For all groups individually and collectively young persons were under-represented and the maximal prevalence was between 25-44 years for all ages. Whites conformed to their general hierarchical pattern and were white-collar workers who had reached partial secondary-school levels. The modal Coloured patient was a workman or labourer who had only attained a primary school education. In both the suicide and alcoholic groups divorced persons were significantly over-represented.

CHAPTER VI.

The Out-Patient Psychiatric Clinic

This chapter describes all new psychiatric patients who presented at the hospital out-patient clinic between December 1st, 1959 and April 30th, 1960. "New patients" implies that such persons had never before attended this clinic for a psychiatric condition; but they might have had previous psychiatric illnesses treated elsewhere, attended other departments of the hospital, or received private psychiatric treatment for their present complaints before presenting at the clinic. In practice relatively few private-class patients do attend, as the hospital admits persons from this economic class to its wards only under special circumstances. The clinic population may thus be regarded as not wholly representative of the upper-income levels in the general community to this extent.

Again, it would be justifiable to draw conclusions for "hospital incidence" only out of the findings of this study. Other official treatment agencies operate in the community. There is a psychiatric clinic linked to the government mental hospital, smaller hospitals have their honorary psychiatric consultants and a new psychiatric department has been initiated at a general hospital in the northern suburbs. In practice it would be fair to say that the hospital (as the largest out-patient centre) sees the bulk of doctor-referred neurotic patients in the community and a fair proportion of the psychotics. General practitioners largely ignore the circularised advice that psychotic patients should not be referred here because they fall under the Mental Disorders Act, and should therefore be admitted to the government mental hospital. Many psychotics present, referred by their doctors for diagnosis and treatment, and a separate out-patient electroplexy clinic is operated for non-certifiable cases, certifiable patients being admitted to the mental hospital by arrangement.

It would also be unwise to disregard the presence

of non-official treatment agencies operating in the different cultural strata. Roman Catholics have their confessionals and other faiths their religious ministers, who in a sense all enter into treatment relationships. Malays have their doekums and sheikhs+, Africans their witch-doctors, and whites their lay and religious faith-healers. African patients have stated that they had always regarded mental disturbance as "native sickness" and have expressed surprise when told that psychiatric disturbances occurred in other groups as well, and that the hospital provided treatment facilities for all. The reason for this appears to be the weaving of mental illness into the fabric of traditional tribal life. The institutions of the izangoma and thwasa described in chapter 3 have been elaborated out of this. One might expect therefore to see only relatively sophisticated Africans come forward for treatment; and also those so disturbed that they can no longer be contained within the community.

+ Religious healers. Sheikhs pronounced "shechs".

> Samson Supate, a young farm labourer awoke one morning to be told by his friends that he had "died" the previous night (he had actually had an epileptiform seizure). Immediately he left for the city in order to seek out a witch-doctor who could help him. He saw two in succession who diagnosed that he had been bewitched by his stepmother in the Transkei, who had placed 'mtagat+ on a letter he had received from his wife the previous week. The patient had now become completely irrational in his panic and fought off those who attempted to control him. His friends bound him to a bed while they went off to work during the day and fed him only at night. When he had a further seizure in their presence he was finally brought to a white doctor who referred him to the hospital.

And even relatively sophisticated Europeans have been known to take their mentally-ill relatives to herbalists, witch-doctors and doekums for advice.

That these non-medical agencies are established among the lesser-developed cultural groups is in fact understandable, when one recalls the historical fact that western psychiatry was until only very recently the

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+ Bad medicine.

concern of the ecclesiastic and not the doctor. In South Africa the psychiatric revolution which took place in Europe and North America one-and-a-half centuries ago is only just evolving.

SETTING

The psychiatric clinic is held on two afternoons a week in the hospital out-patient department, and is combined with the neurology clinic. Staffing during the period studied was by three consultant psychiatrists, two registrars (one from the Park Road Hospital), two house-physicians, and a psychiatric social worker. An additional consultant joined the staff for one afternoon a week. Occasional cases might be mis-sorted and seen by one of the two neurologists or by a medical registrar. These would usually be referred to one of the psychiatrists by them, especially if psychotherapy was indicated.

In fact, such was the understaffing and the pressure of patients that few could be given adequate insight-therapy at the clinic. A few of those who needed concentrated psychotherapy were actually admitted to the

ward (where beds were at a premium) for this purpose. The majority received brief supportive interviews and drug treatment; and the electroplexy clinic was available for those who required this form of treatment on two separate sessions weekly.

The patient-mass was mainly drawn from the people of Metropolitan Cape Town but a small proportion came also from a wider catchment area which embraced small towns and rural villages in the Cape Province. The only fee was one shilling (ten cents) per session, and even this small charge was waived in indigent cases. However, for many poorer Coloured and African patients even suburban transport charges to and from the hospital represented a considerable proportion of their weekly earnings.

All new psychiatric cases were divided among the consultants and registrars, while the house-physicians saw only cases which had been referred to them by the others after diagnosis had been made and treatment established. This "passing-on" process was made necessary by the need to cope with the constant stream of new patients presenting at the clinic.

METHOD

The study goal was to personally interview every "new" patient arriving at the clinic during the five-month period. All the doctors at the clinic were informed of this and were asked to refer their new patients to the interviewer after they had been seen by them. The nursing staff were alerted and a nursing-sister took it as one of her special duties at the clinic to affix special labels to the new-patient folders reminding all staff who came into contact with a patient that he was to be seen. She also explained to patients why they were to be seen by a second doctor. The psychiatric social worker was also involved in the attempt to make the sample one hundred per cent.

It was not, however, possible to see every new patient at the clinic itself for a variety of practical reasons, and appointments had to be made for several who were then subsequently interviewed at their own convenience in the department on non-out patient days. Sometimes patients were not able to wait at the clinic; at other times the number attending was too many for all to be seen in one afternoon; and the interviewer

had routine duties to carry out apart from the research. When indigent patients were asked to attend for research-interviews their transport was paid for as part of the research costs.

The interviews themselves took place according to a schedule (see below). They were however by no means structured question-and-answer exchanges but psychiatric interviews during which emotional rapport was sought and appropriate interpretations made. The interview schedule itself was memorised and maintained only for guidance and uniformity, so that in many cases treatment-relationships were established and the patient subsequently taken over for treatment by the researcher with the approval of the patient's consultant. This participant-observer approach was decided on rather than that of formal questioning which might result in facts being obtained, but not appreciation of the subtle feeling-tones and psychodynamic processes which were operating in the patient's case. Another decision which had to be made was whether patients were to be informed that the interview was for research purposes. It was felt that this might prejudice the story, and so it was de-

cided to go into full explanatory details only in those cases where patients wished to know specifically. Remarkably few patients showed this curiosity and the vast majority were content to accept the general introduction by the sister and psychiatric social worker which told them something about the purpose of the interview but did not go into special details.

THE SCHEDULE

The full schedule is reproduced in Appendix C. The first page provided for identifying information. On it were listed the research protocol number and the hospital folder number. Other data followed such as the patient's name, date of birth, age, address, telephone number, marital state, race and ethnic group, parents' names and marital state and their ethnic affiliation. Method of referral, date examined, and the name of the consultant psychiatrist were also stated.

The second page was blank and available for the notes of the clinical examination. The third and fourth pages listed the diagnostic classification used in the study. The consultant psychiatrist was required only

to ring the appropriate diagnostic group.

The remainder of the schedule contained sociological and family information on

OCCUPATION

Present work.

Previous work.

Where ? How long at each job ? Status ?

Reasons for leaving. Periods of unemployment.

Salary. Additional income from wife or children.

HOUSEHOLD

Type of dwelling e.g. flat, hotel, room.

Construction. Number of rooms and type.

Full list of occupants. Rental or equivalent.

EDUCATION

Names of schools, level of education and educational achievements.

REARING

Birthplace, rearing, type of community (whether urban, semi-rural or rural). Cultural environment e.g. "small Afrikaans village" or "typically English" urban suburb.

LANGUAGE

Home language. Other languages. Languages spoken in parental home.

RELIGIOUS ATTITUDE

Denomination in which reared. Present denomination. Regularity and habits of attendance. When last attended place of worship. Degree of faith (self-assessed) according to the scale: very religious, moderately religious, just religious, not religious, anti-religious.

SOCIAL AND CULTURAL ACTIVITIES

Leisure activities. Reading habits. Type of newspaper, book, periodical. Films. Music. Sport. Dancing. Club membership.

FAMILY

Parental attitudes. Personality of both parents. Siblings: number of siblings, order in the sibship. Present marital state and occupation of other siblings. Dominant parent.

SEXUAL ADJUSTMENT

Age when information obtained and source. Menarche (girls). Masturbation. Age of first heterosexual interest and premarital experiences.

Homosexuality. Love affairs. Engagements. Age at marriage(s) and duration. Marital sexual data. Reasons for marriage.

CHARACTERISTICS OF SPOUSE

Social background, education, religion, home language. In-law information.

RESULTS

During the five-month period 506 new psychiatric patients made their appearance at the clinic of whom 427 were personally interviewed and so entered the study. Seventy-eight patients were "lost" i.e. they did not keep their appointments or might not have been referred by consultants. However the sample reflects 84.6 per cent of the patients presenting.+

+ A double check was made by reference to the out-patient register where however, the neurology patients are unseparated from the psychiatric ones. All folders had thus to be obtained and scrtinised in order to sort out the psychiatric patients. Furthermore the register itself had to be corrected, as many names were repea some omitted and some new and old patients were confused.

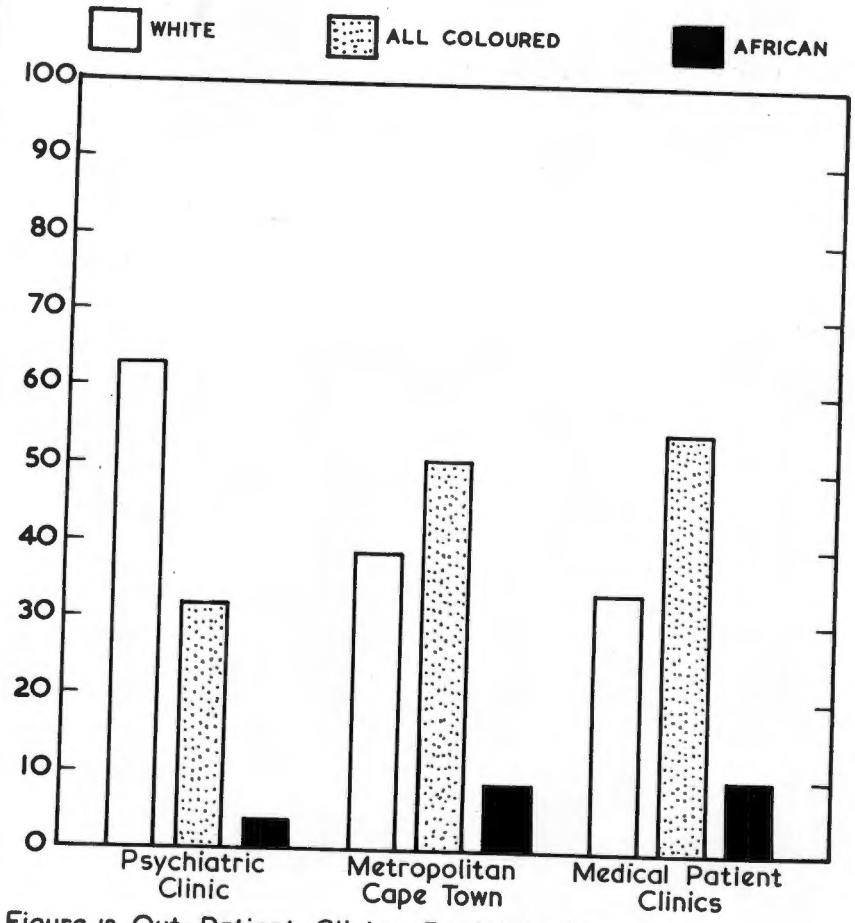

Figure 18. Out-Patient Clinic: Racial Incidence.

The two populations were statistically compared for race, age, sex, marital status and major diagnostic differences and there were no significant differences between the two groups for these variables. They are thus regarded as comparable in these respects, and the sample of patients examined as representative of the whole out-patient population.

RACE

The colour differences we had come to expect from the survey of the casualty populations once more materialised (Table 10.1 and Figure 18). White persons

TABLE 10.1

RACE DIFFERENCES IN OUT-PATIENT SERIES

	White	All Coloured	Asiatic	African
Patients	269	138	3	18
	63%	32%	0.7%	4%
Parameters	278,555	365,475	9,134	65,025
	39%	51%	1%	9%
	$p < .001$	$p < .001$	$p < .001$	

are significantly over-represented, and Coloured under-represented than in their parameters.

However the proportion of white persons is somewhat less, and the Coloured proportion correspondingly higher, than that noted for the combined three casualty sub-groups (see chapter 5).

Thus in every class of psychiatric patient there appears a persistent deficit of persons of the relatively socially-underdeveloped groups. This is in fact a paradoxical situation when one inspects the figures for the medical out-patient department for the same five-month period (Table 10.2 and figure 18), which

TABLE 10.2

NEW MEDICAL OUT-PATIENTS

(Dec '59-April '60)

White	Coloured	African	Asiatics
2099	3449[1]	624	43
(33.8%)	(55.4%)	(10.1%)	(0.7%)

[1] p=N.S.

show not only an excess of Coloured out-patients over white but also an apparent excess of Coloured persons attending the medical clinics over their parameters.

The latter is not however significantly different.

SEX

In every category there is a slight excess of females but this is not significantly different from the general population proportions (Table 10.3).

TABLE 10.3

SEX DISTRIBUTION OF OUT PATIENT POPULATION

	White			Coloured			African		
	No.	%	Pop.%	No.	%	Pop.%	No.	%	Pop.%
Male	113	42	48	58	42	47	8	44	66
Female	156	58	52	80	58	53	10	55	34

p=N.S.

The exception is the African group where the female excess over males is the reverse of the general population picture. The number of Africans in the sample is however small, and the difference between sample and population not significant

AGE

There are significant differences for this variable between out-patient and general populations for the white and Coloured groups when all age groups in the general population are included. The young (0-24 years) age group is under-represented in the sample and the mature (25-44 years) and later (45+) groups over-represented (Table 10.4).

TABLE 10.4

AGE DISTRIBUTION OF PSYCHIATRIC OUT-PATIENTS

	White			Coloured			African
	No.	%	Pop.%	No.	%	Pop.%	No.
0-24	50	19[1]	44	46	33	63	5
25-44	115	43[2]	31	69	50	25	9
45+	104	39	25	23	17[3]	12	4
	269			138			
	$p < .001$		$p < .001$		p=N.S.		

This difference for the Coloured group in the late age group is not significant. Calculations were also

made comparing the sample with the general population figures, corrected to exclude children under ten years of age (since very few in this age group presented at the clinic). The results are depicted in Table 10.5.

TABLE 10.5

AGE DISTRIBUTION OF PSYCHIATRIC OUT-PATIENTS COMPARED WITH GENERAL POPULATION (UNDER TENS EXCLUDED)

	White			Coloured		
Years	No.	%	Pop.%	No.	%	Pop.%
0-24	50	19	31	46	33	47
25-44	115	43	38	69	50	35
45+	104	39	31[1]	23	17	18[2]

[1] p .01 [2] p=N.S.

Substantial differences tending in the same direction as in Table 10.4 persist but these differences are less when the general population figures are thus corrected. The proportion of middle-aged and elderly Coloured persons is equal to that in the general community.

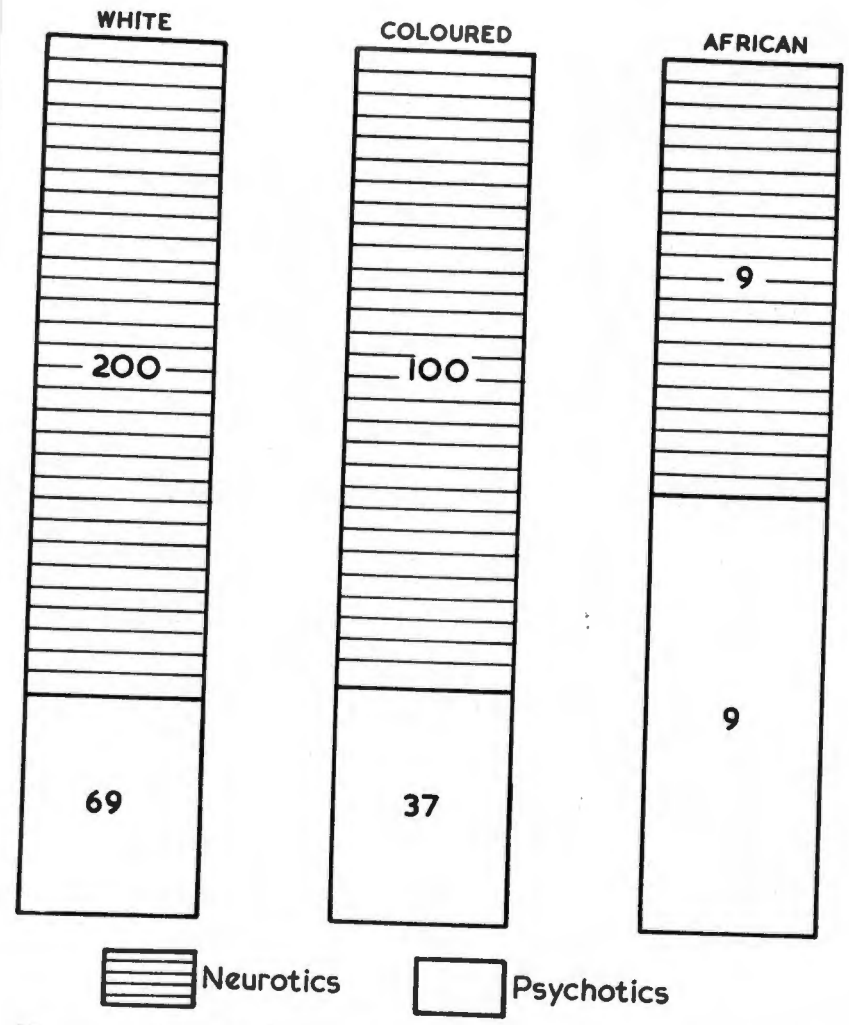

Figure 19. Proportions of Neurotics and Psychotics Presenting at Psychiatric Clinic.

MAIN DIAGNOSTIC DIVISIONS

Three-quarters of both white and Coloured, and half the Africans were patients suffering from neurotic conditions. The figures are represented in Table 11.1 and Figure 19.

TABLE 11.1

MAIN DIAGNOSTIC DIVISIONS: OUT-PATIENT CLINIC

	White	Coloured	African
Neurosis	200 (75%)	100 (73%)	9
Psychosis	69 (25%)	37 (27%)	9
	269	137	

This finding repeats the close parallel in the proportions of Coloured and white patients with psychosis and neurosis presenting as attempted suicides in chapter five.

Breakdown of these categories reveals some interesting differences, however. Psychoses are analysed in Table 11.2 and Figure 20.

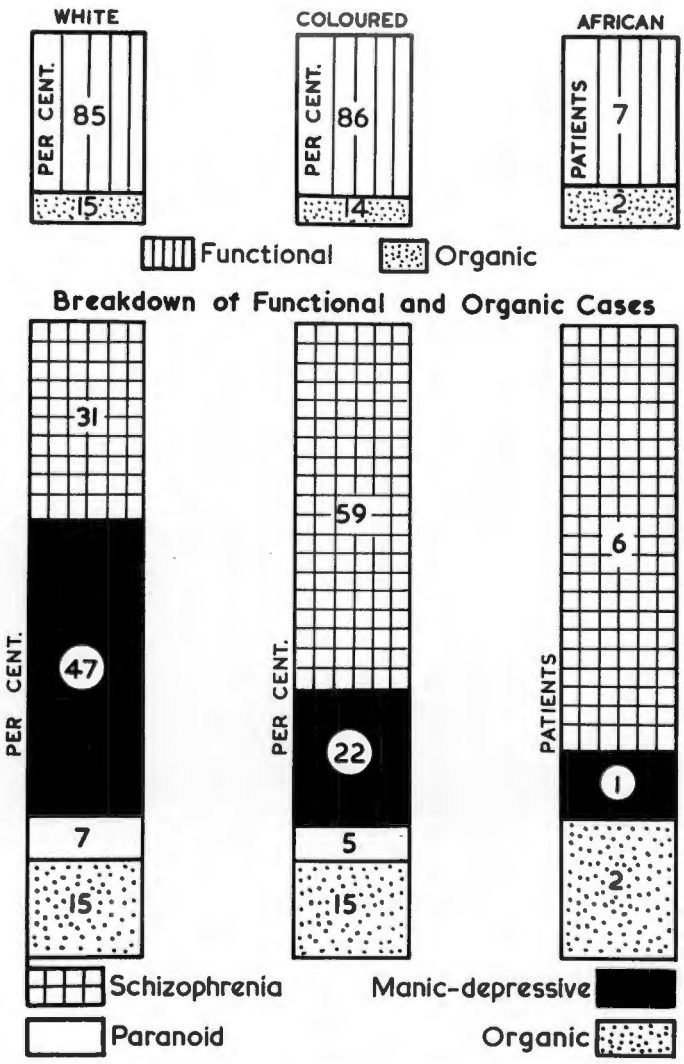

Figure 20. Psychotics Presenting at Out-Patient Psychiatric Clinic.

While the proportions of functional and organic psychotics in both main groups are identical, there are highly significant differences in their mode of presentation.

TABLE 11.2

PSYCHOTICS PRESENTING IN OUT-PATIENT CLINIC

	WHITE	COLOURED	AFRICAN
Functional	59 (85%)	32 (86%)	7
Organic	10 (15%)	5 (14%)	2
	69	37	9
FUNCTIONAL -	59 (85%)	32 (86%)	
Schizophrenia[1]	21 (31%)	22 (59%)	6
Man-Dep.[2]	33 (47%)	8 (22%)	1
Paranoid	5 (7%)	2 (5%)	-
ORGANIC -	10 (15%)	5 (14%)	
Acute	7 (10%)	4	
Chronic	3 (5%)	1	

[1] p .001 [2] p .001

Twenty-one whites (31% of white psychotics) presented with schizophrenia. However, almost double this prop-

ortion of Coloured psychotics was schizophrenic - 22 of 37 (59%). On the other hand, 33 of the 69 whites (47%) had manic-depressive psychosis but less than half this proportion of Coloured patients, 8 of 37 (22%). These differences are significant at the 0.1% level.

The proportion of paranoid psychoses in both colour groups was roughly equal. Five whites (7%) and 2 Coloureds (5%) were in this sub-group. One white patient showed an "acute alien paranoid reaction".

> Imre Crasze, 27 was brought to the clinic by Major X, a tall upright moustachioed ex-officer in a Hungarian cavalry regiment. In contrast with this man's military splendour, the patient himself was a slight, cowed, unshaven individual wearing a tattered shirt and mud-soiled jeans. Through the interpretation of Major X the story was unfolded in Hungarian. The patient was a 'Freedom Fighter' refugee who had been in the country a short while. He had spent the past weeks in a hand-to-mouth existence wandering about the country trying to escape from the police, whom he said were acting for the secret police organization of his home country, and were after him. He feared to read letters from his home country because he believed

that the security police there were copying his mother's handwriting. This patient was admitted to the local mental hospital for treatment.

A white woman in this group had drawn the very hospital into the network of her delusional system.

She was 60, a widow, and strode determinedly about the hospital to which she came every morning punctually at eight o'clock and from which she departed at six. This patient deludedly believed that she was a "cancer specialist" and went about the hospital "diagnosing cases by remote control". In the hospital with a large staff, porters and pages greeted her respectfully every morning as a familiar and authoritative figure in the hospital.

The condition of Samuel Cupido, a Coloured printer in his fifties was less benign.

This patient refused to eat for several days, claiming that his food was being poisoned through a keyhole. He died in the mental hospital to which he was admitted.

The acute organic conditions were noteworthy for the fact that all of the 7 whites but only one of the 4 Coloured patients had delirium tremens resulting from alcohol withdrawal. One white woman had been sent up

simultaneously with her husband, both suffering from acute delirium tremens.

> The Coloured patient was 28, worked as a machinist and lived in a slum area. He said after recovery "ek was sag grootgemaak"+ This man consumed an average of four bottles of cheap wine a day. He spent his leisure hours sitting on the steps of his house until his friends came by, when all would repair to a drinking-house. Afterwards he would return and go to sleep. Although he earned seven pounds (fourteen rand) a week such was the shortage of available accomodation that he lived with his aged mother, a niece of 19, and a nephew of 37 all in one room. His wife and three children usually shared this accomodation but had recently left him after a row.

A Coloured woman of 42 presented with ataxia and confusion resulting from excessive dosage of drugs received for "bronchitis". Another had an acute confusional state on a basis of pernicious anaemia and contributory cerebral arteriosclerosis.

> One of the two African patients in this series was initially misdiagnosed. The consultant wrote: "The mental picture is essentially one

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+ "I was brought up permissively".

> of gross hysteria but....it would be unwise to exclude the possibility of an hysterical reaction ushering in a schizophrenia". Later he added: "P.S. The more I watch this girl the more I suspect schizophrenic psychosis".

However this patient was warded overnight until she could be admitted to the mental hospital. There she developed a fever of 103°F and on examination bubbling rhonchi were audible in the left chest region. She was finally diagnosed as acute tuberculous pneumonia, had a toxic psychosis with schizophreniform symptomatology.

SCHIZOPHRENICS

Three of the 22 Coloured patients were Malays, and these did not differ in form from the unsual clinical picture.

> David Gasant, 36, a van driver, was troubled by auditory voices. He had been off work for five months. He wandered about, was restless at night and had attacked his wife on occasions. A sheikh had failed to help him. However by the time he had presented at the clinic he had largely recovered and no active treatment was necessary.

Abdullah Davids, 25, a teacher, had always been soli-

tary and over-sensitive to criticism. Five days earlier he had begun to hear voices. He believed that people could read his thoughts. There were obsessive coprolalic thoughts which made him clench his fists in resistance. Lying awake at night he would hear a voice in another room telling him to drink poison. The clinical course, observed over a 14-month period, was relentlessly downhill in spite of electroconvulsive therapy.

The third Malay patient was a young dress-maker of 23 who had become upset at apparent hidden meanings in jokes her boy friend was telling her. Soon she began to refuse food saying "Mens kry party mense wat goed in die kos gooi on mens gek te maak - wat jaloers is vir mens"+ Her behaviour changed toward her father whom she would berate when he came into the house. This patient improved after a course of electro-therapy in April,1960, but in August reappeared with a recurrence of her symptoms.

+ "You get some people who put things in your food to make you mad ... who are jealous of a person"

Among the Coloured patients there was also no departure from the European symptomatology. Occasionally content might reflect contemporary preoccupations, but form was consistently and recognisably that of the accepted text books:

> Ralph Josephs, 18, fourth of ten of a labourer's children, showed marked thought disorder. "You see there's a teacher at Bethel school.... people know all about my life....closed all my roads". He deludedly believed that the Africans in the hospital were influencing him with powerful medicine which was acting against that of the white doctors. He believed also that he had been chosen to die for his people.

> Another patient, 38, became aggressive, violent and acutely restless. He too had thought disorder. He said: "You know, doctor, that was my load....there's only one language....English ....where the hell did Afrikaans come from.... my wife's got to take orders from me".

> Another patient believed that the Deity had visited her and given her psychic powers. "Woensdag aand", said she, "die Here het vir my gegee 'n gift....Toe sê die Here: 'Daar's 'n wit man wat vir jou moet vat....maar hy het nie

reggedoen nie....sy meisie was daarby".+

This patient in her grandiose mood stated that "As 'n diener aan my vat....hy moet weet sy arms sal afval....".++

Usually, however, patients manifest more mundane thought-content and activity:

> A puerperal Coloured woman had infanticidal fears with some insight. She said that when she fed her baby she felt like throwing her against the wall. In her bath she would hear babies crying and people speaking to her. Petronella Peters spoke to herself and was withdrawn from other people. Molly Saunders stared fixedly at the table. She would obey simple requests but did not reply to questions. Gerald Patterson had openly masturbated at home. He acted impulsively on occasions such as when he threw water over the family shoes. The apparent precipitation in his case had been rejection by a girl friend.

+ "Wednesday night the Lord gave me a gift .....He said, "There is a white man who must take you, but he has not acted well .... his girl was near". "If a policeman touches me he should know his arms will fall off".

It would be impossible to cite all the Coloured cases, but it may be seen from these randomly chosen samples that the form and even the content of schizophrenia in this series is indistinguishable from the descriptions in western text books of psychiatry.

Among the Africans one woman was brought to hospital because she had been deserted by her "husband", and had no money to pay the witch-doctor's fees. She had been found wandering aimlessly about talking to herself. Any doubts in her friends' minds about her sanity were clinched when she told them she was "committing sexual intercourse with Europeans, Indians, Malays and ordinary natives". Clinically the patient was withdrawn and auditorily hallucinated. A derelict, she lived in a tin "pondokkie"+ in the "Free Ground" at Retreat. Another, from a more sophisticated environment, presented with repeated belching, "doing funny things" and ill-treating her children. Another had projected her "Missus's" voice into an accusatory auditory hallucination.

+ Ramshackle shanty.

MANIC-DEPRESSIVES

Only one African was diagnosed as manic-depressive, 7 Coloureds, 1 Malay, and 33 whites.

Again the clinical picture was recognisably that of accepted European descriptions. In some patients somatic features might be emphasized; in others agitation, but in all a deeply melancholic mood was the prime feature. Mokkies Abduraman, 24, the only Malay, put it thus:

> "I don't feel like talking....I feel sad, like crying....I think about religion....I used to study it....but when I study I get the pains on my brain, so I stopped studying".

This patient conveyed to his interviewer strong feelings of hopelessness and depressive affect. The patient was known to have had many friends and previously had played "soccer" for the "Oasis" club; now he was "by himself" and read the Koran perpetually.

Adelaide Newman, 48, emphasized the physical aspects of her case. She said she had felt "kragteloos", then had developed severe headaches. She felt she wanted to be by herself. "Ek will niks geworry wees nie".

This patient felt her faculties slipping out of control like quicksand. She feared she might go mad: "My verstand raak so weg van my af".+

A third patient a gardener was deeply depressed and suicidal. He complained of feelings of great loneliness and despair and felt that he was a burden on his sister.

After five electro-convulsive treatments he wrote to his consultant in block capitals:-

"ON ACCOUNT OF MY ABNORMALITY I HAD TO CONVULSE TO APPEASE THE SEXUAL DESIRE OF MY INFLAMMABLE BODY, BUT WERE ISOLATED FROM OTHER PEOPLE EVEN MY OWN FAMILY. CHANGING FROM THAT HABIT I FOUND MYSELF SICK AND WANTING TO END MY LIFE... AS GOD'S MY WITNESS I DID PROMISE YOU NOT TO LAY A FINGER ON MY BODY....

P.S. HAVE RECOVERED BUT REMAIN INFIRM WHERE SEXUAL RELATIONS ARE CONCERNED....".

+ "I am going out of my mind".

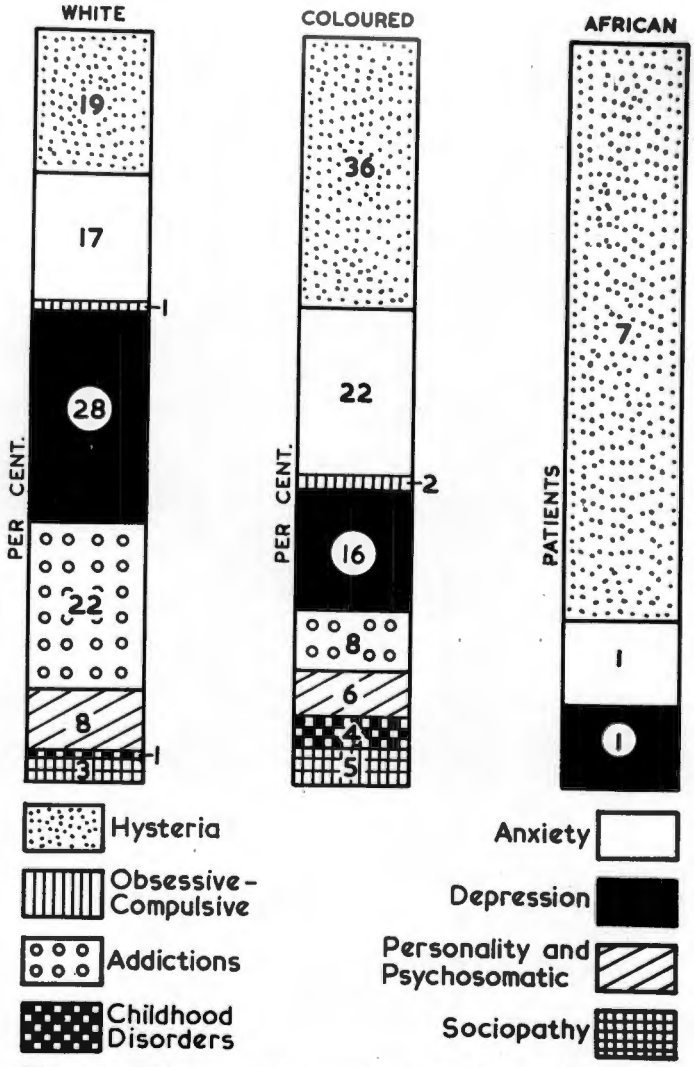


Figure 21. Classes of Neurotic Patients Presenting at Psychiatric Clinic.

THE NEUROTIC GROUP

Again, in the neurotic category, in spite of identical overall proportions, detailed analysis revealed striking differences in incidence. Thirty-five

TABLE 12.1

NEUROTIC SUBGROUPS IN PSYCHIATRIC OUT-PATIENTS

	White	Coloured	African
Hysteria[1]	38 (19%)	36 (36%)	7
Anxiety[2]	35 (17%)	22 (22%)	1
Obsess.	3 (1%)	3 (2%)	-
Depression[3]	57 (28%)	16 (16%)	1
Addictions[4]	44 (22%)	8 (8%)	-
Personality Psychosomatic	16 (8%)	6 (6%)	-
Childhood[5]	3 (1%)	5 (4%)	-
Sociopath	5 (3%)	5 (5%)	-
TOTAL	204	101	9

[1,4] $p < .001$ [2,5] p=N.S. [3] $p < .01$

whites (17%) and 22 Coloured patients (22%) were diagnosed as having anxiety states, a slight difference

not statistically significant. However, proportionately twice as many Coloured patients as whites presented with hysterical conditions ; and almost twice as many whites as Coloureds were depressed. In addition the cultural differences noted for alcoholism in the casualty population reappeared. Forty-four whites (22%) were addicted to alcohol (and drugs) but only 8 Coloureds (8%).

The figures are represented in Table 12.1 and Figure 21.

No differences were found between the hospital incidences of obsessional states, personality and psychosomatic disorders, behaviour disorders of childhood and sociopathy.

Among the Africans hysteria was the most commonly presenting condition (7 cases) while 1 each had depressive and anxiety states.

HYSTERIA

In this group an overwhelming sex bias was found. Only 7 of the all-Coloured group were males, and 29

were females. Among the whites 11 were males and 27 were females (Table 12.2)

TABLE 12.2

SEX DISTRIBUTION OF HYSTERICS

	White[1]	Coloured[2]	African
Male	11	7	5
Female	27	29	2
	38	36	7

[1] $p < .05$ [2] $p < .01$

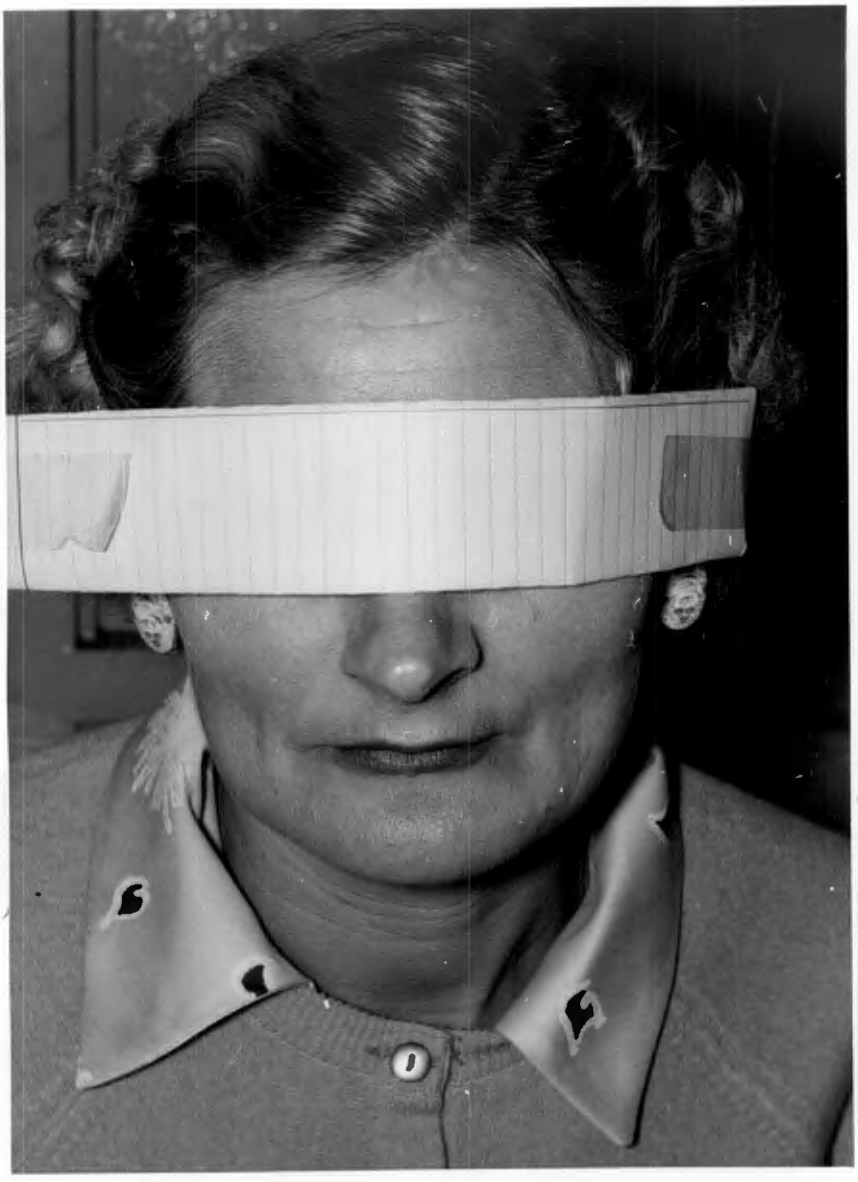
In the small group of seven Africans, 5 were males and only 2 females in consonance with the sex distribution of Africans in the general population.

There were 3 Malays in the series, all of whom were women. One was a deaf-and-dumb widow of forty-eight. After her son went to sea she developed pains in the limbs, back and neck, such that she had to be carried in on a stretcher. Another, a woman of 29, under the stress of an emotionally poor marriage had conversion symptoms. People were carrying stories to her husband

that she was secretly going to the cinema instead of to the Eoan Group, a cultural society. This problem was really only an apparent cause for she was an immature woman incestuously dependent on her step-father. "He may have to come with the aeroplane....We dropped him a telegram that I'm not well. I'm more attached to him than my own father....". Her marriage at 17 was the result of an infatuation "It was a clean marriage....I was three months married when I got pregnant....My husband isn't right for me sexually....he's killed my love".

The third Malay patient, an anxiety-hysteric, presented with attacks in which she was literally out of her mind ("weg van my verstand af"). The attacks would start with cold feet, a cramp in the abdomen, anxiety feelings, and then came a feeling of being far away. Social pressures were operating in her case as in the others. She lived in a crowded quarter where her neighbours fought and drank all day. "Dan klop hulle in die aande aan ons deur en ons vensters - dan werk dit op my senuwees. Hulle wil hê ek moet die "gram" vir hulle speel".+

+ "Then they bang on our doors and windows at night - it works on my nerves. They want us to play the gram (radio) for them".



Photograph 5: Mrs. Susan Henderson.

Helplessness against the aggressive demands of others in the environment to which one is closely confined was not limited to dark-skinned patients.

Mrs. Susan Henderson, 33, manifested mixed conversion symptoms with anxiety. She had pains in her head and abdomen and palpitations of the heart. This patient was terrfied of her ex-husband who was liable to visit her without warning while her present husband was at work.

Many of the Coloured patients had mixed dissociative and conversion symptoms. Either it was the spectacular nature of their complaints which brought them to the clinic; or it was necessary for them to have glaringly deviant behaviour patterns in order to bring home their needs to their families.

A further possible reason for the relative frequency of hysteria among the Coloured patients presenting at the clinic may be the class-status of Coloured people in the social hierarchy. The levels of education and occupation of the groups of hysterics were therefore compared with those of all neurotics.

Table 11.3 shows the educational attainments.

TABLE 11.3

EDUCATIONAL ATTAINMENTS OF HYSTERICS COMPARED WITH ALL NEUROTICS

	White			Coloured		
Level	No.	%	All neur.%	No.	%	All neur.%
Partial primary	4	11	7	20	57	44
Primary	13	37	24	10	29	31
Partial secondary	16	45	50	5	14	17
Upper secondary	1	3	14	-	-	5
University A	1	3	3	-	-	3
University B	-	-	2	-	-	-

p=N.S.

It will be seen that there are no significant differences when one compares the educational levels of the hysterics with all neurotics.

When one refers to occupational status, insignificant differences only are also discovered (Table 11.4).

TABLE 11.4

OCCUPATIONAL STATUS OF HYSTERICS COMPARED WITH ALL NEUROTICS

	White			Coloured		
	No.	%	Neur.%	No.	%	Neur. %
Upper	4	11	12	-	-	7
Middle	18	47	50	1	3	8
Working	11	29	23	24	67	55[1]
Labouring	-	-	-	1	3	10
Undirected	5	13	17	10	28	21

[1] p=N.S.

However when the religious affiliations of the hysterics are investigated, a significant difference does make its appearance (Table 11.5).

This is the excess (at the 5 per cent level of significance) of hysterics affiliated to the minor Christian churches. Of the 6 whites in this group 3 were Apostolics and 1 a Jehovah's Witness. Of the 14

Coloureds seven were Apostolics, 2 were Moravians, 1 a Spaarderheerden, and 3 were Jehovah's Witnesses.

TABLE 11.5

RELIGIOUS AFFILIATION OF HYSTERICS

	White			Coloured		
	No.	%	Pop.%	No.	%	Pop.%
Anglican	6	16	30[1]	10	29	35[3]
Dutch Ref.	16	42	27[2]	2	6	13
Rom. Cath.	3	8	9	2	6	6
Non-Conf.	6	16	16	4	11	10
Min. Christ.	6	13	8	14	40	17[4]
Jewish	2	5	8	-	-	-
Islam	-	-	-	3	9	17[5]
Other	-	-	2	-	-	-

$^{1,2,3,5}p$=N.S. $^{4}p < .05$

Gertrude, 18, a shy withdrawn girl had a white father and a Coloured mother and lived as Coloured. She developed dissociative attacks at 13 (during which she briefly lost consciousness), after the Indian shop-keeper for whom she worked began having sex relations

with her and her sister. At 17 she fell in love with a boy of a different religious faith (her parents were strict New Apostolics, extremely puritanical, who forbade all pleasure outlets, and were opposed to her marrying anybody but a member of their church). Not long after relinquishing this lover, the patient fell pregnant by a young white policeman.

Joan Fredericks, 17, also "went off" periodically. Her father was German and her maternal grand-mother French, but she lived as Coloured.

> A white member of the Apostolics was Miss Betty Johnson, 45, who was troubled by her legs. She had been experiencing nocturnal visions since her childhood. After these spirit visitations her right leg would "go lame". Once a dead pilot and on another occasion the shade of an old beggar had appeared before her. When spiritualists asked her why she did not just accept these people, she said "I want nothing to do with them".

Colour entered prominently into the psychopathology of some cases of hysteria.

> June Masters's father had been a white man, and her mother was a Coloured woman living in a

rural village. Her father died in her infancy and she was taken over by his family so that she could be reared as a white. She saw her mother rarely, visiting her only for Christmas celebrations. In her young womanhood the patient fell in love with a fair-skinned man who was, however, classified as Coloured. Now came violent and bitter opposition from her father's family. The patient had repeated hysterical dissociative attacks which temporarily rescued her from her tensions. Only her paternal grand-mother sympathised with her and persuaded her to leave home.
Legal applications to change the status of her lover to white failed and in the end the patient was required to change her own status to Coloured so that she could marry. Her dissociative attacks, once started, however, continued intermittently after the marriage during times of stress.

In a similar situation was Sally Ndlebe, 29, who had initially been diagnosed as suffering from endogenous depression. Since many of her symptoms were exhaustive ("always tired", "lame") this was not surprising. However she complained of her face "jumping", and of many other conversion symptoms. She was a Coloured woman by birth who had married a foreign African and lived at Nyanga location. There she was isolated from

Photograph 6: The patient-couple opposite, at the outset of their lives together, and the patient twenty years after.

social contacts, and lived in perpetual fear when her husband was away. During the time of the Emergency+ when she was separated from her husband for several days she suffered especially.

Endogenous depression was also initially diagnosed in a white woman who was subsequently considered to be an hysteric.

This was a patient who attended the same clinic psychiatrist as her husband (without the former's knowledge for some time). This patient's symptoms had begun when she was in labour and overheard the obstetrician tell her husband - "You must choose which one you want to live....one of them is sure to die". Said the patient, "It was then that I thought, 'Now I will have to fight for my life'".

AFRICAN HYSTERICS

Of the seven Africans in this group, five were males. One was a 26 year-old office boy who complained that his mind went blank when he was preparing to leave for work. He had been reared in strict authoritarian

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+ March, 1960 when African locations were sealed off by troops.

traditions by his father, a Lutheran minister.

Another, 21, was the son of an Anglican minister and was a university student who complained of black-outs when writing examinations.

A third patient had acute dissociative reactions; a fourth had hysterical mutism, and a fifth vague conversion pains in the abdomen.

The two females both suffered from dissociative states.

Agnes Majeki, 23, had urgently sent for her husband to fetch her from Tsolo. She said her head was sore and her "arms didn't feel to work". She could not even carry a cup of tea. This patient would suddenly begin to shake and run out of the hut screaming. She had seen a witch-doctor who had diagnosed ukuphosela i.e. that she had been bewitched by a jealous person.

When the patient was brought to the clinic the husband asked that a witch-doctor be allowed to treat the patient at the same time. "I haven't heard of anyone healed by the European with (of) his nervousness", he said. However, the patient did respond to ordinary psychiatric treatment much to her husband's surprise.

Photograph 7: Agnes Majeki and family a year later.

REACTIVE DEPRESSIONS

Of the Coloured patients with reactive depression, 6 were male and 10 were female. Most (11) were married, and their depressions were related more to marital disharmony than to direct social pressures.

> Colour complications featured strongly in the case of Clovy Samuels, 30, who had attempted suicide by taking sleeping tablets. She was married to a man forty years older. Since November when she had returned from a visit to find him having intercourse with a 12 year-old, everything upset her so that she felt sad, and cried "for everything". This patient's mother "used to live as a Coloured. Now she goes as a European". The patient was afraid that because of legislation she might not be permitted to visit her mother, who with the defection of her husband, was now her only means of emotional support.

A school-teacher of 26, describing herself as Atheist, exemplified Stonequist's overcompensative aggressive reaction. When asked about her colour this patient bridled "I don't believe in dividing up the human race". This patient felt hopeless about the conditions under which she had to teach. "Their standard is so

Photograph 8: Shirley Foster: The persona hides the inner fears and tensions.

low....their classes are so crowded....teachers cannot get to individual children".

Only one Malay was depressed in this group. This was Latiefa Hendricks who had converted to Islam at nine years. Her father had been an Italian fishmonger and her mother Coloured. When her mother died the patient adopted the religion of her foster-parents. Her symptoms were adulterated by hysterical symptomatology. She said she cried all the time and felt continually depressed. Sometimes, however, "all of a sudden the whole place travels away with me and everything goes dead in my body".

Anxiety as anadditional feature of a basically depressive illness is not , however, the province of any particular group.

> Shirley Foster, 24, was severely depressed on a neurotic basis. Her father had died when she was little and her mother had to work to keep the home together. She felt isolated from her family, unable to make a relationship with her mother who frightened her away with her own anxiety. She felt her problem was "all mixed up with religion and sex". She had headaches and

was frightened. "If ever I was unhappy before I could pull myself out of it through religion and confession. Now I feel I need some help". The patient, a dancing teacher had been referred to a psychiatrist by a doctor-pupil.

ADDICTIONS

Seven of the 8 Coloured patients were alcohol addicts, but one patient was addicted to dextro-amphetamine. This was Solly Sampson, 48, who had been in the army and had contracted malaria while on service. He complained that since then "ek kan nooit 'n balans kry nie. Ek het vreeslik depression....my kop wil nie oop gaan nie".+ In the end this patient had been invalided out of the army as an anxiety state with bilateral quinine deafness. He needed dexedrine to cope with his work and admitted to taking 9-12 tablets per day.

Contrary to the expectation that Coloured alcoholics who present of their own accord at an out-patient clinic might be educated and sophisticated persons (as opposed

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+ "I cannot find my feet. I am deeply depressed. My head does not clear".

Photograph 9: Scenes from the village which produces obsessional disorders in its upper-stratum sons. The patient himself is seen striding before his girlfriend.

to those who appear in the casualty department) only one of these patients fell in the "upper" occupational category. The remainder were at all other levels.

> This was a school-teacher of 42 who, when he finished school at four p.m. tried "to squeeze in as many drinks as possible before 6.30", at which time he was due home. This man had married a socially inferior woman who did not share any of his interests. He had had to give up political meetings and civic affairs on her account, with considerable resentment on his part.

There was one woman in the Coloured alcoholic group who first presented as an epileptic.

OBSESSIONAL NEUROSIS

Patients with obsessive-compulsive illness were a small group. However one interesting finding was made among the three Coloured patients. Two of the three patients were teachers, both from the same small semi-rural religious-settlement.

> The father of James Faro was the school principal and minister of religion at the settlement. The patient accused him of great strictness, especially in his attitudes to sexual be-

haviour. The patient himself had not been able to make a satisfactory sexual adjustment and his outlets were solitary and clandestine. So carefully had he organised his aggressive feelings that at night he carefully pointed all razor blades and knives away from his bed. His shoes were placed so that they did not touch the lines of the floor-boards and were directed away from him. He took care to breathe in when he was talking to someone, and out when he was being spoken to; all his words were uttered in multiples of four.

Psychotherapy at fairly infrequent intervals, together with normal maturation processes have helped this man to make a satisfactory adjustment. In the photograph he will be seen, with great urgency, hurrying in front of his present girl friend.

The other patient complained of compulsive sexual thoughts about his girl pupils. Although he had a girl friend with whom he had regular intercourse, he was tormented by subsequent guilt reactions. This man's brother (not one of this series) was admitted to the ward subsequently with compulsive sniffing.

ANXIETY STATES

As Rennie and Srole[104] observed in their study anxiety knows no social distinctions and anxiety states occurred in this series with equal frequency in the white (17%) and in the Coloured group (22%). Only one African was, however, diagnosed as having the condition.

> She was Edith Mdingaza, 27, a Xhosa, who worked as a cook in a suburban household and complained of "sore neck, sore eyes, sore ears, and something on my head."
> Although she did not complain directly of anxiety this patient trembled and shook like a leaf with free-floating anxiety so that both examiners unhesitatingly placed her in the anxiety group, although some might no doubt prefer to call her an anxiety-hysteric.

This patient exemplified the social problems of the unattached urban African woman. Coming from a strict Methodist home, she said: "They tell us we mustn't go around with boys .... It's no good". Yet a year after she came to the city at 18 years in order to seek work

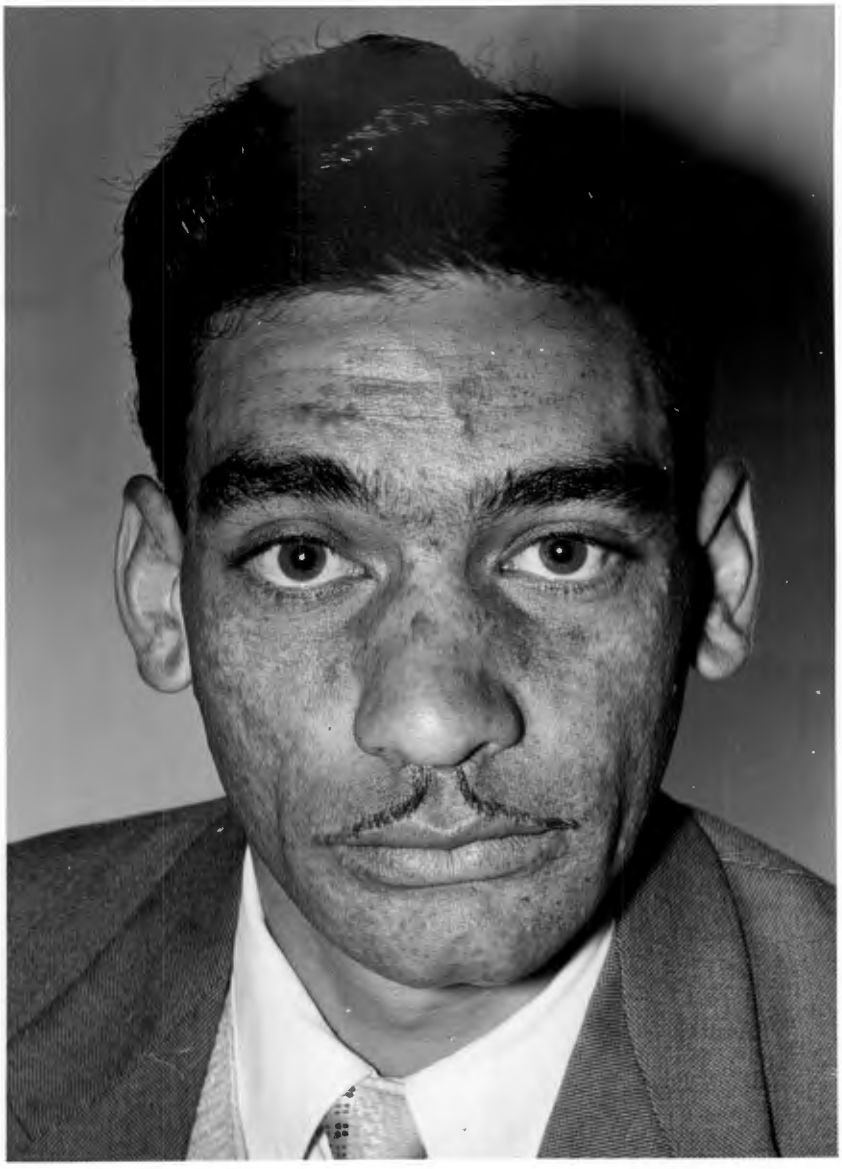
this patient began a series of promiscuous relationships with rapidly shifting partners. No contraceptive measures were employed. "We just take a chance". She already had a child of three years cared for by her parents in the Transkei. Her identity was kept secret from the child, and the child was trained to call her "sister" and to believe that its actual grandparents were its parents. Said the patient when questioned:- "I feel nothing about it....I'm not sad....I send them two to three pounds every month for it..."

There were two Malays in the group, one from each sex. Rukea Kamaldien, 23, a machinist in a dress factory had anxiety attacks in which she recognized that she became "all nerved up". A modal Malay woman, she had stopped her formal education in primary school but had continued her religious training with an instructress until 18 years old. Although her and her plasterer husband's earnings were £11 (R22) per week, they had to rent a room in a private house "because we can't get a place". She spoke Afrikaans at home, uncritically described her parents' personalities as "best" and "good", spent her leisure hours reading "gangster" paperbacks

and attending to her infant. She received no sexual information from her mother but "knew from her friends". When she became menarchal at 14 she was told "not to go out with boys" and was required to inform her mother each month when she had her periods. Sex intercourse took place occasionally before her marriage which was a "must marriage" as she had fallen pregnant.

> The male was a quiet, tense young lad entering his matriculation year. He had failed standard nine the previous year. Reality problems and aspirations combined to release his adolescent anxiety state. His father, a tailor, was out of work. His mother, a teacher, had great expectations for him and was working very hard to support him. Said he, "I'm worried....I would like to have a profession....to be a professional man and provide things for my mother".
>
> This case could well have been one of the Myers and Roberts' series in class III where the sons aspired to fulfill their dominant mothers' high expectations for them and rejected their inadequate fathers as role-models.

Chronically unintegrated anxiety may cripple a patient as completely as any psychosis. Clive Cornwall, a Coloured patient, was unable to fend for himself and



Photograph 10: Clive Cornwall.

in the end, when even sheltered employment proved unsuitable for him, a disability grant (the South African equivalent of "the dole" or "public relief") had to be arranged+.

> This was a young Coloured man of 25 whose presenting symptom had been asthma but who was basically a case of chronic anxiety. In fact, at the time of his disability grant being assessed his asthma was in remission, but his chronic over-anxiety in interpersonal situations was the crippling factor. This patient's mother had had a "nervous breakdown" four years before he first presented. His quiet, but strict father had died a year before of bulbar palsy. The patient's mother was excessively religious and belonged to a small sect which held mission meetings twice weekly in her home. From this atmosphere of self-criticism where "sin" was a household word the patient sought refuge in war stories and science-fiction. However this inner preoccupation with aggressive action was not permitted to enter into his dealings with other persons. He would lie abed all night worrying over the people he was likely to contact on the morrow.

+ Impossibly inadequate sums of money with a differential scale based on colour. White patients received £10 (R20) per month, Coloureds £4 (R8) per month, and Africans 32/6d. (R3.25). Even this paltry assistance could be cut if the patient happened to own his own home.

> It was Clive's tragedy in life that he thus prejudged every social interaction in which he took part, so that he would be overcome with fear and trembling long before the meeting.

Frequently with Coloured patients the underlying psychopathology is readily apparent as a conflict between inner aggressive feelings and a milieu which disallows their expression. One imagines the situation to be similar to that of Victorian England where womenfolk were expected to be sweet, shy and demure and young men chivalrous.

> Ethel Verwey, 31, had a phobic state. "If I'm in a crowd it's almost like I want to run away....when I see a fight or somebody drunk I want to be alone....Even my own husband ....the moment I see him come home drunk I excite myself....I just feel like I can get hold of my children and kill them off....Before I was as a mother should be with her children. Now I work myself up. It's almost like I can't control myself".

This patient had organized her household in an obsessional way and expected her feelings also to

"stay in their proper place" like her domestic articles. Another patient, too, endeavoured to control her inner tensions: "Daar is 'n vrees in my...en my brein werk gedurig....ek voel gespanne en ek voel altyd ek moet besig wees".+

Ordinary preoccupations such as with examinations and relationships with the opposite sex are frequently found as with Roland Roberts who was awaiting the results of his teachers' examinations and Stafford Johnson who lay anxiously awake at night thinking of his girl friend in a country town by whom he had had a child, and who had not contacted him for a very long time.

Occasionally a relatively well-educated Coloured man may present with primitive fears.

> Leonard Owens, 35, a teacher, complained of irritability, tension and phobias of spiders and "crawly objects". A woman had foretold that he would be dead at 36 and when he went to sleep he feared that he would never wake up. At night he dreamt of violent themes such as Mars and Earth colliding.

+ "There is a fear within me....my brain races....I feel taut.... and I feel I must be constantly busy".

MARITAL STATUS

Tables 12.1 - 12.3 show the figures for psychotics, neurotics and all clinic patients respectively. Never-marrieds are under-represented to highly significant degree, and this is contrary to the overall experience

TABLE 12.1

MARITAL STATUS OF PSYCHOTICS (PSYCHIATRIC CLINIC)

	White.			Coloured.			African
	No.	%	Pop.%	No.	%	Pop.%	
Never married	20	29	48	16	43	65	5
Married and Cohabiting	38	56	44[1]	19	51	29	2
Divorced	5	7	1.6[2]	-	-	0.6	1
Widowed	5	7	6[3]	2	5	4	-

1, $p < .01$. 2, $p < .001$. 3, $p <$ N.S.

of Ødegård and Norris. However the general population figures have not been adjusted to excluded children as no figures are available for the Coloured people for marital status by age.

Married patients show an interesting variability in the present series, being significantly in excess of their parameters among the white psychotics but not different from their parameters for white neurotics and the overall population. However, significantly larger

TABLE 12.2

MARITAL STATUS OF NEUROTICS
(PSYCHIATRIC CLINIC)

	White.			Coloured.		
	No.	%	Pop.%	No.	%	Pop.%
Never married	68	34	48 [1]	49	48	65 [2]
Married and Cohabiting	93	46	44 [3]	45	44	29 [4]
Divorced	20	10	1.6 [5]	4	4	0.6 [6]
Widowed	20	10	6 [7]	3	3	4 [8]

1, 2, 5, 6, $p < .001$. 7, $p < .05$. 3, 8, p = N.S.

numbers of married Coloured patients of all three categories break down psychiatrically. For white and Coloured patients there is an excess of divorced persons at significant levels (the exception being the small series of Coloured psychotics where no divorced persons presented). White widows and widowers were in significa

excess in the overall population and also in the specifically neurotic group, but this was not so for Coloured patients. If this finding is valid it suggests the possibility that the lack of social isolation among the Coloured community is protective to widows, while the social structure of the white group permits of their isolation and psychological distress.

TABLE 12.3

MARITAL STATUS OF ALL PSYCHIATRIC CLINIC PATIENTS.

	White.			Coloured.		
	No.	%	Pop.%	No.	%	Pop.%
Never married	88	33	48	65	47	65
Married and Cohabiting	131	49	44[1]	64	46	29
Divorced	25	9	16[2]	4	3	0.6[3]
Widowed	25	9	6[4]	5	4	4

1, p = N.S. 2,3, p $<$ .001. 4, p $<$ .05

It is however, necessary for the exercise of caution in the interpretation of these data as the comparative general population figures are not adjusted for children. It is not possible to say what the effect of such an adjustment

would be except to say that generally one might expect the never-married proportions to diminish and the others to correspondingly increase in size. The never-married proportions in the present sample would therefore loom larger and the others diminish.

RELIGIOUS AFFILIATION

Tables were again constructed for psychotic, meurotic and overall categories showing the religious affiliation of patients.

It will be seen that Coloured minor Christian sects are excessively represented in the overall and specifically neurotic groups. This is due to the weighting of their numbers by the 17 members of the Apostolic sects who formed on their own, 12 per cent of the Coloured sample. In the general community this group accounted for 6.5 per cent of the Coloured population (1951 Census). White Apostolics were not significantly over-represented. They numbered 14 (5%) and in the general population form 2.7% of the white community.

White Roman Catholics were over-represented in the neurotic and overall samples at the 5 per cent level of

significance, and Jews were under-represented to the same degree. Moslems were also under-represented in both these samples at significant levels.

TABLE 13.1

RELIGIOUS AFFILIATION OF PSYCHIATRIC CLINIC PSYCHOTICS.

	White.			Coloured.		
	No.	%	Pop.%	No.	%	Pop.%
Dutch Reformed.	18	26	27	5	13	13
Anglican	18	26	30	14	38	35
Roman Catholic	8	12	9	3	8	6
Non-Conf.	12	18	16	1	3	10[1]
Minor Christian	7	10	8	6	16	17
Jewish	5	7	8	-	-	-
Islam	-	-	-	5	14	17[2]
Other	-	-	2	-	-	2

(Exclusions 3 whites, 3 Coloureds - information unavailable).

1, p = N.S. 2, p = N.S.

In the psychotic category there were no significant

departures from the general population proportions.

Since it is hardly likely that a social force in a given religious community produces increased incidence of psychiatric illness specifically neurotic and not

TABLE 13.2

RELIGIOUS AFFILIATION OF PSYCHIATRIC CLINIC NEUROTICS.

	White.			Coloured.		
	No.	%	Pop.%	No.	%	Pop.%
Dutch Reformed	61	30	27	8	8	13[1]
Anglican	50	25	30	30	30	35
Roman Catholic	27	13	9[2]	9	9	6
Non-conf.	29	14	16	9	9	10
Minor Christian	12	6	8	29	29	17[3]
Jewish	7	4	8[4]	-	-	-
Islam	-	-	-	8	8	17[5]
Other	8	4	2	5	5	2

(Exclusions - 7 whites, 3 Coloureds).

1, p = N.S. 2, 4, 5, p .05. 3, p .01

psychotic the interpretation of this finding is arguable. It may be that neurotic Moslems and Jews are contained

within their community. On the other hand Roman Catholics, who were found to excess in this series, have their confessionals-machinary for coping with neurotic illness.

TABLE 13.3

RELIGIOUS AFFILIATION OF ALL CLINIC PATIENTS.

	White.			Coloured.		
	No.	%	Pop.%	No.	%	Pop.%
Dutch Reformed	79	29	27	13	9	13
Anglican	68	25	30	44	32	35
Roman Catholic	35	13	9[1]	12	9	6
Non-Conf.	41	15	16	10	7	10
Minor Christian	19	8	8	35	25	17[2]
Jewish	12	5	8[3]	-	-	-
Islam	-	-	-	13	9	17[4]
Other	8	3	2	5	4	2

(7 whites, 6 Coloureds excluded)

1, 2, 3, 4, $p < .05$.

Patients from the Apostolic group are subjected to dual stresses. Not only is theirs a brooding puritanical sect, but in some forms spirit possession enters into

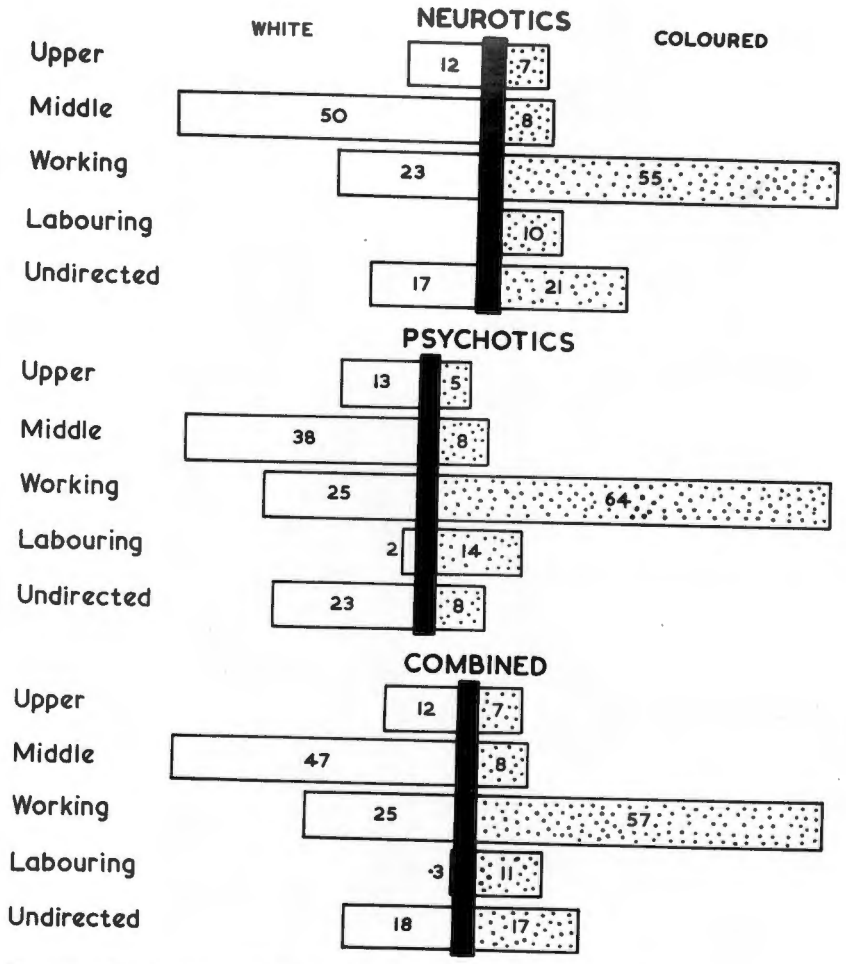


Figure 22. Occupational Status of Psychiatric Clinic Population.

the act of worship and it is conceivable that an atmosphere conducive to hysteria prevails.

OCCUPATIONAL STATUS

Tables 14.1 - 3 and figure 22 illustrate the occupational structure of the psychiatric, neurotic and overall communities.

TABLE 14.1

OCCUPATIONAL STATUS OF CLINIC NEUROTICS.

	White.		Coloured.	
	No.	%	No.	%
Upper	23	12	7	7
Middle	100	50	8	8
Working	45	23	55	55
Labouring	-	-	10	10
Undirected	33	17	21	21

There are no striking differences between any particular category for each colour. Whether whites were psychiatric or neurotic they clustered in the upper and middle strata. Fifty-one per cent of the white

psychotics were in either of the first two levels and 62 per cent of the neurotics. Coloured patients congregated in the working and labouring strata. Seventy-eight per cent of the Coloured psychotics were in these two occupational levels and 65 per cent of the neurotics.

TABLE 14.2

OCCUPATIONAL STATUS OF CLINIC PSYCHOTICS.

	White.		Coloured.	
	No.	%	No.	%
Upper	9	13	2	5
Middle	26	38	3	8
Working	17	25	24	64
Labouring	1	2	5	14
Undirected	15	23	3	8

Almost identical proportions of patients were in the "upper" occupational stratum for each race for psychotics and neurotics. Thus 12% of the white neurotics and 13% of the white psychotics were in the professional and managerial class. Seven per cent of the Coloured neurotics and 5% of the psychotics were in this category.

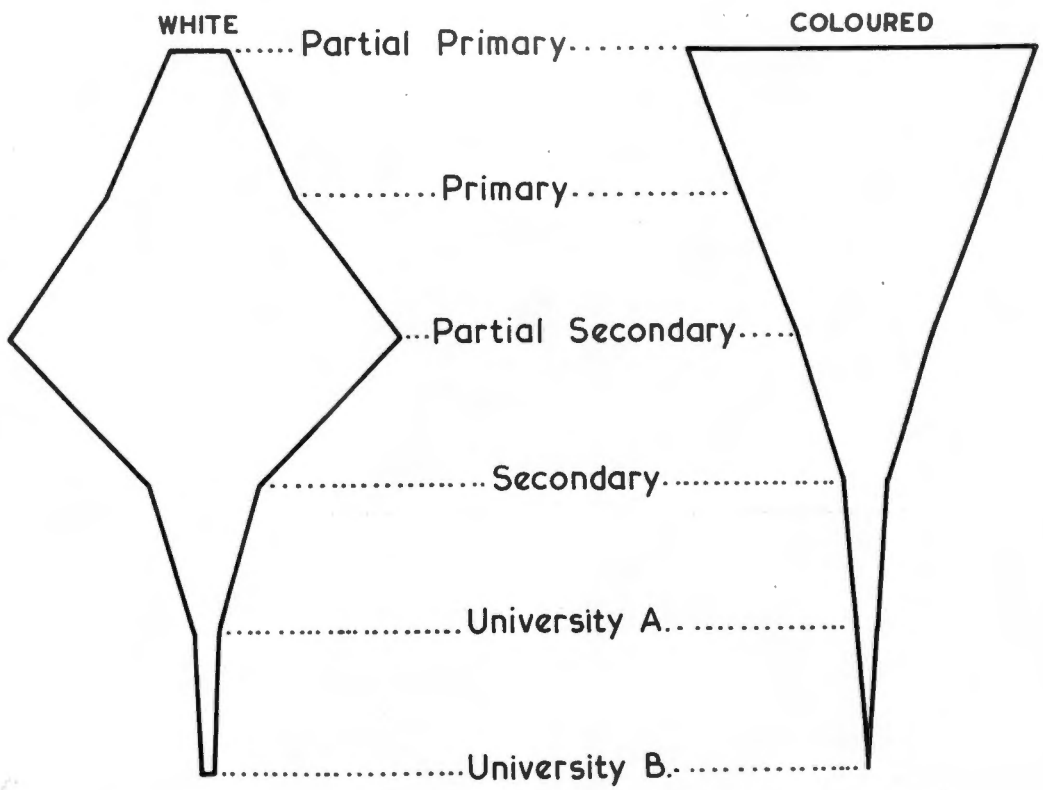


Figure 23. Educational Levels of Neurotic Patients.

This finding rules out the theory that there is a "drift" of psychotics down the occupational scale.

EDUCATION LEVELS

These are shown in figures 23 - 25 and Tables 15.1-15.3.

TABLE 14.3.

OCCUPATIONAL STATUS: ALL CLINIC PATIENTS.

	White.		Coloured.	
	No.	%	No.	%
Upper	32	12	9	7
Middle	126	47	11	8
Working	62	23	79	57
Labouring	1	0.3	15	11
Undirected	48	18	24	17

Again a distinctive colour pattern emerges, but not different from that previously observed in the emergency population, nor from that expected according to general population patterns.

Most of the whites whether psychotic or neurotic had reached at least the partial secondary school level

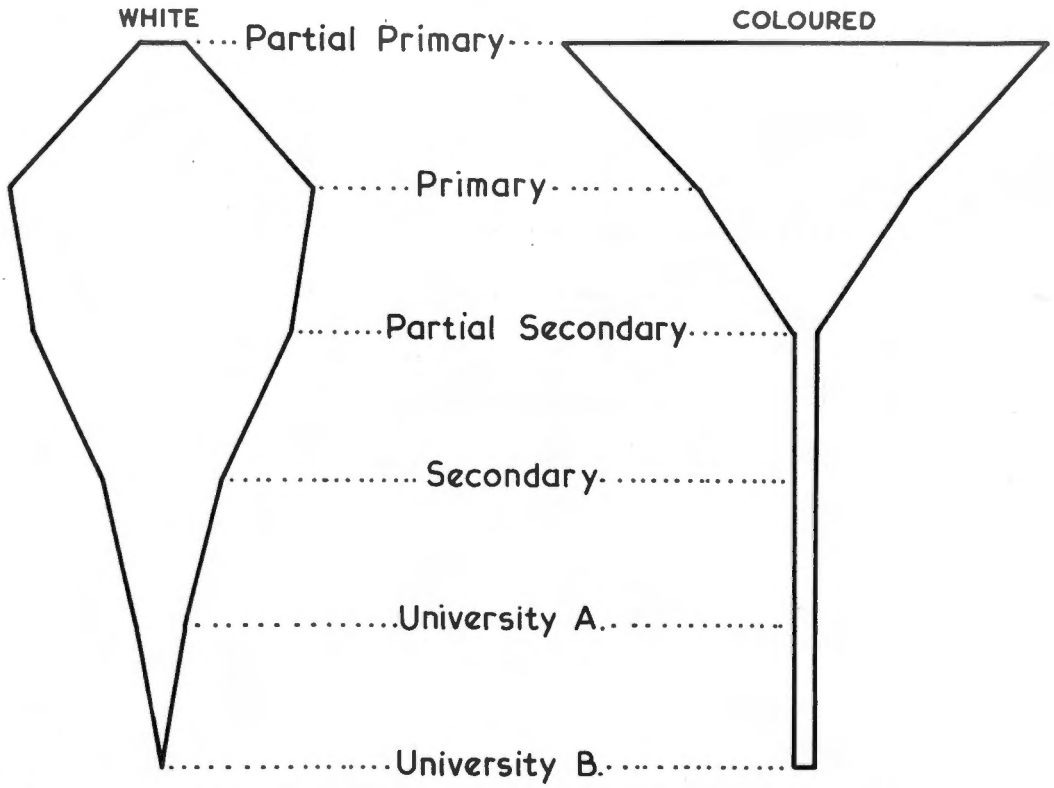


Figure 24. Educational Levels of Psychotic Patients.

(65%) but only 22 per cent of the Coloureds.

TABLE 15.1

EDUCATION OF CLINIC NEUROTICS.

	White.		Coloured.	
	No.	%	No.	%
Partial primary	14	7	42	44
Primary	47	24	29	31
Partial Secondary	96	50	16	17
Secondary	27	14	5	5
University A	5	3	3	3
University B	1	2	-	-

(Exclusions - 8 whites, 6 Coloureds).

HOME LANGUAGE

Patients in the clinic series were classified according to their home languages and the findings are recorded in Tables 16.1 and 16.2. It was felt that language is a useful indicator in a country like South Africa where, on a mass level, home language is a pointer to cultural background and even political views. In the 1951 Census of the whites 66.4% were

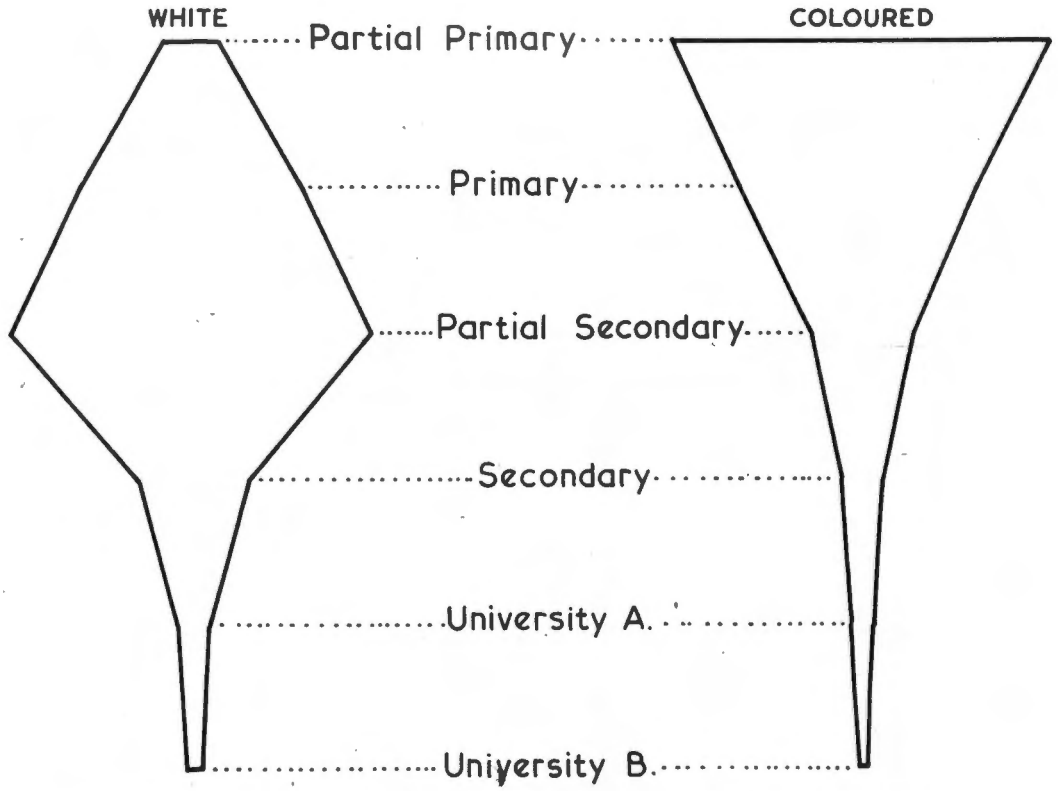


Figure 25. Educational Levels of Combined Out-Patients.

English-speaking and 28.2% Afrikaans-speaking. Only 2.3% were registered as having both official languages as their home languages. Those with other

TABLE 15.3

EDUCATION OF ALL CLINIC PATIENTS.

	White.		Coloured.	
	No.	%	No.	%
Partial primary	18	7	62	48
Primary	73	28	38	30
Partial secondary	118	46	17	13
Secondary	37	14	6	5
University A	9	4	4	3
University B	4	2	1	1

(10 whites, 10 Coloured excluded)

home languages totalled 3.1 per cent. Of the Coloureds in the Census 19.5% were English-speaking and 78.7% Afrikaans-speaking. Only 1.7% identified with both and 0.1% with "other" languages.

TABLE 16.1

HOME LANGUAGES OF CLINIC PSYCHOTICS.

	White.			Coloured.		
	Afr.	Eng.	Other.	Afr.	Eng.	Other.
Schizophrenia	4	17	-	19	3	-
Manic-Dep.	13	18	5	8	-	-
	17	35	5	27	3	0

TABLE 16.2

HOME LANGUAGES OF CLINIC NEUROTICS.

	White.			Coloured.	
	Afr.	Eng.	Other.	Afr.	Eng.
Hysteria	1	4	-	3	2
Anxiety	19	19	-	29	7
Obsessional	16	17	2	17	6
Depressive	-	3	-	3	-
Addictive	19	36	2	13	3
Personality	10	33	1	7	1
Childhood	7	9	-	5	1
Sociopathy	3	-	-	4	1
	75	121	5	81	21

In this series Afrikaans-speaking psychotics were in a 1:2 relationship to the English-speaking psychotics. This was slightly larger than their parameters but not significantly so. However, 75 of the white neurotic patients (38%) were Afrikaans-speaking and this finding is significant at the 0.1% level. On perusing the table the only excess which would account for this is in the group of hysterics where the number of Afrikaans- and English-speaking persons are equal (19). However, it is possible that this finding is weighted by other factors, such as religious affiliation to the Apostolic church.

No differences were found for the Coloured patients for this determinant from the general population parameters.

ASIATICS

Only 3 of the 428 patients in the clinic series (0.7%) were Asiatics and were therefore not included in the comparative review. This low figure conforms to the proportions of Asiatics in the Metropolitan area.

All three patients were male Hindus. Two were

boys and the third a married adult presenting with delirium tremens.

> He was Ronald Rajput, 37, a brandy-drinker whose usual consumption was a bottle each day. He worked as a waiter at an exclusive hotel where, he said, many of the clientéle relied upon his judgement of wines. Of his earnings of £10-£15 per week (R.20-30) about forty per cent were spent on his alcoholic needs.

This patient presented with Lilliputian hallucinations of tiny people and also venomous snakes whom he would intermittently keep at bay with a chopper. This was his first attack of delirium tremens. An only son, he said "I am my mother's angel". His father had been a Hindu priest who had died when he was eighteen. His parents had reared him in an atmosphere illuminated by the light of the Hindu Temple, and abhorring the three evils of drink, tobacco and the cinema.

> One of the two boys a 15 year-old presented with school refusal. His home had been disrupted at six years when his father left. After his mother's remarriage to a Christian he was adopted by his maternal grandmother. He said he was staying at home "because I want to

go to work to support my Granny."

The other boy was 16 and referred for a stammer. He complained that there seemed to be a little ball coming out of his throat. This boy's life was a drudgery. Immediately after school he was required to work in his father's barber-shop. His parents were unacculturated Gujerati-speaking Hindus, the father being illiterate. The boy himself had the ordinary interests of a western boy growing up in this country. He attended the cinema on Saturday afternoons , followed a science-fiction radio-serial, and read school-boy comic papers. The boy deeply resented the inadequacy of his father as a role-model and guide to the social techniques he was required to possess in his South African milieu.

Our sample of Asiatics is too small to permit of statistical conclusions. It is interesting however, to record here the impressions of child guidance clinic workers in Durban.[232] Harris and Hunkin feel that the Hindu in a multiracial South African white-oriented society has difficulty in maintaining religiously enforced passivity in the repressive situation in which these

people find themselves. This finds expression in symptoms such as "stammering and in the general nervous excitability and volubility of the typical Indian."

SUMMARY

In this chapter was recorded experience with a series of 428 psychiatric clinic patients. As with the emergency population a racial incidence disproportionate to the general population was encountered. White patients presented in excess, Coloured and African patients in deficiency. When these figures were compared with the patients attending combined medical clinics over the same period, it was found that this distribution did not extend to the patients with physical disorders.

On further analysis it was discovered that while presenting in such significantly different proportions, white and Coloured patients showed the same proportions of psychosis (75% and 74%) and neurosis (25% and 26%). The 18 African patients were divided equally into the two categories.

Psychotic clinic patients of both main colour groups showed the same proportions of functional (85% and 86%) and organic illness (15% and 14%). Differences were however noted for nosological types. Whites tended to be depressed and Coloured patients schizophrenic at significant levels, the relationships approaching 2:1 proportions.

Among neurotic patients identical proportions of white and Coloured suffered from anxiety neuroses, personality disorders, obsessional neuroses and anti-social (sociopathic) reactions. However more Coloured patients were hysterical and more whites depressed in 2:1 proportions. With regard to alcohol and other addictions this disproportion further increased so that 22% of the whites but only 8% of the Coloureds were diagnosed as having this condition.

In specific diagnostic categories it was found that hysterical females outnumbered males almost 3:1. Contrary to expectation hysterics did not come from significantly lower occupational and educational strata than all neurotics combined.

One religious difference was discovered in the group of hysterics; Coloured persons from minor Christian sects presenting more commonly at the 5 per cent level. This was considered to be due to the comparatively large numbers of Apostolics in this subgroup.

When the whole population was considered for psychosis and neurosis no religious group was found to be either excessively prone or protected from psychosis. On the other hand among neurotics white Roman Catholics and Coloured members of minor Christian sects presented more commonly; Jews and Islamics less commonly. Again the Apostolic patients accounted for the excessive liability of Coloured minor Christian sect patients. The differences found for neurotics were still present when the total clinic population was analysed for religious affiliations.

For social class, comparative population figures were not available. From internal comparisons, however, it was found that the majority of whites were at upper levels; and the majority of Coloureds at lower

levels of occupation and education. This was not thought to differ from what is found from impressions of the general population. Nor was there any obvious difference for social level between psychosis and neurosis. Racial social differences eclipsed any such differences that might have existed.

There were generally no significant sex differences to be found. Young persons of both colours were underrepresented at the expense of other age-groups, even when the population figures were adjusted to exclude small children. Exploration of marital status revealed that significantly more patients were drawn from among the divorced.

Finally, the home languages of psychiatric patients did not differ significantly from the population proportions. Significantly more Afrikaans-speaking neurotics presented at the clinic, particularly in the hysteric sub-category.

CHAPTER VII.

Evaluation

The main hypothesis of the study must now be examined and tested against the evidence. It was felt that the Coloured community provided a unique opportunity of studying the psychiatric effects of the particular stresses felt by a marginal society. Here was a group claiming identity with the dominant white group, yet being denied this. On the other hand they had no wish to integrate with the larger but inferior-status African community.

Surely, as Stonequist had suggested when he drew his picture of the marginal personality, such a group suffered more ambivalence, more inner tensions, more unchanneled resentments ? Surely a fringe group with no well-developed sense of belonging would suffer, as Erikson's theories had suggested, from role diffusion with its consequent psychological handicaps ? Wheelis[233] has implied that this identity is something for which all humans constantly search, and that its

elusiveness is responsible for much of the anxiety of our age. How much more so for this group under study when added barriers are placed in its way both from within and without ? Leighton had hypothesized that interference with status-striving is a potent source of psychological mischief. Was this to be seen in the community under observation ?

The overall figures of the study do not confirm this expectation of more psychiatric illness within the Coloured community. Proportionately less Coloured people presented than did whites under emergency and ordinary clinic conditions. Were the hospital able to claim that it swallowed up all the psychiatric patients in its catchment area one might even have argued that the findings show that the Coloured community are psychologically healthier than the whites. But other and subtler social variables are operating. Presentation incidence does not mean community prevalence. Other treatment agencies operate in the community and mental illness is not yet fully accepted as being the preserve of the medical doctor.

Our findings can merely be taken as proving what they actually show, viz. that Coloured patients present less commonly at medical psychiatric services, whether emergency or out-patient clinics. It remains for an actual community survey to show whether the Coloured community is psychologically unhealthier or not. In fact this was one of the main criticisms of the Hollingshead and Redlich study that it could speak only for <u>treated</u> and not <u>actual</u> prevalence. And this was a very highly organized research project which included a sample of 5 per cent of all households in the community.

We expected to find more drastic and society-clashing illness presenting among the Coloured group. We found instead incredibly close proportions of Coloureds and whites with psychotic illnesses in both our samples. However when this was further analysed schizophrenia was commoner in the Coloured group and manic-depression in the white. Certainly schizophrenia is the more drastic psychosis. As yet we have no satisfactory means of treating it. But it is also a condition which firstly, occurs more commonly in lower social status groups, and secondly, is so disturbing to its environment that

it cannot be contained. If non-medical agencies are operating in the Coloured community or if families are psychologically unsophisticated they would be more likely to contain their depressives and to submit their schizophrenics for treatment.

Similarly we may apply the same arguments to assessment of the neurotic findings where again depression was commoner for whites and hysteria for Coloureds. Hysteria has been shown to be more common in lower-class persons. The Yale class IV "ached physically". The class V patient stormed against his environment. Furthermore more of the Coloured hysterics were dissocietive acting-out cases. However we did not find that Coloured hysterics were at lower status levels than all Coloured neurotics. Could there be another possible explanation ?

It seems likely that the answer is that the different groups are each at different levels of psychosocial development. Most of the whites are "inner-directed". They internalize parental standards as buried consciences which ache with depression ("heart-sore") when they fail to meet standards of judgement.

Coloured families are both at this level of functioning and also at another level which stems from overcrowded living conditions that weaken family ties. Whites live in family units. Coloured persons live in a sort of joint household in which several families are thrown together. Constantly different identifying contacts are made which come and go so that sense of family identity is weak and attenuated. Furthermore in many households there are stem families where members of the same family of three or more generations live together. The authority of the parents is undermined by the grandparents. (We saw earlier that this had also its good effects in that it protected Coloured widows from the effects of social isolation).

Whether this construct is borne out by an actual psychiatric survey of the community presents fascinating temptations.

APPENDICES

A P P E N D I X A.

A. DIAGNOSTIC CLASSIFICATIONS.

That used in the present study (adapted for teaching purposes at this university):

(i) Major illness : Psychosis.

(ii) Minor illness : Neurosis and personality disorder.

1. MAJOR - PSYCHOSIS:

(i) Functional:

(a) Schizophrenia.

(b) Manic-depression with involutional depression.

(c) Paranoid reactions.

(ii) Organic reaction types:

(a) Acute.

(b) Chronic (dementia).

2. MINOR:

(a) Neuroses:

(i) Hysteria.

(ii) Anxiety - phobic reaction.

(iii) Obsessional neurosis.

(iv) Reactive and neurotic depression.

(v) Addiction to (i) alcohol.

Addiction to (ii) drugs.

(vi) Psychosomatic reaction.

(vii) Adolescent reactions.

(viii) Behaviour disorders of children.

(b) Personality Disorders of various types.

(c) Sociopathy and Conduct Disorders.

B. INTERNATIONAL STATISTICAL CLASSIFICATION. 214.

(i) Psychoses:

300 Schizophrenic disorders.

301 Manic-depressive reaction.

302 Involutional melancholia.

303 Paranoia and paranoid states.

304 Senile psychosis.

305 Presenile psychosis.

306 Psychosis with cerebral arteriosclerosis.

307 Alcoholic psychosis.

308 Psychosis of other demonstrable etiology (from brain tumour, epilepsy, etc).

309 Other and unspecified psychoses.

(ii) Psychoneurotic Disorders:

310 Anxiety reaction without somatic symptoms.

311 Hysterical reaction without anxiety.

312 Phobic reaction.

313 Obsessive-compulsive reaction.

314 Neurotic-depressive reaction.

315 Psychoneurosis with somatization affecting circulatory system.

316 Psychoneurosis affecting digestive system.

317 Psychoneurosis affecting other systems.

318 Psychoneurotic disorders, other, mixed, and unspecified

types (including hypochondriasis, depersonalization, occupational neurosis, and asthenic reaction).

(iii) Disorders of Character, Behaviour, and Intelligence:

320 Pathological personality.

320 0 - Schizoid.

1 - Paranoid.

2 - Cyclothymic.

3 - Inadequate.

4 - Antisocial.

5 - Asocial.

6 - Sexual deviation.

7 - Other and unspecified.

321 Immature personality.

322 Alcoholism.

323 Other drug addiction.

324 Primary childhood behaviour disorders.

325 Mental deficiency.

C. LEWIS'S CLASSIFICATION (in Price's "Textbook of Medicine" [215]).

Organic disorders. (This category includes intoxications such as those due to alcohol and drugs, and infections).

Affective disorder.

(i) Excitement.

(ii) Depression.

(iii) Anxiety.

Schizophrenia.

Paranoia.

Hysteria.

Obsessional disorder.

Psychopathic personality.

Mental deficiency.

D. CLASSIFICATION OF MAYER-GROSS, ROTH, SLATER. [216.]

1. Psychopathic Personality and neurotic reactions:

Depressive reaction.

Neurasthenic reaction.

Anxiety reaction.

Hysteria.

Anorexia nervosa.

Obsessional states.

Irritability.

Hypochondriasis.

Paranoid reaction.

The unstable drifter.

The cold and emotionally callous.

The sexually perverse.

2. Affective Disorders.

3. Schizophrenia.

4. Symptomatic Psychoses.

5. Chemical Intoxications and Addictions.

6. The Epilepsies.

7. Mental Disorder in Trauma, Infection, and Brain Tumour.

8. Ageing and Mental Diseases of the Aged.

9. Child Psychiatry.

E. VETERANS ADMINISTRATION SYSTEM.

(Modified by Hollingshead and Redlich [40].)

(i) Neurotic Disorders:

1. Antisocial and immaturity reactions.
2. Character neuroses.
3. Phobic and anxiety reactions.
4. Depressive reactions.
5. Obsessive-compulsive reactions.
6. Psychosomatic reactions.
7. Hysterical reactions.

(ii) Psychotic Disorders:

1. Affective psychoses.
2. Psychoses resulting from alcoholism and drug addiction.
3. Organic psychoses.
4. Schizophrenic psychoses.
5. Senile psychoses.

F. MODIFIED KRAEPELINIAN SYSTEM.

(Henderson and Gillespie, 217)

1. Traumatic psychoses.
2. Senile psychoses.
3. Psychoses with cerebral arteriosclerosis.
4. General paralysis.
5. Psychoses with cerebral syphilis.
6. Psychoses with Huntington's Chorea.
7. Psychoses with brain tumour.
8. Psychoses with other brain or nervous diseases.
9. Alcoholic psychoses.

10. Psychoses due to drugs and other exogenous toxins.
11. Psychoses with pellagra.
12. Psychoses with other somatic diseases.
13. Manic-depressive psychoses.
14. Involutional melancholia.
15. Dementia Praecox.
16. Paranoia or paranoid conditions.
17. Epileptic psychoses.
18. Psychoneuroses and neuroses.
    (a) Hysterical type.
    (b) Psychaesthenic type.
    (c) Neuraethenic type.
    (d) Anxiety neuroses.
    (e) Other types.
19. Psychoses with psychopathic personality.
20. Psychoses with mental deficiency.
21. Undiagnosed psychoses.
22. Without psychosis (e.g. Epilepsy, alcoholism, drug addiction).

APPENDIX B.

DATA FOR METROPOLITAN CAPE TOWN

(Union Population Census of 1951)

AGE DISTRIBUTION.

AGE	RACE GROUPING							
	White	%	Coloured	%	Asiatic	%	Africans	%
0-15	65,477		110,508		3,269		10,090	
15-24	41,009		58,246		1,533		9,133	
0-24	106,486	44	168,754	63	4,802	60	19,223	39
25-34	37,876		38,403		1,299		16,301	
35-44	37,096		28,596		915		8,734	
25-44	74,972	31	66,999	25	2,214	28	25,035	51
45-54	28,477		18,832		485		3,785	
55-64	18,773		9,924		303		1,047	
65-74	12,569		5,270		199		334	
45-74	59,819	25	35,026	13	987	12	5,166	10
TOTAL	241,277	100	269,779	100	8,003	100	49,424	100

MARITAL STATUS.

Status	Whites	%	Coloured	%	Asiatics	%	Africans	%
Never Married	119,895	48	178,028	66	4,647	57	24,771	50
Married	108,656	44	80,328	29	3,250	40	21,735	44
Widow	14,839	6	11,727	4	200	2.7	1,314	2.6
Divorced	3,937	1.6	1,755	0.6	48	0.6	243	0.5
Cohabiting	-	-	184	0.1	-	-	902	1.8
Unspecified	115	0.0	292	0.1	4	0.05	830	1.7
TOTAL	247,442	100	272,314	100	8,099	100	49,795	100

RELIGIOUS AFFILIATION.

Denomination	Whites	%	Coloureds	%	Asiatics	%	Africans	%
Dutch Reformed	67,781	27	35,271	13	21	6.3	1,102	2
Anglican	73,683	30	94,223	35	285	3.5	8,696	17
Roman Catholic	22,914	9	17,545	6	593	7	2,397	5
Main Non-Conf.	39,701	16	28,087	10	61	0.8	18,816	38
Minor Christian Group	18,842	8	46,360	17	105	1.3	8,180	16
Jewish	20,446	8	-	-	-	-	-	-
Islam	-	-	46,610	17	5,769	71	49	0.1
Other	4,075	1.6	4,218	1.5	1,265	16	10,555	21
TOTAL	247,442	100	272,314	100	8,099	100	49,793	100

A P P E N D I X C.

Groote Schuur Hospital
Socio-Cultural Survey
of Psychiatric Patients

Protocol No. .....
Hospital No. .....

A. SCHEDULE AND INTERVIEW GUIDE.

Date of interview ..... 19 ....

Patient's Surname (Block capitals): Mr./Mrs./Miss .....

First name/s .....

Date of Birth ..... 19 ..... Age .....

Present Address .....

Telephone No: .....

Source of referral: (Specify) If private doctor: Dr. .....
Other hospital department .....
Casualty .....
Other .....

First seen by (Consultant) Dr. ..... on ..... 19 .

Marital state (Ring): Never married/Married/Cohabiting/Separated/Divorced/Widowed/er.

Group: White/Coloured/Malay/African/Asiatic.

Precise ethnic group (where known).....

Mother: ..... Father: .....

Informant: Mr./Mrs./Miss ..... Age .....

Address: ..... Race .....

Tel. No. ..... Rel. to patient .....

ADDITIONAL CLINICAL DATA:

B. PSYCHIATRIC DATA:

1. Presenting symptom and duration .....

.....

.....

2. Subsidiary symptoms and duration .....

.....

.....

3. Mode of onset .....

.....

.....

4. Precipitating environmental event .....

.....

5. Premorbid personality .....

.....

6. Summary of clinical examination .....

.....

.....

.....

.....

For Consultant's use:

NOSOLOGICAL DIAGNOSIS:

Psychosis/Neurosis/Personality disorder.

(Please ring appropriate category on this and subsequent pages).

PSYCHODYNAMIC FORMULATION.

(State effects of socio-cultural influences apparent)

C. SOCIO-CULTURAL DATA:

Occupation:

Present occupation ..... Duration .....

List previous occupations and duration .....

.....

.....

Economic status:

Income .....

Supplementary (e.g. from wife) .....

Joint income .....

Household: House/Flat/Hotel/Room.

Construction e.g. Concrete or temporary wood and shanty .....

Number of rooms and designation .....

Occupation .....

Rental or equivalent .....

Education:

.....

.....

Birth place: ..... Type of rearing: .....

Language ..... Home language .....

Additional .....

Religious attitude:

Denomination .....

Self assessed attitude on scale .....

Habits .....

When last attended .....

SOCIO-CULTURAL ACTIVITIES:

.....

.....

.....

.....

FAMILY:

Parental attitudes .....

Mother .....

.....

Father .....

.....

Sibship .....

.....

.....

Dominant parent .....

Sexual adjustment .....

.....

.....

.....

Marriage Age .....

Reasons .....

.....

Marital history .....

.....

PSYCHOSES:

A. Functional.

Schizophrenia.
Depressive.
Mania.
Agitated depression of elderly.
Paranoid psychosis.

B. Organic.

Acute delirious.
Chronic (dementia).

PSYCHONEUROSES:

Anxiety neurosis.
Hysteria (Specify Dissociative/Conversion).
Obsessional neurosis.
Phobic state.
Reactive depression.

PSYCHOSOMATIC REACTION: Specify e.g. asthma.

.....

PERSONALITY DISORDER:

Schizoid.
Obsessional.
Hysterical.
Cyclothymic.
Paranoid.
Sociopathy.
Alcoholism.
Drug addiction.
Other.

UNCLASSIFIABLE:

Mixed states or patterns which for cultural reasons are not applicable to above categories. Please give reasons in detail.

.....

.....

.....

.....

Characteristics of wife/husband:

Education ..... Religious attitudes .....

Language ..... Occupation .....

Personality .....

.....

.....

.....

Previous marriages:

.....

.....

.....

A P P E N D I X D.

STATISTICAL METHODS EMPLOYED IN THE STUDY.

METHOD 1.

To test the difference between an observed proportion in a sample and the true proportion in the population.

Let P = population proportion, e.g. the population percentage is 38·4%, then P = 0·384.

and p = proportion in sample under consideration.

e.g. if 30 out of 120, then p = 0·250,

$$\sigma^2 \text{ (the variance of p)} = \frac{P(1 - P)}{n}$$

$$= \frac{(0\ 384)(1-0\cdot384)}{120}$$

where n is the number in the sample.

Then u (standard normal deviation) will be $\frac{p - P}{\sigma}$

$$= \frac{p - P}{\sqrt{\sigma^2}} .$$

METHOD 2.

To test the difference between observed proportions in two different samples (A and B) where knowledge of the true proportion in the general population is not available.

Let p_1 = proportion in sample A.

p_2 = proportion in sample B.

r_1 = number of persons out of sample A.

r_2 = number of persons out of sample B.

n_1 = total number of persons in sample A.

n_2 = total number of persons in sample B.

u = Variance of $p_1 - p_2$ will be $\frac{P(1 - P)}{n_1 + n_2} \times 2$

where $P = \frac{r_1 + r_2}{n_1 + n_2}$.

Evaluation for methods 1 and 2.

If u is less than 1·96 there is no significant difference.

If u is greater than 1·96 the difference is "significant" at the 5°/₀ level (·05) .

If u is greater than 2·58 the difference is "highly significant" at the 1°/₀ level (·01).

If u is greater than 3·51 the difference is "very highly significant" at the 0·1°/₀ level (·001).

METHOD 3. χ^2 test for association.

Suppose a sample is classified according to two different criteria e.g. race and sex.

Then, employing actual numbers and not percentages a "2 x 2 table" may be constructed :

	White	Coloured	Total
Male	a	b	a+b
Female	c	d	c+d
Total	a+c	b+d	a+b+c+d = n

$$\chi_1^2 = \frac{[\,|ad-bc| - \frac{1}{2}n]^2 n}{(a+c)(b+d)(a+b)(c+d)}$$

where $|ad - bc|$ is the absolute value of $ad - bc$.

e.g. $|2 - 5| = 3$.

If χ^2 is less than 3·84 there is no significant association.

If χ^2 is between 3·84 and 6·64 the association is significant at the 5°/₀ level (·05).

If χ^2 is between 6·64 and 12·32 the association is significant at the 1°/₀ level (·01).

If χ^2 is greater than 12·32 the association is significant at the ·1°/₀ level (·001).

If χ^2 is significant it means that the proportion of males is significantly different for White and Coloured, or that the proportion of Whites is different for males and females.

METHOD 4. χ^2 test for association between three different groups for two characteristics or two groups with three characteristics.

Construct a "3 × 2 table" using actual numbers

of the sample and not percentages. No cell must contain less than 5 individuals and any individual is only to be represented in one cell.

	Male	Female	Total
White	a	b	a+b = g
Coloured	c	d	c+d = h
African	e	f	e+f = k
Total	a+c+e = l	b+d+f = m	a+b+c+d+e+f = n

Expected frequencies will be :

	Male	Female
White	$\frac{(l \times g)}{n} = e_1$	$\frac{(m \times g)}{n} = e_2$
Coloured	$\frac{(l \times h)}{n} = e_3$	$\frac{(m \times h)}{n} = e_4$
African	$\frac{(l \times k)}{n} = e_5$	$\frac{(m \times k)}{n} = e_6$

Then $\chi^2 = \frac{a^2}{e_1} + \frac{b^2}{e_2} + \frac{c^2}{e_3} + \frac{d^2}{e_4} + \frac{e^2}{e_5} + \frac{f^2}{e_6} - n$.

Assess according to χ^2 tables for 2 degree of freedom. [An $r \times p$ table has $(r-1)(p-1)$ degrees of freedom i.e. here $(3-1)(2-1) = 2$.]

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