should be vigorously pushed forward. If the Clinical Meeting he had spoken of could be held at Rampton Institution, probably many of the members not associated specially with mental deficiency might still think it worth their while to go to that particular meeting. He believed they would find it extraordinarily interesting.

Another announcement he had to make, and that a very pleasurable one, was that Sir James Crichton-Browne had presented to the Association a portrait of himself, and it had been accepted with thanks, and hung in the Library.

PAPER.

Dr. W. M. FORD-ROBERTSON read a paper entitled "**The Blood Differential Picture in Mental Disorder, with Special Reference to the Lymphatic Reaction**".

[This paper, with the ensuing discussion, will appear in a later number of the Journal.]

SOUTH-EASTERN DIVISION.

THE AUTUMN MEETING of the Division was held on October 7, 1933, at the Lady Chichester Hospital, Hove, by the kind invitation of Dr. Helen Boyle and of the Governors.

During the morning members and guests inspected the hospital, and later enjoyed a motor drive to the Devil's Dyke. They were kindly entertained to lunch by the Governors, being welcomed by Dr. W. Broadbent, Hon. Consulting Physician to the hospital, who apologized for the unavoidable absence of the President, The Countess of Chichester. Dr. Rambaut expressed the thanks of the meeting.

Dr. Rambaut took the chair at the meeting, and was invested with the Divisional Chairman's badge by Dr. G. W. Smith, who expressed the members' gratification at the honour now being bestowed upon Dr. Rambaut.

The minutes of the previous meeting were taken as read and confirmed.

The CHAIRMAN proposed a vote of thanks to Dr. Haynes for his successful efforts in organizing, on behalf of the Division, the reception and dance at the Annual Meeting. This was carried by acclamation.

The following were unanimously elected members of the Association:

HENRY LAING GORDON, M.D.Edin., Visiting Physician, Mathari Mental Hospital, Nairobi; P.O. Box 950, Nairobi, Kenya Colony.

LESLIE THEODORE HILLIARD, M.A., B.Ch.Camb., M.R.C.S., L.R.C.P., Assistant Medical Officer, Hanwell Mental Hospital, Southall, Middlesex.

The invitation of Dr. C. McDowall to hold the Spring Meeting, 1934, at Ticehurst was accepted, the meeting to be held on a date in April to be fixed by the Secretary in consultation with Dr. McDowall.

Dr. H. L. GORDON read a paper on "Psychiatry in Kenya Colony" (*see below*). A discussion followed, in which Drs. RAMBAUT, GOODALL, JAMES, BAIRD, G. W. SMITH, DOUGLAS TURNER, HELEN BOYLE and SERGEANT took part. Dr. GORDON replied.

Members and guests were then entertained to tea.

PAPER.—"**Psychiatry in Kenya Colony,**" by H. L. GORDON, M.D.

The whole lunacy law of Kenya is the Indian Act of 1858, which has never been amended. Civilian doctors are not allowed to certify. The duty is performed by the members of the Colonial Medical Service, including its unqualified members. There is one mental institution, the Mathari Hospital, Nairobi; its native section has been overcrowded ever since it was built in 1910. To provide for the waiting list, certain prisons of the colony are called asylums, and these also are overcrowded. Treatment, as psychiatry knows it, is nowhere provided; prevention has not been considered, for the colony is very young. Official medicine is preoccupied with urgent problems of physical disease; official education has had no opportunity to consider the importance of amentia; the law is engaged in the heroic task of applying civilized codes to an uncivilized race; the Government is not constituted to seek guidance from science. The situation has one advantage in regard only to amentia: we are not hampered by legal and educational definitions of the condition; we are able to avoid setting aside the organic origins of the condition on the ground that its social symptoms are all that matters. It is something of a shock to find in a recent European textbook a dictum that the doctor needs to know the mental defective "only by his fruits".

I found the psychiatric field in East Africa wholly unexplored, and investigation of the mental condition of a native by no means easy. Family history is never obtainable, social

and medical history only very occasionally. The certificate is seldom enlightening. Then there is the language difficulty—some forty tribes each with its own language.

The most serious difficulty, however, is the lack of standards for judgment between normal and abnormal social behaviour, normal and abnormal mental products—a situation incapable of remedy without scientific survey of East African social and cultural anthropology. A few facts only are indisputable. The "right to live" is not a content of native ethics; there is no regard for the sanctity of life. That has to be considered in tales of violence and murder, along with what we think we know about tribal tradition and custom. Again, European standards of decency are no guides. A medical certificate from a prison said, "Stands naked at the door of his cell when it is opened". Clearly that was questionable evidence of insanity in one who was a born and bred nudist.

The curse of Africa, witchcraft, creates many difficulties, and is a common cause, in my experience, of hysteria in all its forms, of violence and of murder and suicide. It enters disconcertingly into the consideration of delusions, and I have learnt that this powerful influence does not forsake the native who goes through mission education and enters into service for Europeans and Asiatics. A perfectly good house servant, wearing a Christian cross, told me that his newborn baby was dying and must die, because, on the night of the intercourse which resulted in its birth, an evil neighbour had smeared the father's hut with his own evil seminal fluid. This was undoubtedly a socially determined native belief. How far in the Christian make-up of the man it was what Dr. Devine, in his philosophic study of delusions, calls "an intimate perception of fundamental organic realities" I do not feel qualified to say. It might have been possible to certify the man as a deluded Christian, but his discharge as a normal native might have been more reasonable. Again, a farm boy got married by Christian ceremony. There were festivities of pagan character round his hut while the clan awaited news from within of consummation, *i.e.*, of proof that the bridegroom was, indeed, a man. The festivities were unusually prolonged. In answer to calls, the bridegroom appeared and confessed failure. There were jeers; he attempted suicide, and would have succeeded but for the timely interference of the native policeman. Subsequently the European police officer proposed his certification. The doctor, however, discovered that suicide was the correct social behaviour in the circumstances. The cause of the failure did not enter into the consideration of bridegroom or clan, who were quite unmoved when the doctor diagnosed the bride as a bad case of occlusion of the vagina from bungled circumcision.

The stage of transition from the state we call uncivilized to the state called civilized is one of great difficulty for administrators, and probably of trying mental conflict for the neophyte. I have found delusions often enough to be a distortion of Christianity and a revelation of fundamental paganism. Amazingly confident statements about the primitive African mind are made in both psychological and general literature by writers who appear to be satisfied with the authority of tourists, explorers and missionaries, and with the anecdotal evidence supplied by amateur anthropologists and psychologists. There is a very real need for collaborative field research by social and cultural anthropology on the one hand, and social psychology, free from the chains of a school, on the other hand.

On the question of mental deficiency in the native, I shall have the privilege of speaking elsewhere.* I have found the biologically-based method of diagnosis introduced by Prof. Berry a valuable method. It is by biological rather than social criteria that we are most likely to succeed in the great problem of raising the African native.

I have found the majority of cases of *mental disorder* in our natives to be classifiable as organic psychoses attributable to spirochætal infection of the central nervous system. All the cases of epilepsy fell in this group, and there were cases which might have been either the Parkinsonian syndrome of epidemic encephalitis or a spirochætal mesencephalitis. The toxic group was represented by puerperal cases, a confusional state after pneumonia, and by the results of Indian hemp smoking. The only involutional type seen was senile dementia, and I have not yet seen a paranoid case. You may be more surprised to hear that I have not met a case which would justify the popular label of manic-depressive. Mania and depression, when seen, have always been very mild, short in duration and never alternating. I have found native cases presenting symptoms of dementia præcox, but none of these was in a "raw" native. All were in natives who had come in boyhood and adolescence under the influence and mental strain of European education and religion.

In symptomatology, East African mental disorders impress one as but poor imitations of European disorders. Stupor, mutism, verbigeration, echolalia, mannerisms—all these occur in a mild form. Euphoria is often extreme, and accompanied by histrionic dancing. Evidence of hallucinations is hard to elicit in the native. The East African is not the true negro, either ethnologically or in temperament. His pigmentation varies from yellow through attractive

* To the Eugenics Society on November 7th, 1933.

shades of red or copper-brown to black. His bearing is, for the most part, composed, distant, superior. The evidence I hope to put before the Eugenics Society may be interpreted as evidence of cerebral subinvolution. Unquestionably these hybrid tribes have been also victims of environment.

The fragments of information concerning mental disorders in another race may suggest to you that psychiatry may advance materially when it ceases to be studied in watertight compartments determined by national boundaries. Even in Europe systematic study of comparative racial psychiatry cannot be said to have begun, yet it seems to offer the best path to solution of a world-wide problem, provided it is pursued alongside the equally neglected studies of comparative psychology and anthropology supported by genetic and statistical research. We know a good deal more about animal and plant heredity than we do about human heredity. The intricate nature of genetic inquiry is no excuse for neglect of the subject by our profession, particularly by the rank and file in psychiatry. To every scientific approach Kenya offers a virgin field, with unexcelled opportunities to acquire new knowledge of universal value, provided it is sought before the entry of civilization complicates the search. The psychologist, for example, will find on the one side the untutored mind of the raw native, on the other side that of the native newly within our social organization, its complexities and bewilderments.

The ignorance of the mind of the native, of his adaptability to a new environment, is an obstacle to native development and progress. How are we to judge him for his benefit without standards? Shall he be judged by the standards of our civilization, or by standards of his own race, biological and social, found for him by us? Simple as it may sound, this question penetrates all essential problems of African administration, and may be regarded, in my opinion, as a challenge to our ignorance of the genetic basis of racial differences and social behaviour. If systematic scientific inquiry did no more than remove race prejudice from consideration of African problems, it would do a service of untold value to the Continent. The common variety of race prejudice is based upon feelings of inherent superiority; a more subtle kind is sheltered by other prejudices and based upon medieval egalitarianism. We require knowledge of the causes of the present low biological backwardness. The psychiatric is not the least hopeful of approaches to this study. In his *Genetic Principles in Medicine and Social Service*, Prof. Hogben has given our profession at once a discipline and an inspiration. "The present situation (in Europe)" he says, "in the classification of mental defects and disorders, suggests that fruitful inquiry should first concentrate upon those types which can be already regarded as distinct biological entities". I need hardly repeat emphasis of the opportunities for such fruitful inquiry in Kenya. In the painful turmoil of controversy over the future of the native, optimism for that future finds little encouragement until it perceives the possibilities from biological research into causes.

At the moment a sense of proportion is not always preserved in the consideration of native problems. Kenya, in particular, suffers not a little from the hasty generalizations of itinerant publicists. British influences reach, in fact, only a fraction of our native population, and are represented over huge areas by no more than an isolated skeleton establishment. The spheres of the religious missions are limited, but within them native membership increases daily and scholastic education aims high. The administration and the law labour industriously to carry out traditional British methods and to inculcate our traditional social standards. We may see official medicine, sadly understaffed, fighting lethal disease and introducing elementary principles of hygiene, well aware that tenfold greater efforts would not be enough. If we see only these and other beginnings we may say all is well; but there is a companion picture for psychologist, psychiatrist and sociologist. Out of and from beyond the influences I have named, natives go eagerly into the new experience of work; into farm labour, trade employment, domestic service for European and Asiatic; into settled areas and growing towns, where practical civilization has brought other institutions to await other expected results of its arrival. Prisons, reformatory, asylum—all are filled to overflowing; the distracted law has created a new class of minor convict to meet the situation. The types of crime now include familiar European types, even forgery and the confidence trick. Degradations of urban life, previously unknown to the native, show alarming development in him. In the towns our own standards are threatened by street-loafing day and night, spitting and nose-blowing on the footpath, and other such practices; by disregard in the public streets for the decencies of life; by drinking, drugging, sexual perversions and assaults; by the creation of squalor and slums of the worst character—new growths all of these, in the wake of so-called civilization. What are we building up? Are we being careful to balance success with failure, and profit by the result? Can our civilization safely afford to avoid expert study of the less pleasing results from its arrival? Accumulation in another race by our initiative of the costly sores and burdens of society our own race knows well and bitterly—is science obliged to stand by and regard this creation as inevitable?

Confusion arises from loose interpretation of the word "civilization." If, with some, we

believe social organization to be synonymous with civilization, we may logically consider a native civilized who wears European clothes, rides a bicycle, sacrifices five shillings to the tote on Saturday and a penny to the collection on Sunday. But if we agree with Prof. McDougall that civilization is more and greater than social organization because it is *the sum of the living moral and intellectual tradition of the people*, our conception of native progress is widened and sobered. We feel our task in East Africa to be greater and more inspiring; more in need of scientific foresight and guidance than statesmanship is yet aware.

SOUTH-WESTERN DIVISION.

THE AUTUMN MEETING of the Division was held by kind invitation of Dr. R. Eager, O.B.E., and the Committee of Visitors at Devon County Mental Hospital, Exminster, near Exeter, on Thursday, October 26, 1933.

The following members were present: Drs. R. A. G. Penny, C. F. Bainbridge, G. de M. Rudolf, E. Casson, P. W. Carruthers, A. H. Firth, B. M. Mules, A. S. Mules, A. Darlington, J. W. Fisher, B. J. Mullin, R. Craig, J. G. Smith, N. R. Phillips, E. Poynder, John Keay, W. R. Dawson, J. L. Jackson, R. Eager, Isabel G. H. Wilson, and S. Edgar Martin (Hon. Divisional Secretary).

The undermentioned attended as visitors: The Rev. J. Barney, Dr. L. A. Weatherly, Messrs. L. E. Claremont, W. H. Ross, E. W. Mayer, the Rev. Ian W. Elliot (Chaplain), Col. G. J. Ellicombe (Chairman of the Hospital Works Sub-committee), Mrs. D. E. Bainbridge and Dr. R. J. W. Minshull.

Dr. J. L. Jackson was in the chair.

Apologies for absence were received from the President (Dr. Turner), the Registrar (Dr. Rambaut), Dr. E. Barton White and others.

The minutes of the last meeting were read and confirmed.

On the proposition of Dr. C. F. BAINBRIDGE, seconded by Dr. J. G. SMITH, Dr. S. Edgar Martin was nominated as Hon. Divisional Secretary, and Dr. E. Barton White and Dr. J. L. Jackson as Representative Members of Council, the latter to be Chairman of the Division.

On the proposition of Dr. C. F. BAINBRIDGE, seconded by Dr. N. R. PHILLIPS, Dr. A. A. D. Townsend was nominated to serve on the Mental Nursing Advisory Committee to the General Nursing Council.

The following were elected as Ordinary Members:

JOHN LANGDON FAULL, M.R.C.S., L.R.C.P., D.P.M., Assistant Medical Officer, Dorset County Mental Hospital, Herrison, Dorchester.

Proposed by Drs. J. J. B. Martin, G. W. T. H. Fleming and Stanley M. Coleman.

MICHAEL JOHN WILMOTT MINSHULL, B.M., B.Ch.Oxon., Assistant Medical Officer, Devon Mental Hospital, Exminster, Devon.

Proposed by Drs. R. Eager, R. A. Greenwood Penny and S. Edgar Martin.

The place of the 1934 Spring Meeting was left in the hands of the Hon. Divisional Secretary.

Dr. R. EAGER, O.B.E., then read a paper and opened a discussion on **"Occupational Therapy".**

The Rev. J. BARNEY, Drs. N. R. PHILLIPS, E. CASSON, G. de M. RUDOLF and E. POYNDER took part in the discussion, and Dr. EAGER replied to the points raised.

Dr. Eager had kindly prepared a printed route as a guide to enable members to make a tour of the hospital in order to view the various occupations which have been introduced since the beginning of the year, and this proved of great use. The members expressed their keen interest in everything they saw. The various occupations included, on the male side: Knitting of vests and pants; coir-mat making and upholstery; making of brown paper bags, netting, face- and dish-cloths, fire-lighters, etc.; brush and basket making, floor cloth weaving, rag-picking and cabinet making; weaving (by automatic hand-looms) of blankets, serge, tweed and towelling; making of rubber mats from disused motor tyres; printing and book-binding. On the female side: Tooth-brush, hair-brush and plaited straw basket making; envelope cutting; wool rug making and raffia work; book-binding and toy making, and other similar occupations to those seen on the male side.

A film was also shown of the various occupations carried on by the patients in the hospital.

An opportunity was also given to members of inspecting the new Nurses' Home.

Members were entertained to lunch and tea by the kind invitation of Dr. Eager and the Committee of Visitors, who were represented by Col. G. J. Ellicombe, Chairman of the Hospital Works Sub-committee, in the absence, through illness, of Major R. P. Kitson, Chairman of the Hospital Committee.

Col. ELLICOMBE gave a short history of the Devon County Mental Hospital, and mentioned