The double blind technique was used throughout with the dose standardized at two tablets three times a day (120 mg. daily). In every case all other psychiatric treatment was withdrawn for the duration of the trial.

Substantial improvement was noticed in three patients and some improvement in a further five.

No side-effects were noted.

It would appear that further trials with this drug in disturbed hallucinated patients would be justified and possibly very helpful.

I should like to thank Dr. D. F. Macgregor, medical superintendent of Carlton Hayes Hospital, for his co-operation and assistance with the trial. Also Mr. Mills, senior technician, Mr. Cannings, and other members of the nursing staff. My thanks are also due to Mr. B. A. Weightman, of Riker Laboratories Ltd., who kindly supplied the azacyclonol used in the trial.

REFERENCES

- Cohen, S., and Parlour, R. R. (1956). *J. Amer. med. Ass.*, 162, 948.
 Fabing, H. D. (1955a). *Neurology*, 5, 603.
 — (1955b). *Ibid.*, 5, 319.
 — (1955c). *Science*, 121, 208.
 — and Hawkins, J. R. (1955). *Dis. nerv. Sys.*, 16, 329.
 Ferguson, J. T. (1956). *Antibiot. Med.*, 3, 146.

AN AFRICAN'S MENTAL OUTLOOK IN BRITAIN

BY

W. I. B. ONUIGBO, M.B., Ch.B., B.Sc.

House-physician, General Hospital, Enugu, Nigeria,
 W. Africa; Lately Nigeria (Eastern Region)
 Government Scholar, Glasgow University

"Were all the circumstances, internal and external, scanned closely and weighed accurately it would be seen that there is no accident in madness" (Maudsley, 1879).

To-day, considerable effort is being expended on establishing "scientifically attested knowledge" about how to keep normal persons mentally healthy (Bartlett, 1949). How to maintain the mental health of university students is a serious problem (Parnell, 1951; Gibson, 1953). Indeed, tuberculosis and mental diseases are "the two major medical problems among undergraduates" (*Practitioner*, 1957).

Immigrants suffer mental ill-health more commonly than do the indigenes (Hill, 1943; Crew, 1955). It stands to reason that the mental health of foreign students must be an even graver problem than that of the British-born.

Otis (1955), of Illinois University, has discussed the mental-health problems of foreign students in America. He recommended that "in order to better prepare future students" there was need to analyse problems "met by one's countrymen who have been students abroad." I wish, therefore, to report my own experiences while studying in Britain. It is hoped that this may be of some help to those who are in a position to counsel foreign students.

Writing on colour prejudice in Britain, Richmond (1954) stated that "examples can be cited of psychotic individuals whose behaviour is clearly conditioned by the conflicts that they have experienced through racial prejudice in this country." Sclare (1953) also drew attention to the effect that racial discrimination has on the neurotic pattern seen among American negroes.

If colour prejudice can thus undermine mental health, in what way may the negro student be safeguarded? In presenting my own solution I have in mind what Max-

well (1871) told a meeting of the British Association for the Advancement of Science in 1870: "It was a great step in science when men became convinced that, in order to understand the nature of things, they must begin by asking, not whether a thing is good or bad, noxious or beneficial, but of what kind is it? and how much is there of it?"

Present Investigation

Human beings are "notoriously elusive subjects for objective study and quantitative measurement" (McCalman, 1953). An objective assessment of discriminatory trends in a British city has been made, using a simple, measurable, behavioural quantity—namely, the presence or absence of courtesy in a public utility.

Between November 22, 1954, and November 8, 1955, whenever I paid my fare in any Glasgow Corporation transport I took careful note of whether my fare was accepted with thanks or not with thanks. As a control, I observed whether a European passenger, whose fare was taken just before, or, failing that, just after mine, was thanked or not.

In all, 500 journeys were made. Three types of data were obtained and entered in my diary, each record being made soon after the journey.

Type I—408 cases in which a European fellow passenger and I were both courteously thanked; type II—73 cases in which neither of us was thanked; type III—19 cases in which a European was thanked but I was not. In no case was I thanked but not a near-by Caucasian.

Discussion

It was Lord Lytton (1956) who said that "courtesy is a duty public servants owe to the humblest member of the public." Indeed, the General Manager of Glasgow Corporation Transport Department (1955) reported that his "greatest difficulty is to inculcate amongst the staff a spirit of courtesy and pride of service." Since courtesy is valued so highly in Britain, this social grace is a dependable criterion for a scientific analysis of discriminatory behaviour in this country.

From the above analysis we see that in only 19 cases out of 500 was there acceptable evidence of discrimination. This finding is not statistically significant ($\chi^2=0.72$, $P<0.05$).

The 73 type II cases are noteworthy. Each is potentially fraught with the danger that the negro might think that there was discrimination. If he is not to think so, then comparable discourtesy to Europeans travelling with him has first to be observed. How often, we may well wonder, would such a controlled observation be made in everyday life? Kenneth Little (1947) has said that the negro in Britain may often suspect discrimination and aloofness "where they were never intended." I think that this is true.

What clinical clue, if any, does this conclusion contribute? Weinberg (1955) found that "too frequent and embarrassing uncertainties may lead to inner insecurity, or cause a latent insecurity to become overt." Or, as Hume (1947) put it, sociological factors may undermine mental health by "multiplying precipitating situations." Consequently, the negro student who overestimates prejudice multiplies psycho-social trauma and runs a graver risk of mental breakdown. It is in his own interest that he does not make this mistake.

Admittedly, other investigations may yield a different result; for example, if a criterion other than courtesy is employed. Nevertheless, we may conclude that if there is insight into the difference between real and imagined prejudice the probability is that the threshold of what is unbearable will not be approached. Mental hygiene requires that "environmental difficulties should not be excessive" (Stevenson, 1945). As Bartlett (1949) also said, "there are limits of toleration, both environmental and internal, the persistent passing of which leads to mental trouble."

In education for mental health, correct perception of reality is important (Florence Clothier, 1951). If other

essentials such as financial backing and academic background are satisfactory, a correctly oriented negro student will, like Richmond's (1954) ideal, "not be unaware of the frustrations and tensions which negroes experience, but he will be able to face up to such conflicts, precisely because he has succeeded in achieving, for himself, a measure of status and security. He is less bound by the personal anxiety and inner conflicts which besiege so many of his fellows."

Conclusion and Summary

In Britain to-day the mental health of undergraduates is receiving considerable attention. Since immigrants and those open to racial discrimination are prone to suffer mental ill-health, the mental health of the negro student must be an even graver problem than that of the British-born.

Courtesy shown to me and to European fellow passengers by Glasgow Corporation transport workers has been scientifically analysed. The survey suggests that the negro student may easily overestimate the incidence of racial prejudice.

Now, unfavourable sociological attitudes such as prejudice tend to precipitate mental breakdowns, particularly when they are recurrent. Consequently, adequate insight into the racial environment in Britain will, by ruling out instances of imagined rather than real discrimination, help the African student or a student of other lands to maintain a healthy mental outlook while in this country.

REFERENCES

- Bartlett, Sir F. C. (1949). *Brit. med. Bull.*, 6, 7.
 Clothier, F. (1951). *Ment. Hyg. (N.Y.)*, 35, 560.
 Crew, F. A. E. (1955). *J. roy. Inst. publ. Hlth Hygiene*, 18, 181.
 General Manager of Glasgow Corporation Transport Department (1955). *Report of the General Manager for the Year 1954-5*. Glasgow, September, 1955.
 Gibson, H. J. (1953). M.D. Thesis, University of Edinburgh, p. 97.
 Hill, O. B. (1943). *Indian med. Rec.*, 63, 225.
 Hume, P. B. (1947). *Ment. Hyg. (N.Y.)*, 31, 567.
 Little, K. L. (1947). *Negroes in Britain*, p. 268. Kegan Paul, London.
 Lytton, Lord (1956). Quoted in *John Bull*, March 24, p. 54.
 McCalman, E. D. (1953). In *Prospects in Psychiatric Research*, edited by J. M. Tanner, p. 1. Blackwell, Oxford.
 Maudsley, H. (1879). *The Pathology of Mind*, p. 84. Macmillan, London.
 Maxwell, J. C. (1871). In *Report of the Fortieth Meeting of the British Association for the Advancement of Science, Notices and Abstracts of Miscellaneous Communications to the Sections*, p. 2.
 Otis, J. (1955). *Ment. Hyg. (N.Y.)*, 39, 581.
 Parnell, R. W. (1951). *Lancet*, 1, 731.
 Practitioner, 1957, 179, 3.
 Richmond, A. H. (1954). *Colour Prejudice in Britain*, p. 115. Routledge and Kegan Paul, London.
 Sclarc, A. B. (1953). *Brit. J. med. Psychol.*, 26, 278.
 Stevenson, G. H. (1945). *Canad. med. Ass. J.*, 53, 115.
 Weinberg, A. A. (1955). *Ment. Hyg. (N.Y.)*, 39, 450.

Medical Memorandum

Congenital Reduplication of Ileo-caecal Valve Presenting as an Acute Intussusception

The presence of two separate openings in an intussusception protruding from the anus is unusual enough to be worthy of record. Kolb *et al.* (1956) reported a case of intussusception presenting at the anus with duplication of the caecum, but not of the ileo-caecal valve.

CASE REPORT

A male child aged 19 months was admitted to hospital on July 1, 1955, with a diagnosis of intussusception. He was a firstborn, and was quite well until a week before admission, when he developed abdominal pain and looked ill. Forty-eight hours before admission this pain seemed to become worse, and on the next day he vomited four times and passed loose stools. No blood was seen. On the day of admission he vomited three times, and the mother noticed "that something was protruding from the back passage."

On examination he was a well-nourished but very ill boy, being pale and listless, with a temperature of 99.4° F. (37.4° C.) and a pulse rate of 130. A sausage-shaped tumour was felt in the left iliac fossa and a portion of bowel 5 cm. long was protruding at the anus. On closer examination this was found to have two separate openings, one at the tip and one on the left side. A catheter could be passed into each opening separately for a distance of 15 cm. without difficulty.

At operation the prolapsed bowel was reduced inside the rectum. Laparotomy through a left lower paramedian incision showed a little blood-stained fluid in the peritoneal cavity. The intussusception was felt at the level of the pelvic floor and reduced without difficulty. The appendix and caecum were congested but viable. The terminal ileum was adherent to the ascending colon for 5 cm. above the ileo-caecal valve. As the child was very ill the abdomen was closed rapidly, but, despite emergency measures, he died a few minutes later.

Necropsy (Dr. J. B. Enticknap).—The terminal ileum and lower right colon were congested. The last 4 cm. of the former was firmly attached to the caecum and opened into it at both ends of this length (see Diagram). The lower opening was a normal valve in position and form. At the upper one the ileum entered the caecal lumen and almost immediately left it again. Histological section at this point showed the muscular walls of caecum and ileum to be continuous and regular, about 6 mm. of the ileum in the fixed and paraffin-embedded specimen forming part of the caecal wall. There was moderately advanced bronchopneumonia of the right upper lobe and an acute tracheobronchitis causing partial collapse of the periphery of both lungs.

COMMENT

The necropsy findings suggest that the two openings in the bowel prolapsing at the anus were separate ileo-caecal valves, and the regularity of the continuous smooth-muscle layer surrounding them makes it probable that this was a congenital reduplication and not an acquired internal fistula. Gross (1953) reported that 3 out of 702 intussusceptions were due to duplication of the terminal ileum, but neither in his report nor elsewhere have any instances of two valves on a single terminal ileal tube been found.

I thank Mr. R. Parkinson for his help and permission to publish this case.

E. DAYAN, F.R.C.S.

Surgical Registrar, East Ham Memorial Hospital, London.

REFERENCES

- Gross, R. E. (1953). *The Surgery of Infancy and Childhood*, chapters 17 and 20.
 Kolb, L. H., Hirsch, M. M., and Emanuel, B. (1956). *Ann. Surg.*, 144, 1067.

The Government is prepared to consider proposals for individual colours to be added to or removed from the permitted list now embodied in the *Colouring Matter in Food Regulations, 1957* (S.I. No. 1066), and the *Colouring Matter in Food (Scotland) Regulations, 1957* (S.I. No. 1123). The list as a whole is likely to be reviewed in less than five years, but interim modifications to the list are envisaged should new developments in colour manufacture or food processing, or fresh evidence relating to the safety or otherwise of colours, make this desirable. All such proposals should be addressed in the first instance to the assistant secretary, Food Standards, Hygiene, and Slaughterhouse Policy Division, Ministry of Agriculture, Fisheries, and Food, London, S.W.1.