SOME PSYCHOLOGICAL CONCEPTS OF URBAN AFRICANS

Thesis

submitted in partial fulfilment

of the requirements for the degree of

M.Soc.Sc. in the Department of Psychology,

University of Natal,

by

LEONARD BLOOM,

B.Sc.Economics (Honours), London University

Durban 1962.

A C K N O W L E D G M E N T S

The author is grateful for specific information and advice to the following, without whose co-operation this project might not have been satisfactorily completed:- Professors E.J. Krige and M.G. Marwick; Drs. C. Callaghan, H. Kuper, D.C. Luswazi, D.W.McK. Malcolm and J.W. Mann; Messrs. R.C. Albino, H.J. Benghu, A.S. Ngubo and Mrs. H. Mann; and my able and conscientious interpreter-interviewers Mr. E.F. Dube and Mrs. D.V. Xaba. Thanks are due to the City of Durban, Department of "Bantu" Administration, for permission to enter Lamontville "location" for the purposes of the research.

C O N T E N T S

L I S T O F T A B L E S

CHAPTER ONE

INTRODUCTION

This thesis is a study of how some Africans living in urban areas conceive certain psychological matters.

The sample includes Africans drawn from a variety of levels of education (from the completely illiterate to university undergraduates), from the completely urban-living to those who have spent but a short while in the town, from both sexes and from a wide range of age groups.

The author has chosen about twenty basic, non-technical terms commonly used in general and abnormal psychology, about which the layman might be expected to have concepts and knowledge based upon his everyday experience and his education, and has attempted by means of a structured interview to discover how the terms are interpreted by the varying groups of his informants.

In particular, the author suggests that the concepts of his informants will vary in levels of sophistication, and he has therefore been concerned to relate different degrees of psychological sophistication to his informants' various education, urbanization, age and sex. For example, it might be hypothesized that the more urbanized the informant, the less he is likely to give responses that imply or reveal a belief in witchcraft as a determinant of human behaviour. Further, the author has attempted to relate the informants' interpretations to their personal or familial problems, so for example it might be expected that the beliefs about mental illness of an informant who has had direct experience in his own immediate circle, would differ from those of one who has had no such experience; and the beliefs about the nature of cure, in particular the opposition of magical to medical cure, might depend upon the informant's experiences.

Among the informants interviewed were fourteen izinyanga (practitioners of African traditional medicine), who are widely regarded as a conservative force in African society and, therefore, as repositories of traditional beliefs. The author accordingly made a particular examination of the izinyanga's material and obtained from this a consensus of interpretations of the terms, which he could use as a basis on which to compare the interpretations of the other informants. Traditionally, the izinyanga have been among the more powerful and influential of the leaders of the society, and the author, in his comparison of the izinyanga material with that of his other informants, has attempted to suggest the extent to which the laity in an urban community are still holding the same beliefs as the izinyanga.

The tendency of psychology during the last 20 years or thereabouts has become less obviously ambivalent towards considerations of the 'internal psychosocial determinants of behaviour; the 'Behaviourist' has become a Tolmanian 'Neo-Behaviourist', and the essentially introspective approach of Psycho-analysis has been integrated within general psychology, firmly and with little effective protest. Psychology tends increasingly to analyse behaviour within what is often called the 'Personal Frame of Reference', in which the psychologist attempts systematically and objectively to understand behaviour from the point of view of his subject (Combs & Snygg, 1959, Snygg, 1941),which implies that the psychologist is acting upon the basic postulate that no understanding of behaviour is possible unless the investigation is directed towards evaluating those aspects of direct experience determined by and relevant to the subject's personal frame of reference. It is not, therefore, sufficient to analyze and appraise the objective psycho-social field within which the individual operates, because this is largely an abstraction or artificial construction of those factors which the psychologist has evaluated as relevant. The psychologist must examine the individual's 'phenomenal field': he must accept as his basic data the

world of naive experience, the everyday situations and surroundings in which the individual lives and which he accepts as the reality to which he must accommodate his personal needs.

Psychoanalysis has long been aware that the finer details of behaviour are determined by the individual's unique and idiosyncratic perception of his external world, and a cardinal feature of the case-history of a patient is an evaluation of the processes by which the patient's relationship with, and understanding of his external world has been distorted. Psychoanalysis has, in fact, been deeply concerned with the peculiarities of the patient's misperceptions of the external psycho-social world because the processes of misperception can suggest means for the better understanding of mental functioning in general. It is not sufficient to know of a patient that he is a member of a particular social group and that he is subject to certain socio-economic pressures; it is also necessary to appreciate how he relates his personal malaise to these external factors, that is, it is necessary to understand the patient's misunderstanding of the external world by evaluating his interpretation of the external world and the processes through which he passed to make it. (Main, 1958).

An understanding of the particular "universe of naive experience" which each individual constructs may, therefore, suggest to the psychologist: (1) a view of the basic processes of perception on a behavioural (that is, non-physiological) level of any individual, and (2) a view of the peculiar universe of naive experience common to the members of a group of individuals.

A defect of modern psychology has been that despite the return to methods of investigation that are substantially similar to the introspectionist methods of Tichener and Freud (et al.), there has been a tendency for investigators to ignore the broader views of the psychologically naive, or lay, individual about his basic concepts. The universe of naive experienc

is rarely found within the psychological laboratory, and the social psychologists and psychoanalysts who often attempt to describe it are too frequently concerned with highly specific or with abnormal behaviour.

Indeed, despite the masses of investigations which attempt to demonstrate the influence of motivational, voluntary and group determinants upon such basic processes as perception or concept formation, since Bartlett's "Remembering" broke new ground in 1932, the psychologist has confined himself in the main to a universe not of naive experience but of the experience of men, women and children in artificial and carefully controlled situations in which the subjects' psychologically untrained views play little part in determining the psychologist's approach to finding a solution to his problem.

Though the social psychologist and the psychoanalyst are frequently bolder in their direct employment in formal studies of everyday experiences of the layman, it is rarely that they attempt systematically to explore the views of the laymen on general psychological topics, and it is rarer still that the psychologist can think and feel less as an academic than as a layman, untrained and untutored in the techniques and concepts of his scientific discipline. In describing the disability of the ethnologist to appreciate the nature of the lives of his subjects intuitively, Radin (1957) wrote that

> "It is conceivably demanding too much of a man to whom the pleasures of life are largely bound up with the life of contemplation and to whom analysis and introspection are the self-understood prerequisites for a proper understanding of the world, that he appreciate corporate and individual expressions which are largely non-intellectual, where life seems, predominatingly, a discharge of physical vitality, a simple and naive release of emotions or an enjoyment of sensations for their own sake".

It is probable that this dichotomy of understanding between the "contemplative" man and the "non-contemplative" man be more marked where

the investigations are carried out among a group which has not enjoyed generations of an education and a social system which places a considerable emphasis upon intellectual and scientific activity, and in investigating psychological questions in such a society the psychologist and his informants might find great difficulty of communication - not because of any deficiency of intelligence and goodwill of the informants - but because of a failure to share a basic approach to the analysis of problems, relatively more abstract than those discussed in everyday life outside academic and scientific circles. Even within a complex society such as England such failure to communicate can arise despite there having been universal education for nearly 100 years.

Hoggart (1958), who has written of his working-class childhood in the 1920's in the industrial north east of England, has described the then working-class splitting of the world into "Us" and "Them", attributing this to the working-class difficulty of handling abstract or general questions.

If this observation be valid and reliable it is conceivable that a psychologist educated and brought up in another, more intellectually rigorous environment, might well fail to communicate with "working-class" informants, not solely because the psychologist and his informants have different knowledge, information and beliefs but because of their holding different assumptions about and attitudes towards thinking. It is surprising that only within recent years have psychologists followed the example of Cyril Burt, who, in as long ago as 1915, when gathering material for his "The Young Delinquent", lived for several months as a member of a working-class family in London. The doctor in a predominantly working-class area must learn that the logical and neat categories of a diagnostic interview belong to the world of logically and neatly arranged text-books, and that he must learn to conduct his diagnostic interview in such a way that he can obtain the information he needs despite the unmethodical manner in which

the patient may present it to him, embedded perhaps in a mass of medically irrelevant material, which, though irrelevant to the making of a medical decision is nevertheless thought significant by the patient in his perception of the situation. Further, it is probable that physical and emotional stresses and strains that I would be unable to surmount might be surmountable by members of the working classes, and that others to which I (as a member of a particular social class) are prey and that I can conquer, are beyond the resistance of a working-class man of my age and stamina. These disparities are as significant in emotional as in physical disorders, and the advice given to a working-class patient might, therefore, be inexplicable and inappropriate to him because of his different assumptions and the social limitations to his action, though to the doctor the advice is clear, concise and accurate. Hoggart (1958) describes an incident that he watched as a child:-

> "I remember watching a middle-aged mother with a full shopping-basket passing through Hunslet Feast (Fair) one Friday obviously 'ailing' and worried. She was attracted by the patter of a ..... woman in a herbalist stall. After a few moments of hesitation she went over and whispered her problem. She was sold ..... some sort of crystals ..... 'Never mind what the doctors tell you, me dear. Take these ..... and they'll wash the stone away. You'll know no more about it .....'."

He continues that the members of the working-class at that time had little money or time for doctoring, a timidity about troubling the doctor and that there was (and probably still is) a wealth of medical lore and superstition fostered by poor education and the cupidity of patent-medicine firms. How difficult it must be to explain to the woman whose pains continued despite the assiduous use of the crystals and despite her conviction that her backache and lassitude were because that mysterious and potent thing "the stone" had lodged firmly in her "bladder", that her condition is only to be remedied by drastic surgery and no quantity of swallowed crystals would cure her.

To a great extent the Africans in South Africa have a status position similar to that of the working-classes in England so shortly ago as when Hoggart was a boy: unable to enjoy educational and economic opportunities as fully as upper-class members, confined to inferior accommodation and virtually excluded from the more sophisticated amusements and recreations, living in fact on the periphery of an industrialized-urbanized society, and within the society having a lower status in the social-class hierarchy regardless of individual attainment and merit.

If the gap of understanding between members of social classes is not easy to bridge, how much more difficult must it be to bridge a gap that not only spans social-class differences but differences in a substantial cultural approach to ways of thought about medical-psychological problems. How much more difficult must it be to assimilate to one's sophisticated intellectual bias the views of a patient that "the evil eye" is responsible for the failing strength of her baby, and to explain sympathetically and with insight to the patient the remedy and why the remedy will probably be successful if carefully followed. And just as the working-class mother is unable to grasp easily the true nature of "the stone", so we might expect for similar reasons some African mothers to fail to understand fully the causes of kwashiokor, or we might expect it to be difficult to demonstrate that a "traditional" disorder as "hyeza" is explicable and curable in a rational medical-psychological context. As Lewin would have said, the patient's and the doctor's "psychological environments" are dissimilar; and it is difficult to transfer oneself imaginatively from the one environment to the other. It is neither simple nor effective to inform the patient of the errors of his views, as though a formal explanation were enough to induce an individual to exchange one set of integrated notions which he has gradually pieced together from his experience of the experience of his culture, and from the holding of which he derives some sense of intellectual

security. Besides, when we are wrong we behave in accordance with our beliefs, in error though they are, and not in accordance with reality, and we may strongly resist altering our beliefs to accommodate them to reality. Understanding and changing human behaviour demands that we understand the manner in which we perceive reality, erroneous though our perceptions be, and our perceptions vary from culture to culture and, within cultures, from individual to individual.

If there be diverging assumptions within what is broadly one social system, a greater divergence must be expected between two social systems that are more or less distinct and only recently growing together to develop similar basic assumptions. It might be expected that an examination of the psychological concepts of Africans (who have been prevented from sharing actively much "western" culture, including intellectual assumptions), would reveal wide divergencies between the psychological concepts of Africans and those accepted by "western" psychologists. We might, in particular, be able to distinguish concepts in which a compromise is effected between the traditional views of the culture and the concepts of "western" psychology, or those in which a modification of formal psychological concepts to meet local and persistent traditional situations and needs is implicit. On the other hand, we might find that there is a substantial acceptance of some "western" concepts, either shown by direct absorbtion into traditional culture, or by the replacing of the content of a traditional term.

For example, the conflict situations and the particular patterns of stress that conduce to emotional maladjustment might suggest that the Africans' concepts of emotional maladjustment (dependent as they are upon the social situations peculiar to Africans) differ from the concepts held by the psychologist or psychiatrist. We might expect, further, that in a society in which social and economic security is forever shattered by arbi-

trary governmental intervention, that a tendency to explain emotional maladjustments in terms of environmental factors might be replacing explanations defined in terms of "witchcraft" , innate factors or the individual's wilfulness.

Bascom and Herskovits (1959) warn that

> "analyses of the contemporary African scene too often fail to grasp the fact that selection /of cultural elements from outside/ is additive and not necessarily substitutive. European cloth adds to the range of fabrics and patterns ..... but ..... African weavers ..... are still active".

Likewise European ideas of the etiology of disease may add to African beliefs, but the traditional beliefs might still be held by some Africans. Within the sample studied in this thesis for example, many subjects were able to add to the traditional cures by means of herbs, "steaming" and prayer, medical injections and tablets. The author met an inyanga who, not content with the traditional status symbols of his calling,also carried a stethoscope (which he wore correctly at a particular stage in his diagnostic interview): he was tacitly acknowledging that he could no longer rely upon the traditional respect for his calling, and that only by incorporating to his calling a status symbol and cultural element from the culture that was threatening his very existence could he continue to function in his transitional society and retain any degree of status. No doubt, as the inyanga adds to his cultural equipment the stethoscope-symbol, so he and his patients add terms and concepts, and we may expect that as the outside concepts prove more adequate to express ideas or formulate problems than the traditional concepts and terms, so will the traditional ways of thought be absorbed and replaced by what were formerly outside elements.

The problem of studying concepts is practical no less than academic, because the need to change the conceptual framework of society is crucial and urgent if the full benefits of an industrialized society are

to be shared equitably and the frictions of bringing about industrialization are to be minimized. In Africa, the mingling of traditional with industrialization elements in the one society is proceeding speedily, and could proceed with less friction were the processes of concept formation better understood and applied by those claiming to control economic-political affairs. Only by knowing how a certain concept develops in responce to given social conditions, how there may be an interaction between a given concept and changing needs of society, and how tenaciously different groups in the society maintain their belief in given concepts, may we most effectively seek to change concepts. A particular question is that of the ease or difficulty of the transmission of concepts from the professional expert to the laity, so that the concepts and skills that are part of the experts' frame of reference (and, therefore, directly influential in directing day-to-day affairs), may be communicated to the layman. It is of little advantage to a society if there be a sharp dichotomy between the professional and the layman, if the concepts and techniques of the former are misunderstood and fail to be applied by the latter. The doctors' concepts of the germ-theory of disease, and their practical applications of these concepts, will not save many from disease or deformity or death if the concepts are ignored, misunderstood or misbelieved by a laity with whom the doctors are not in touch. Communications between the professional man and the laity may, conceivably, vary among different groups in society, and this, too, makes it necessary to attempt an understanding of the mechanism of concept information as a social activity. If for example it be found that in a given society it is the young women who have the more radical and flexible attitudes towards innovation, and that the young men are more conservative and inflexible, then it would seem that the spread of new concepts would be first and faster through the young women's group than the young men's, and that a practical means to spread concepts might be by starting in the women's organizations and meeting places.

An interesting example of the percolation of psychological concepts from the psychoanalysts to the layman in both literature and the intellectual climate of the age is given by Joad (1948), who suggests that the more obvious effects can be classified as "determinism" and "irrationalism", and include such tendencies as scepticism of the power of reason to discover the truth, and a correlative belief that reason is the "slave of the passions" (as Hobbes quaintly puts it); other tendencies are a general distrust and rebellion against traditional authority, a fatalism that accepts that our character, beliefs and will are determined by forces beyond our control, and finally, that the individual should seek the greatest possible enjoyment and self-expression. In literature, too, psychoanalysis has made its influence felt: character and plot are subordinated to the attempt to record in the fullest detail the complexity of the thoughts and feelings of the characters, emphasizing their inner life in all its immediate richness and variety. Joad calls this the "put-everything-in school". Joad might have drawn attention to the manner in which psychoanalytic terminology has spread to the layman, terms such as "complex", "inferiority complex", and "rationalization" being found not infrequently in everyday conversation and in the "popular" press.

Another instance of the irradiation of concepts from the professional man to the popular imagination is described and analyzed by Cohn (1942) in his survey of "Changes in public attitudes toward medicine ....". He interprets the irradiation as a broad substitution of irrationality for rationality, as barbers became surgeons, herbs were experimented with, anatomy and physiology were developed, public health conquered many infectious diseases, and he suggests that there is a relationship between public enlightenment and the state of medical discovery: the more effective medicine appears to be, the less will the layman relay upon faith-healing or other irrational methods.

This traffic in ideas and in artifacts is, of course, no more peculiar to the changing African scene than it is to any other society that is in contact with other societies, and the author does not sympathise with nor accept the mischievous and erroneous doctrines which seek to demonstrate that (1) African problems of changing culture are in some way "unique" and that (2) <u>because</u> selection of ideas is (in some ways) 'additive' rather than 'substitutive', "African thought" is inferior to non-African thought to the extent that less sophisticated notions may exist side-by-side with more sophisticated. This is not to deny that some unsophisticated and irrational beliefs are held and acted upon by even highly-educated Africans; but this is evidence that African problems of changing and conflicting values are precisely similar to those of non-African peoples, for none but a tiny part of the thinking of a tiny minority of thinkers is ever predominantly rational, and the gravest problem of all mankind is to increase the proportion of rationality to irrationality in individual thought and social behaviour.

Even though, therefore, many of our informants' responses mention supernatural forces as explanations for, say, mental illness, this must not be construed as support for an argument that even educated Africans are irrational in any unique or significant manner. It is difficult for the author to compare the degrees of rationality and irrationality implicit in the Christian priest's exorcising a ghost and in an <u>invanga's</u> curing a patient suffering from an illness caused by an offended ancestral spirit.

Further, the author does not subscribe to views of "<u>the</u> African Personality" (which seems to him to be as fictional as would be American or an Asian personality), and he has neither attempted to explore nor verify the content and operation of such a conception.

The author has avoided generalizations "about some aspects of the African personality at this point in time" (Huxley, 1961)[1], of the order of vague impressionism that: "rooted in tribe and family, it is inward looking, defensive, and sustained by intricate patterns of kinship and age grade stratification which afford protection against a world always hostile and dangerous", or, "it is a personality at once sustained and ruled by spirits who practice no apartheid between ghosts and men. Causality arises not from logic but from natural mysteries and from human malignancy". Further: "..... in the climate of personality there is little room for compromise and postponement, for everyone giving way a bit, for keeping open minds", and, "it is a personality that puts manners above principle, family above self, race above humanity ..... at the heart of it a profound cynicism, derived partly from a religion based on fear of the supernatural rather than the divine .....".

In part, the motivation of the author in carrying out this study, was to evaluate the divergencies and convergences of ideas arising in the meeting and mingling of African and non-African ways of living and thinking. That many of the informants, even of little education, employ in conversation the term 'inferiority complex' to explain why certain people are exceptionally prone to blame others for their shortcomings, may be less exciting to some readers than florid accounts of "The African Personality". The author in selecting a set of terms for discussion with informants, and cleaving to a fairly prosaic analysis of the informants' answers, neither hopes nor expects to provide an elaborate account of changing "African Personality", but he does hope to offer a preliminary picture and analysis of certain defined areas in which traditional ideas and terminology are changing (or resisting change) in response to the stimulus and challenge of non-African terms.

---

1) All quotations in this paragraph are from Huxley, 1961.

The administrator, physician, teacher or any one who meets and is interested in making contacts with Africans at a level more than the shallow formal depth must be dissatisfied with generalizations such as those of Mrs. Huxley, and the deeper his contacts become the more unable he will be to translate the broad generalizations into terms that can guide and govern him in a spontaneous and informal situation. One may be warned against making elementary blunders in thinking if one is to carry out an investigation such as the author's, which is solely concerned with topics of immediate significance indicating general attitudes about specific and definable issues.

Although the author at no time during the fieldwork of his research felt that he was treating with hostile, indifferent or cycophantic informants (the last would, presumably, be eager to offer the information that he or she thought the investigator would like to have), he was always aware of the difficulties arising in any research which attempts to bridge cultures that have some elements not in common. The author, a native of London and not of Lamontville, has obviously many assumptions and biases that are different from those of his informants, and further he comes from a social class and occupation far different from those of many of his informants. These apparent disadvantages can be turned to the investigator's profit, for as a result of his distance from his informants he can be particularly sensitive to elements of the culture that are not noticeably significant to a member of the culture. He may also be able to elicit information as a stranger that might not be given to an investigator belonging to the culture, much as troubled people sometimes unburden themselves to a stranger rather than to a member of their close family.

The aim of the study was to obtain an account of how a sample of Africans interpreted certain topics that are of interest to the psycholo-

gist, and (in particular) to compare the accounts of the izinyanga with the non-izinyanga, and to relate the accounts of the non-izinyanga to their rural or urban background, sex, age and level of education.

CHAPTER TWO

METHODS AND PROCEDURES

1. Introduction:-

In this chapter the author considers problems arising in the execution of fieldwork in a community the members of which do not share the fieldworker's language and who may regard him with suspicion as a member of an alien class, and describes the manner in which he chose the topics and subjects for his study.

2. Preliminary Problems:-

In all field studies the psychologist has to be ready to meet informants who misunderstand him and the problems that he is investigating, and he may need to interview informants from a different social class and educational level from his own. Inasmuch as a great deal of psychological research is carried out within relatively well-educated groups such as scholars and students, the problem may often be ignored or minimized by the academic psychologist. But the social psychologist cannot escape; the problems of the social psychologist working with informants who do not share all his cultural assumptions far exceed those of his laboratory colleague.

The author of this study does not speak Zulu (the language in which most of the interviews were conducted), and he understands only a few words and phrases. He was continually harassed by social, legal and geographical difficulties in meeting his informants. For example: it is necessary for a non-African to obtain a municipal permit to visit the area from which most of his Durban informants came, and although he had little difficulty in obtaining a permit, it was clear that if he were unwittingly

to commit some breach of officially-prescribed behaviour the permit would be summarily cancelled. The author inevitably felt constrained and ill-at-ease: it would have been difficult for him to attend a dance in the area, or even informally to visit at a home for a cup of tea and a chat, and he might therefore be excused for feeling an interloper at the outset of his fieldwork in an area in which non-Africans are very rarely seen, and those seen are mostly officials or policemen. However, after a short time the author was no longer conscious that children and adults were staring at or whispering about him, and he frequently was greeted in a spontaneous and friendly fashion.

Dollard (1957) described similar difficulties in his fieldwork in "Southerntown", where he had to overcome a double barrier between his informants and himself; he was obviously and visibly a member of two groups, each of which was liable *prima facie* to arouse suspicion. To the Negroes he was a "white", and to the Whites he was a Yankee from the North. Dollard, too, had difficulty in obtaining free and informal access to his Negro informants because of the local geography and conventions, because there was as marked a geographical separation between Whites and Negroes in Southerntown as in Durban, though in the former the separation was not directly imposed by law but by custom. Gradually however Dollard established rapport because of the relief that his Negro informants felt on talking about the problems of being a Negro to a relatively objective outsider, and as he became accepted by the Whites as that "Yankee down here studying Negroes".

The author shared Dollard's experience that interviews were used as a medium by informants for expressing their dissatisfaction with many social and political matters, and as it rapidly became clear that the author was in no way identified with either officialdom or with the South

African Whites in general, he became more and more to find himself at ease in many informal situations outside the specific business of his research. Thus the problem of grasping what Dollard calls the "emotional structure" of the society through the material obtained from individuals was less difficult than it first appeared to be. Besides his being able to draw attention to his being a foreigner (and thus not sharing local White attitudes), the author had several other advantages: he was known to many people in the area from which the informants were drawn, including leaders in the community, and visited friends in the area. He is confident that in the social context of South Africa, his having and visiting African friends and his interest in African ways of life and thought, and the everyday problems of Africans, readily gave him a rapport with informants he interviewed, and led to an acceptance of the research as a genuine enquiry. The author further feels that his informants rapidly became at ease with him, despite their sometimes having little or no English, and their initial suspicion of him (if any) soon dissipated despite the cautious tendency of many Africans to regard a questioning "European" as probably representing a governmental agency or the police. Once it was clear that the author was not an authoritarian figure, nor one (like many South African Whites) aloof, distant and conscious of his higher status and power, the interviews were frank and relaxed. Often the author and his interpreter and informant were given tea or a cold drink by a member of the informant's household, and the author has many times been greeted by a man or woman who was at first sight a stranger and then was recognized from an interview of maybe months before. The author considers it important that he did not use professional informants, but men and women whose apparent interest in the research was their own reward for giving him of their scanty spare time. Informants frequently wanted to know if the author intended to write a book about what he discovered, and the author (to minimize (1) the danger of informants gushing large quantities of material, irrelevant, dramatic and therefore of doubt-

ful accuracy; and (2) suspicion that he would reveal the private affairs of his informants and their society), emphasized that he was a member of the staff of the University of Natal, and that his findings would only be published in the form of professional papers in which no informant could be recognized and no secrets would be disclosed.

These difficulties - linguistic, social and legal - were much mitigated by the author's two interviewers (Mr. D and Mrs. X), both of whom have had considerable experience in interviewing. Mr. D has majored in Psychology and Sociology at the University of Natal, and was trained (and practised in the interview area) as a social worker; Mrs. X was a member of the Cancer Research team of the Faculty of Medicine of the University of Natal. Both interviewers knew the author personally and were very well known in the area from which the informants were drawn. Both were fully bilingual in English and Zulu, and though essentially urban in outlook and upbringing, had knowledge of rural ways of life, thought and belief because of having rural relatives and having spent time in the country. In order to ensure that the interviewers fully understood the type of material which the interviews were intended to elicit, the author spent considerable time with them before the research began,working with them on a small pilot study. He feels that his interviewers were, as a result of working with him and of long discussions about the general purpose of the research sensitive to the material desired, and that they were able to carry on interviewing independently of the author, sufficient check being provided by their reporting to the author with their collected material at least twice weekly. The author intended to check the accuracy of his interviewers by having them independently interview the same informant, and then to compare the resulting two interviews, but problems concerned with the employment of the interviewers has made this impossible to carry out.

An advantage (possibly questionable) of working with interpreter-interviewers is that they knew the cultural assumptions of their community and were better able than the investigator to decide whether the information given by an informant was probably accurate, or for example was coloured by the informant's obvious eccentricity or low intelligence, or his eagerness to pretend to a greater knowledge and wisdom than were truly his. Goffman (1959) suggests that the individual acts not only in pursuance of some objective or to satisfy some motive, but regardless of these he also acts in such a way as to control the manner in which others respond to him. The relationship of informant-interviewer is delicate, particularly where there are marked differences of class, education and status between the parties. An informant might be anxious to demonstrate that he is loyal, law abiding and contented to an enquiring white man, and his responses would be distorted in favour of what he imagines the interviewer will accept and approve as apt expressions of his docility. Another type of informant might be over-anxious to act the part of a rational and untraditional sceptic about witchcraft beliefs, which he thinks the investigator would not accept and of which he might disapprove. The use of African interviewers minimized the complications of the informants playing a role other than that of informants: there is little inducement to influence or impress someone whom one knows (or of whom one has heard), who lives in the same area, speaks the same languages and who is carrying out a job and is unlikely to be concerned with, or impressed by, anything other than the collecting and recording of the material required.

However, the author is well aware of the inadequacies of working with an interpreter, however gifted and conscientious, and does no more than to claim that the known inadequacies can be compensated (to some extent) by less well-known advantages.

Both interviewers interviewed in Zulu or in English (according to the preference of the informants) and made a running-translation into English, inserting the Zulu terms for various concepts that the author wanted to verify and any other material that they thought worth recording.

The interviewers worked to an interview-schedule drafted in English (see: Appendix A), which they had discussed and studied with the author before and after carrying out a pilot-run, so that the questions could be phrased clearly, interestingly, and in a way that might encourage the informants to talk freely. The author and the interviewers agreed to a fairly-well standardized manner of asking the main questions and of eliciting and recording additional information. All informants were encouraged to give examples from their own experience or that of their family or neighbourhood, in order that the answers might be sufficiently clear and unambiguous to be readily classifiable, and with few exceptions the material proved to be amenable to content analysis. Interviews lasted about 1½-2½ hours.

3. Choice of Topics:-

The topics were chosen after a systematic survey of the indices of Henderson and Gillespie: A Textbook of Psychiatry, D. Russell Davis: An Introduction to Psychopathology and Krech and Crutchfield: Elements of Psychology. The author eliminated technical terms such as involutional melancholia or j.n.d., and from the remaining items he selected some thirty which appeared sufficiently general and fundamental to be within the understanding of the layman of average intelligence. This preliminary list was administered in a trial-run, and some ten terms were eliminated which proved to be too technical or narrow to stimulate discussion, leaving nineteen substantial issues in normal and abnormal psychology arranged systematically in a standardized interview. It was hoped that if informants were encouraged to

talk from their experience they would be less likely to repeat the conventional belief and lore uncritically but would modify them, thus enabling the author to construct an addendum to the conventional interpretation of the terms.

A second part of the interview consisted of a list of psychological terms culled from Doke, Malcolm and Sikakana: English and Zulu dictionary and some terms from Henderson and Gillespie (supra), which the informant was asked to explain in his own words and for which he was invited to offer a Zulu equivalent of the English terms. For example: an informant would be asked for the Zulu equivalent for the term "Conscience" and would be required to elaborate on his answer by asking him to give his interpretation of the terms given in Doke et al: isazelo, unambeza and ugovane. Much of this type of linquistic material was obtained during the body of the interview and required no amplification. By this means the author obtained a small and preliminary glossary of the Zulu equivalent for some psychological terms.

4. The Subjects:-

The informants interviewed can be divided into two: the laity (that is, the non-izinyanga) and the izinyanga; all of the former and 9 (out of the 14) of the latter are residents of Durban. All but an insignificant number of the informants live in the African municipal "location" of Lamontville (about eight miles from Durban), which has an estimated population of about 18,000 which includes residents with a wide range of incomes, occupations and education. It includes men and women who have lived their entire lives in the town, and whose parents are also town-dwellers, and others who have recently come to the town or who still have strong links with the country, such as some of the men and women of the Old Age Refuge Home who may have only come to the town very recently because they have had

no relatives or friends to look after them in the country. The population includes therefore, people of a wide range of sophistication: in one short road there can be living an inyanga (holding many of the traditional rural beliefs), a Fort Hare graduate and a medical student (neither of whom share any or little of their less-sophisticated neighbour's values). Even the same family can include a child studying for his Matric and with interests and values far removed from those of an illiterate parent or grandparent. However, it is probable that few residents of Lamontville are as unsophisticated and bound by traditional beliefs as many of the Africans living in the rural reserves; therefore, the sample cannot be treated as an adequate indication of those holding traditional and unmixed beliefs. Even the izinyanga are not a group of typical izinyanga: they have chosen to settle in the towns to practise, and they are influenced (and have chosen to be influenced) by town life and urban ideas. On the other hand the older informants and the izinyanga probably retain sufficient rural traditional beliefs to demonstrate the effects of contact between more and less sophisticated ways of thought and belief.

The author employed different methods to obtain his izinyanga from those he used to obtain lay-informants. The interviewers made local enquiries of residents of who and where were to be found reputed izinyanga, and the reputed izinyanga were asked if they considered themselves to be izinyanga and to describe their training and qualifications and their willingness to take part in the enquiry. At least two reputed izinyanga when interviewed to establish their bona fides were rejected by the interviewer, who found that they had not the appropriate background and training and that they were in fact, masquerading as izinyanga to earn a living. The laity were obtained by house-to-house visiting by the interviewers, and by interviewing the residents of the Old Age Refuge Home. Although no systematic attempt was made to obtain a random sample of informants, the intervie-

wers were given specific instructions to include informants in various groupings, and were given a record-blank in which to make a check-mark for each informant the group to which he belonged. As a further precaution against having a too highly selected group, the interviewers confined their house-to-house visiting to a specific area of Lamontville in which the residents come from a wide range of age, education and occupation.

TABLE 1

COMPOSITION OF SAMPLE

	Izinyanga (N=14)	Other (N=96)
(a) Urbanization:		
Rural	5	37
Urban	6	59
Doubtful	3	0
(b) Sex:		
Male	13	47
Female	1	49
(c) Age:		
13-20 years	0	11
21-35 years	2	35
36-45 years	3	12
46-95	9	38
(d) Education:		
No education	3	20
Std. 4 and below	4	15
Std. 5 and Std. 6	1	22
Std. 7, J.C., T.4.	3	31
T.3., and Matric	0	4
Above Matric	0	4
No information	3	0

The non-izinyanga were not a random sample, but were selected by the author to include representatives of a wide range of social conditions - from the least to the highly sophisticated.

The author broke down the information obtained from the laity into four sub-groups, which he considers adequately represent the main variables

of the study:- (1) Rural-Urban; (2) Male-Female; (3) Thirteen to Thirty-five years - Thirtysix years and above; (4) No education to Standard Six - Standard Seven to Bachelor's degree (See Table 1).

Except for the groups (1) and (4), the breakdown within the sub-groups is reasonably balanced and reflects satisfactorily the broad difference, but it could be objected that the marked preponderance of urban informants and of the less educated might bias the results. It might be expected that the pro-urban weighting would bias the results towards opinions that were more rational, more sophisticated and less inclined to refer to magical and other traditional beliefs. On the other hand, the pro-low-education weighting might be expected to bias the results the opposite way, that is towards less sophisticated and more traditional beliefs.

The author does not think that results will be seriously affected by this double-weighting, because in some questions this might be irrelevant to the formation of opinions, and where it is important there might tend to be a balancing out of the traditional and the "modern", which is after all, what one might expect in a community in the throes of rapid cultural change.

The distribution of the ages of the non-izinyanga was, unlike that of the izinyanga, widely scattered and included an adequate sample of the young. Again, the educational standards of the non-izinyanga ranged more widely than those of the izinyanga: a little under 25% of the laity were illiterate, but over 55% fell within the range between Std. 5 to the T.4. Certificate.

5. Background material obtained from informants:-

The izinyanga and the laity were asked for certain basic information: age, "ethnic grouping", occupation, education, aspirations and

where the informant had lived, this last question in order to classify the informant as having a rural or an urban background. A similar group of questions was asked about the informant's spouse and parents, and a last question was asked about the present whereabouts, occupation and education of the informant's children and siblings.

The classification of informants as either predominantly urban or rural was inevitably in part a subjective decision of the author, but he had to decide somewhat arbitrarily in only a very few cases. In general the author classified the informant according to where he had passed the first third of his life, and if this was still ambiguous, he examined the background of his parents, judged if they were predominantly rural or urban and decided for the informant accordingly. For example, an informant aged 53 spent the first 22 years of her life in a rural area and was with little hesitation classified as rural: the formative years of her life were exclusively rural, and her basic values and beliefs were rural. More difficult to classify was an informant of about 81 who had lived on the outskirts of Durban in a semi-rural area for some thirtysix years, moving to the town about thirteen years ago; her parents were completely rural and she was classified as rural, though she too had lived entirely in an urban or semi-urban area during the greater part of the last half of her life.

The informants were also asked general questions to elicit their knowledge, information and beliefs about the nature, causes and cure of mental illness among Africans and non-Africans, though the information did not extend to detailed accounts of specific syndromes. The informants were encouraged to offer examples from their own experience or neighbourhood, and the author was particularly interested to discover if there was a tendency to express a general theory of the causation of mental illness, or if there were a variety of causes mentioned of which one might be most prominent. It was also hoped that the responses would reveal the extent to which in-

formants differentiated between mental illness that are specific and indigenous to Africans and those that are not, which would suggest those that are only amenable to traditional medicine and those that might be diagnosed and treated by "western" medicine.

In addition to the general questions asked of all informants, the izinyanga were asked to give details about the length of time they had practised, any other occupation that they had had, the circumstances surrounding their choice of this profession, and their experience of diagnosing and treating patients who were mentally disturbed. The author wished to get an impression of the extent to which the izinyanga accepted that there were specifically emotional disturbances, what form these disturbances showed, and which of these he treated by traditional medicine and which he referred to a medical doctor. The information that was elicited in this part of the enquiry, gives an indication of the etiology, treatment and incidence of mental disorders, though in a loose and impressionistic way. It was interesting material further in that it indicated to the author the changing views of the incidence and treatment of mental disorders, and that it was possible to attempt to compare the views of the laity with those of the izinyanga.

6. Analysis of information:-

The information obtained from the two principle groups of informants, izinyanga and non-izinyanga, was analyzed in substantially the same way. The information given in reply to each question was analyzed into categories that were determined by the author in outline before the analysis, but which he revised as the material dictated (Berelson, 1956). The major aim of the investigation being to relate different attitudes and concepts to the age, sex, education and membership of rural or urban groups of the informant, the units of information were tabulated within the groupings

of the variables, so that it was possible to compare, for example, the descriptions of elder and younger non-izinyanga of the causes of suicide both with each other and with those of the izinyanga. When the material had been quantified, where appropriate a series of chi-square tests was carried out or simple percentages were computed. All statistical analysis, unless otherwise stated, involved chi-square, 2X2, two-tailed testing, and is computed according to Siegel (1956). Results were taken as significant at the 0.05 level, unless otherwise stated.

It was considered to be outside the scope of this study to investigate the relationship of the laity to the izinyanga, the extent to which the laity consulted the izinyanga, and similar problems.

In tabulating the results in Chapters 4, 5 and 6, the only evaluations of chi-square recorded are those significant ($p \leq 0.05$) or near-significant ($p < 0.10$). For the purposes of computation, the izinyanga and the laity were regarded as near-unanimous if no more than 25% held a minority view, and an internal analysis of the laity was generally carried out only if the minority view was held by twenty-five informants or more, because otherwise no significant differences would be found.

Throughout the analytical chapters (4, 5 and 6) of this thesis, the material has been tabulated and discussed in units that have been called "subquestions"; thus, in Chapter 5, section 1, "Dreams and Daydreams", the material has been divided into seven"subquestions" which briefly express the topics that the author analyses. The interviewers were not given a standard series of statements to check or questions to pose, but within the limits and guides of the interview-schedule and the discussions with the author, were free to obtain the material informally, but were to record it methodically. From the interviewers' account of the interviews (written during the interview), the author abstracted the relevant material and organized it into the "subquestions".

CHAPTER THREE

THE IZINYANGA

1. Introduction:-

One of the problems that this study is intended to clarify, is the nature of the working-relationship and conflicts between traditional and "western" psychological concepts. It was earlier suggested that one approach is to compare the concepts of the non-izinyanga with the more conservative concepts of the izinyanga, who are commonly regarded as protagonists of the traditional ways of life and thought.

In this chapter the author (1) outlines the role and function in society of "medicine-men" in general, and (2) gives an account of the traditional izinyanga.

2. The medicine-men:-

The izinyanga are medicine-men and have much in common with their colleagues of Siberia, Australia, Melanesia, Polynesia and the North American Indians; Sigerist (1955) notes their particular similarity to the Siberian shaman, who is the archetypal medicine-man in anthropological literature. Examples from the African continent are not difficult to find: in Ghana, Field (1960) describes the dunsuni who is a medicine-man but is not possessed, divining with a special apparatus, making "good" talismans to protect the wearer from disease, from enemies, or to help him in hunting, and generally practising as a herbalist and physician. Evans-Pritchard (1937) writes of the Abinza (Avule) among the Azande who are witch doctors or diviners, and are believed to diagnose and combat witchcraft by the influence of medicines they have eaten, with the aid of dances and by "leechcraft". Laubscher (1951) describes four classes of medicine-men

among the Tembu of the south-east Cape, with distinct roles, functions and powers of healing and divining, similar to the division among the Zulu izinyanga. In the late 1930's, when he collected his material, there were three major categories of medicine-men: (1) Amatole or Isanuses-diviners, who correspond to the Zulu izangoma, who are known also as isanuses if they are males; (2) Amaggira-doctors who also employ divination, and who appear to correspond to the izinyanga where they are inspired by the ancestors, and (3) Amaxhwele-herbalists, who are reputed to practise sorcery. Laubscher further reports that the isanuses hold the highest prestige and act as consultants to amaggira, and are consulted by the amaggira if there is a difficult case to diagnose. The amaxhwele may also consult the isanuse who will diagnose the disease of the patient, and the herbalist who will prescribe the appropriate medicine. It seems clear however that in the towns, and even among the rural communities influenced by urban values and techniques, the medicine-man (among whom the izinyanga) have lost (and are losing) much of their former power, influence and prestige.

In the traditional tribal society the medicine-men had a unique position as the first members of a distinctly demarcated professional class (Sumner, 1959) and they derived considerable power from their secular and divine functions. Despite the name "medicine-man", he is not concerned exclusively with the healing of sickness in the strict medical sense, but is concerned with welfare in a general and pervasive sense more akin to the modern social and preventive medicine. He is responsible for combatting the many evils and harms that threaten the safety and normal functioning of the tribe or an individual in whatever form the evil might appear; he destroys enemies, fosters the crops, propitiates the ancestors or the gods, and cures sickness and disease. In many tribes the medicine-man is also the chief, and he then assumes duties far beyond those regarded as "governmental" in an urbanized society. The medicine-man is therefore, more than

a proto-physician, because he combines in himself the personal qualities and the occupational techniques that are appropriate to a physician, wizard or sorcerer, priest and (sometimes) a chief.

Ackerknecht (1942) has criticized the anthropological cliché that the medicine-man is the ancestor of the modern physician, on the grounds that the former has so wide a range of functions that he cannot be said to be exclusively (nor perhaps even largely) concerned with healing sickness. Further, Ackerknecht argues that the medicine-man plays his

> "role as the most irrational man in an irrational pattern", whereas on the contrary the modern physician "gains social leadership by expressing the rational tendencies in society, rationalizing even the irrational as for instance the psychoanalyst, and invading in this way the oldest domain of the priest".

But just as there is in the thought and practice of the medicine-man a constant and inextricable intertwining of irrational-magical, empirical, pragmatic and common-sense factors, so a similar (although less markedly irrational) mixture is found in the practice of the modern physician. The fundamental sociological difference between the role of the medicine-man and that of the modern physician is (in Sigerist's view) the much more pervasive influence of the medicine-man in managing the secular and the divine affairs of his society; paradoxically, the influence of the modern physician has decreased as his rational power and ability to heal have increased.

The term "medicine-man" is derived from the terminology of the North American Indians, inadequate though the term be to indicate the full range of his professional activities. Other words have been suggested to name the medicine-man; thus Sigerist discusses the distinctions that have been made between the "shaman" and the "seer", employing the former term to describe a medicine-man who is voluntarily possessed, who exorcises and prophesies, and whom the spirits use as a medium through which to speak.

On the other hand, Sigerist proposes that the term "seer" is used to describe the medicine-man who is not possessed, but who has the ability to talk to a guardian spirit when he wishes, which answers him but which does not act through him. Rivers (1924) uses the term "leech" to describe the medicine-man who, although he is principally a healer, invokes magical or spiritual assistance in effecting a diagnosis and cure of disease.

However he be defined, the medicine-man is paid for his skills and his fee is adjusted to the success of the treatment and to the social status and wealth of the patient; in this way a professional group is developed in societies that are sufficiently complex and advanced to employ magic for economic exploitation and for strictly commercial non-magical relationships (Radin, 1957). Sigerist comments that in the wealthier and more populous tribes, the medicine-men have often organized themselves into societies, sometimes named after animals, and that these societies come to specialize in the diagnosis or treatment of particular diseases or in a special relationship with particular guardian spirits. Evans-Pritchard (1937), has for example shown how among the Azande there are closed associations or "corporations" of diviners the members of which practise magical rites, and Field (1958, 1960) has demonstrated in Ghana a similarly exclusive class of intermediaries between the spirits who 'dwell' at particular shrines and the lay supplicants. Traditionally the izinyanga seems to resemble the Siberian shaman: his vocation is revealed to him in dreams, he hears voices calling him, he may have fits and periods of mental and physical disturbance and disorientation, and he suffers from a type of mental disorder that is clearly recognized by the laity who know that it can be cured only if the patient passes successfully through the initiation into becoming a fully-fledged inyanga. Once the patient has accepted his vocation he becomes an apparently normally adjusted member of society, whereas if he refused to accept the calling, he would presumably continue to be-

have in a quasi-psychotic manner unless he were spontaneously to recover. Laubscher (1951) has likened the state of emotional disturbance prior to initation to some variety of schizophrenia, but Simons (1958) has disputed the validity of this analogy.

Although the content of the learning of medicine-men is very different from that of a modern physician, they are not implausibly to be regarded as among the proto-types of empirical scholars: they have devised means to cure disease and to manipulate to the use of man the spiritual world and the many mysterious forces that affect man's day-to-day life, safety and comfort. It is an anthropological cliché now falling out of date (Krige, 1947) that medicine-men are charlatans and humbugs, who as a class exploit the laity for the sake of gain and prestige. No doubt among medicine-men, as among modern physicians, there are some whose primary concern is to use their power and their prestige to further their own advantage, but in general the (to us) absurd magical and mystical powers employed by the medicine-men are not evidence per se of their duplicity, because they are operating within the assumptions of their society and they have not created them. They may be exploiting these assumptions, but they need be no more insincere than the priest who blesses the harvest or who exorcises a poltergeist.

Ackerknecht (1943) lists four reasons for the success of Primitive Medicine: (1) its armamentarium includes some objectively therapeutic techniques such as massage, bloodletting, inhalations, baths, inoculation and even a knowledge of drugs (among which are opium, cinchona, eucalyptus, podophyllin and quassia) is quite widespread. (2) Much primitive medicine employs (although without the conscious intent of the practitioner), psychotherapeutic techniques which would assist in the remission or alleviation of functional, neurotic disorders. "The whole weight of the tribe's religion, myth, history, and community spirit enters into the treatment. Inside

and outside the patient he [the medicine-man] can mobilize strong psychic energies no longer available in modern treatment". Further, the sharp dichotomy that exists in modern treatment between physical treatment and psychotherapy is far less sharp in primitive medicine. (3) The strength of magic is the strength of society, and the power of society is invoked to assist in the cure of the patient. The medicine-man has "an aura of secular and eternal power" that his modern colleague has largely lost and is rapidly losing as he becomes increasingly a professional business-man. (4) The appeal of the irrational in primitive medicine is a symbolic appeal to the unconscious; by which Ackerknecht appears to mean that there is a fundamental and universal need in man for some means to propitiate the unknown which is satisfied by primitive medicine, by such quasi-religio-magical movements as Occultism and Christian Science, and that is indicated by the mystical aura that now surrounds such scientific discoveries of great power as vitamins, penicillin and antibiotics.

Rivers (1924) in a major study of the relationship of magic and religion to medicine, distinguishes between magic and religion (on the one hand) and medicine (on the other), and he makes corresponding distinctions between their practitioners.

> "When I speak of magic, I shall mean a group of processes in which man uses rites which depend for their efficacy on his own power, or on powers believed to be inherent in, or the attributes of, certain objects and processes which are used in these rites ..... Medicine, on the other hand, is a term for a set of social practices by which man seeks to direct and control a specific group of natural phenomena, viz. those especially affecting man himself, which so influence his behaviour as to unfit him for the normal accomplishment of his physical and social functions".

As a corollary of this distinction, Rivers distinguishes between the "Leech" and the "Priest" or "Sorcerer"; he suggests that the term "Leech" be used to describe the medicine-man who is first and foremost a healer, although he may invoke magical or spiritual assistance in the diagnosis and cure of a disease.

The functions of the Leech are primarily medical, and secondarily include mediation between the secular and the divine; Rivers's usage of Leech thus includes the medicine-man whose weekly tasks might include producing rain, warding off lightning, blessing the crops and curing disease.

3. The traditional picture of the izinyanga:-

Great difficulty is experienced by the investigator who seeks up-to-date and scientifically gathered and ordered source material about the izinyanga of pre-urban times; and it is to be regretted that no attempt has been made to verify and expand this material by methods and standards satisfactory to modern social science, before what remains of the crumbling ruins of a vanishing tribal organization is little but an archaic and doubtfully picturesque vestigial social system. Krige (1957), the standard compilation of material about the tribal Zulu life appears to be unchanged since its first edition was published in 1936, and the two substantial accounts of social change and its impact on a tribal organization (Hunter, 1961; Marwick, 1950) dealing with medicine and magic in detail, refer to tribes other than the Zulu. The author has had therefore to base his account upon source material of varying standards of reliability, in particular: Bryant, 1949; Callaway, 1884; Hunter, 1961; Jackson, 1918; Kohler, 1941; Krige, 1957 and McCord, 1918.

The term izinyanga, although it should be confined narrowly to name practitioners of traditional African medicine, is more often used loosely to name any expert or specialist, whether he be concerned with medicine or not. Thus, Callaway (1884) writes:-

> "Inyanga, generally rendered doctor, means a man skilled in any particular matter-magus. Thus, an inyanga yokubula is a doctor or wise man of smiting, that is, with divining rods - a diviner. Inyanga yemiti, a doctor of medicine" (131)

The izinyanga, because they are practitioners of medicine must follow an unspecified (but often lengthy) period of training and apprenticeship, during which they are attached to qualified izinyanga for whom they carry the bag containing medicines, and from whom they learn the herbs, potions, and medicaments appropriate for specific diseases. The izinyanga are fundamentally herbalists and are concerned with the secular aspects of activities centered about healing; they are healers and seekers of medicines, and are neither qualified per se nor interested per se to discover who or what might have bewitched (uthakathi) a patient to have his disease. The izinyanga's livelihood is made by their skills as proto-physicians: they diagnose diseases and they proceed with the treatment in a matter-of-fact way to attempt to heal with the knowledge and skills at their command. If an izinyanga is unable to effect a cure he can refer the patient to another more experienced inyanga, or to one who specializes in the disease. However, traditionally many diseases are caused by magical or by occult means, and the inyanga, following the practices and upholding the beliefs of his society, could not carry on his practice in an exclusively empirical and quasi-rational way, knowing that certain diseases are the result of magic and that they must, therefore, be treated appropriately by magical methods. Many izinyanga have therefore acquired the ability and skills to cure both in a proto-medical manner, and to use methods that are (by western standards) less rational. In particular, the group of emotional disturbances known collectively as amafufunyane, corresponding approximately to classical hysterical states, may be caused rationally, as by worry and emotional stress, or may be the result of bewitching. The inyanga must be able to recognize the different etiologies, and will obtain a case history from his patient to clarify the situation, and will attempt to cure the patient by the appropriate method.

The inyanga's practice therefore, mingles the rational and the irrational: the straight-forward herbalist, wandering immense distances

about the countryside to seek herbs of different curative properties, will at another time be a diviner, seeking to bend irrational forces to his will for the relief of his patient. The greatest prestige accrues to the inyanga who is also a diviner, who has an advantage in status over the mere herbalist, unless he be a herbalist of great fame. It is interesting that several of the author's informants (including the Secretary of the "Natal Bantu Medical Association" hinted that there were even some unscrupulous izinyanga, who had no powers to divine but who claimed untruthfully to have had visions in order to increase their status and their clientèle.

The inyanga with no power to divine therefore functions simply as a herbalist, and may even act as a sort of consultant for a diviner if he be a herbalist with a high reputation for skill and knowledge: the diviner will divine the causes of the disease and then refer the patient to the inyanga for treatment.

Callaway (1884) quotes an informant's account of the condition of a man who is about to become an inyanga with inspirational powers:-

> "At first he is apparently robust; but in process of time he begins to be delicate ..... he is continually complaining of pains in different parts of his body. And he tells them that he has dreamt that he was being carried away by a river ..... At last the man is very ill, and they go to the diviners to enquire ..... At length an inyanga comes and says ..... "... I see nothing else but that he is possessed by an Itongo ..... If you bar the way against the Itongo, you will be killing him. For he will not be an inyanga; neither will he ever be a man again; he will be what he is now ..... Just leave him alone, and look to the end to which the disease points ..... He will not die of the sickness, for he will have what is good given to him"."

Callaway comments that "what is good" was the expression for the power to divine. The novice inyanga continues to behave strangely, having convulsions, yawning and sneezing (both activities traditionally symptomatic of possession), weeping without reason and uncontrollably, shouting and singing, and finally after some time, having taken special medicines "he comes back quite another man, being now cleansed and an inyanga indeed".

An interesting question for the anthropologist to solve, is: the extent to which the inyanga, in the semi-tribal conditions which prevail in the rural areas where the political power and prestige of the chief has diminished, has regained some of the medical power that was formerly shared with the chief by izinyanga. Sundkler (1961) makes the suggestion that healing powers and leadership are related. Especially among those religious groups that employ faith-healing there is an intimate link between the personality of the prophet and his power to heal. His ability to heal gives the prophet an opportunity to assert that he is an inspired prophet, and therefore regardless of his intellectual and leadership qualities, the prophet with a reputation for effective healing can "hold his own in comparison with the chief type of leader". Such a prophet was Isaaih Shembe of the Zionist Church. It becomes reasonable political practice therefore, for the chief in the traditional society to attempt to minimize the power of a potential opposition by a prophet-healer class by abrogating to himself the most powerful medicines - a device that is describes in detail by Callaway.

Barker (1961), the Medical Superintendant of a missionary hospital in a remote rural area of Zululand, where one could reasonably expect the African inhabitants who had been born and bred there to have retained much of their traditional belief and practice about disease and its cure; one would expect the modern doctor to meet serious difficulty in winning the confidence of his local rivals, the izinyanga, and of the sceptical laity, whom one would expect to take the izinyanga's lead. After fifteen years in his hospital, Barker writes with rare sympathy of the izinyanga:-

> "Beyond the ignorance, and the unquestionably bad consequences of that ignorance, there is yet to be recognized in these medicine-men a certain rough integrity and logic. Believing as they do in the profound influence of the ancestors upon the living members of the clan, they act rationally enough and in a sufficiently disciplined way. They have served an apprenticeship and learned their craft at the feet of its masters; they have in their make-up both compassion and

> tenderness; watching their influence decline before the new learning, they often behave with humility and dignity".

He writes of the difficulties of the doctor in an unsophisticated rural area that:-

> "Because we did not accept magic and witchcraft as causative of the suffering and discomforts of our patients, we were often unable to answer their fundamental questions in terms comprehensible to them. This put us at a disadvantage before the medicine-men who could and did accept the connection and whose explanations so well accorded with the prejudice of their patients ..... But it would be unjust to suggest that more than a minority still clung to the traditional beliefs of their fathers about magic and witchcraft. There was so much solid good sense in the attitudes of so many parents to their sick children; so much desire among the women-folk for safe childbirth in hospital ..... that it was evident that the old attitudes were losing their hold",

and no doubt the izinyanga, who are the guardians of those attitudes, were correspondingly losing their influence.

4. The urban izinyanga:-

The author's sample of izinyanga was not a random sample, but was chosen to include a range of men and women of different ages, backgrounds and education; the author considers that a consensus of opinions of a heterogenous group might be more illustrative of the range of beliefs and of the extent to which tradition is still kept alive, than the opinions of a homogenous group who might be expected to share similar views. It proved however remarkably difficult to find more than one woman who could spare time to be interviewed; several women were approached, but they put the author off by expressing their willingness to be interviewed but finding themselves overburdened with patients, with the need to go to the country to seek herbs ..... It was however found that the interview with the one woman, did not reveal any material that seemed to be related directly to her role as a woman. All the izinyanga interviewed were, after initial hesitation and shyness, interested in the research and anxious to help the author.

The impressions of the author, and the opinions of his two interviewers, suggest that the sample is, in traditional African terms, elderly to old; it is common in the author's experience for not only the less sophisticated informants to describe a man as 'an old man', although they may be describing a man whom the author would regard as middle-aged 45. The ages ranged from 32 to about 65, but only two izinyanga were below 40, and only four were between 45 and 50. The majority of the izinyanga were children and adolescents during the time when rapid urbanization and the dissolution of traditional tribalism was beginning, but had not yet attained the rapidity that resulted from the economic developments of the period after about 1938.

Eleven of the izinyanga were Zulu, and the three exceptions (one Sotho, one Xhosa and one Shangaan) had spent much time with Zulu, and none of them volunteered information that differed substantially and significantly from that of their Zulu colleagues. Hunter (1961), describing the Pondo system of medicine and magical beliefs, reveals close resemblances between the essential beliefs of the Pondos and those of the Zulu, which suggests that many concepts have irradiated to a wide circle of related tribes, possibly because the high reputation that is claimed by non-Zulu for Zulu medicine and medicine-men. The Sotho informant had so high a regard for Zulu medicine that he told the author, that after his son had completed his studies in medicine in England, he must return to this country and be apprenticed to a Zulu inyanga in order to learn the best knowledge about African medicine.

The izinyanga tended to be of a lower average educational standard than the other subjects, and with considerably less variation: none had a higher standard than a "T.4." certificate, and three of the fourteen were completely illiterate. The sample as a whole was therefore drawn from the less educated. There were often economic reasons given for the izinyanga's

lack of schooling: many of them came from rural or recently-rural families, poor and with large numbers of children, and were of school-going age at a time when jobs in the towns and places in the country-schools were few. The two best educated izinyanga were also the youngest, and both have spent much of their lives in town or within reach of schooling.

There is slight preponderence of rural over urban backgrounds, but the family background of the izinyanga is almost exclusively rural. The laity included a significant proportion, particularly of young people of under 35, who were urban, whose parents were urban and, in some cases, whose grandparents had lived a large proportion of their lives in the town. The izinyanga can therefore be regarded as nearer to traditional rural ways of life and thought than the laity.

The izinyanga have practised their calling for a wide range of years: from over fourty to under five; the mean length of experience is about 20 years. It is interesting, however, that not all the izinyanga have spent all their working-lives in this calling, but many have had other jobs and some only became izinyanga after having suffered some crisis in their lives. For example: Mr. J., aged 32, had been a clerk since he passed his J.C.III. until about four years ago when he claims that Shaka came to him in visions, telling him to leave his employment and to help his people by becoming an inyanga. Despite the opposition of his wife (but with the encouragement of his mother) he became apprenticed to a Mrs. N. (who is famed locally as an inyanga and as a diviner) who taught him about diseases and medicines until he was sufficiently experienced to begin to practise on his own; he has had no further visions since he became an inyanga. Another informant, Miss K., aged 34, had a T.4. certificate and had been teaching continuously and uneventfully until about 4 years ago, when she claims to have been visited in her dreams by her ancestors, and to have seen other visions. She became (she reports) mentally disordered, and against the

wishes of her parents she became both an inyanga and a diviner and left her teaching career. She still has visions which guide her to places where she will find herbs for particular diseases, and the ancestors appear to her in dreams to advise her on the causes of a disease. A third informant whose initiation to becoming an inyanga was accompanied by a period of emotional upheaval, was Mr. A., aged 45, who had a job in Cape Town when he was called to his home where his young daughter had suddenly died. He reports:-

> "When I heard what had happened I was convinced that this was a case of witchcraft, so I decided that I was going to sell all I had and leave home for good. My mother-in-law tried to persuade me not to go. She was scarcely three days with us when she suddenly died of the same throat complaint that had killed my daughter. This embittered me even more and made me think that the people responsible for this had to pay for it".

Mr. A. found a Zulu inyanga to whom he became apprenticed for three years, and who dissuaded Mr. A. from revenge replacing it with the desire to become a great healer. The majority of the informants, however, had less dramatic introductions to their career: most of them had had an inyanga in the family who took a fancy to them when a child, encouraged them to accompany him when seeking herbs, taught them medicine and medical-lore, and to whom they became apprenticed when old enough, beginning by practising part-time while having another job, and gradually setting up full-time practice. Thus a more typical start to the career is that of the Secretary of the "Natal Bantu Medical Association", whose father was an inyanga, practising part-time as a herbalist while a night-watchman. His son learned about herbs and diseases from his father and from an uncle, and when he had learned sufficient and the apprenticeship ended he came to Durban and was employed as a cook, during which time he practised as an inyanga part-time. After a few years he began to practise full-time.

In accordance with custom all the informants had been apprenticed to a qualified inyanga, except Miss K., and they carried the medicine-bag

(uhlaka) of the teacher for periods up to about four years, during which time the apprentice learned the different herbs for different diseases, ground barks and roots to powder and mixed medicines, learned the symptoms of diseases and the appropriate manner in which to interview patients and their families. Where there was a member of the family who was an inyanga the informant was usually apprenticed to him (or her), and in many interviews the informant pays a more than conventional tribute to the encouragement and help that he had from his teacher. Only two of the izinyanga had decided to follow their calling in sharp opposition to the wishes of their family, and it may be significant that these were the two youngest of the informants and among those who had a traumatic introduction to becoming izinyanga. Rivers (1924) drew attention to the tendency of leeches to specialize in the diagnosis and treatment of disease, and this trend towards specialization is characteristic of the author's izinyanga. Of the izinyanga three specialize in treating childhood disorders (of whom one lost his young daughter in tragic circumstances, and the other is an unmarried woman in her mid-thirties); the other specialist specializes in treating childhood diseases (especially that known as inyoni) claiming that his interest is partly because he has a flair and partly in order to limit the number of patients he had to treat. Two informants are interested mainly in treating emotional disorders: one treats them generally and the other specializes in treating amafufunyane. Two other informants specialize in forms of divination to aid diagnosis: one concentrates on bone-throwing, and the other inspects the contents of a sealed, magical medicine bottle filled with a secret fluid.

The material obtained from all informants was organized and analyzed to reveal the extent to which the hypothesized tendency of the izinyanga to disagree with the non-izinyanga on many issues, was substantiated. That the izinyanga appear to make some different assumptions on psychological matters from the laity, might reflect the changing in their role and

status, and the competition to their beliefs and techniques in an urban community which provides many of the services that they formerly were able to provide in the traditional rural society. The izinyanga have a vested interest in maintaining traditional beliefs, because when the traditional beliefs are sufficiently eroded their role becomes vestigial and their status declines: they can expect to become no more than "survivals" such as palmistry and astrology. The izinyanga respond to the pressures of urbanization largely by clinging firmly to their traditional beliefs, and paradoxically by trying to incorporate to the traditional beliefs elements of urbanization. The author was informed, for example, that a well-known and reputable inyanga interprets the oscillations of his radio as messages from the amadlozi (the ancestors), and there has been little difficulty in incorporating hypodermic injections to the traditional methods of treatment by introducing medicines into the body by smearing them into small incisions.

The interview with the izinyanga followed a similar pattern to the interview with the laity, except that tape-recordings were made of interviews with 10 informants. The author and the interviewer-interpreter were together in 5 of the recorded interviews, the others being carried out by the interpreter alone. In the joint interview, the interpreter worked through the interview schedule, providing the author with a running translation and commentary, the author intervening when necessary to ask further questions. This cumbersome-sounding process seemed not to upset the informants, all of whom were excited to hear extracts of the interview played back to them after the interview. Each evening, the interview was played back to the author who typed the verbatim account as rendered by the interpreter, and made notes of matters that he wanted to clarify. If any part of the interview had not been completed it was found always possible to return later and continue. It was intended to have the translation of the "tapes" checked by an independent linguist, but they were stolen from the author's office before this could be arranged.

CHAPTER FOUR

BASIC PSYCHOLOGICAL QUESTIONS

Introduction:-

In this and the following two chapters, the author analyses the material obtained from administrating the interview-schedule (Appendix A) to izinyanga and non-izinyanga.

Section One: Brain and Mind:-

Introduction:-

This section comprised four sub-questions to obtain the views of informants about (1) the overall importance of the brain; (2) the parts of the brain and their functions; (3) the results of damage to the brain as a whole or to parts of it; (4) the results of inadequate development of the brain (Appendix A).

The main purpose of the section was to investigate the extent to which the informants accepted modern medical concepts as distinct from traditional, and this was hypothesized to be indicated by the extent to which informants spontaneously employed medical terms (as distinct from traditional terms) for parts of the brain. Therefore the major sub-question asked was about the belief that the brain is divided into four traditionally-named parts, which revealed the extent to which this belief was accepted or rejected by informants (Table 2:A1 and B).

The izinyanga and the laity were compared throughout, and the non-izinyanga's usage of medical as distinct from traditional terms was analyzed as an indication of the extent to which they accepted or rejected this distinction (Table 2B).

Results:-

The izinyanga were unanimous in their support of the view that the brain is the master organ of the body, that the brain is divisible into four traditionally named parts and that damage to the brain leads to physical or psychological disability. The izinyanga were divided in their tendency to reject the view that inadequate brain development results in mental deficiency. The laity were unanimous in their support of the view that the brain is the master organ, that damage to the brain results in disability and that inadequate brain development leads to mental deficiency. The izinyanga and the laity differed significantly in their support of the views of the results of inadequate brain development: the proposition being more strongly held by the laity; there was a near significant difference between izinyanga and laity, where the former more strongly support the traditional division and naming of the brain (Table 2A). Among themselves the laity differed significantly in the use of anatomical as distinct from traditional terms: the urban, younger and better educated informants supporting the use of modern medical terms (Table 2B).

In the comparison of the non-izinyanga's usage of anatomical terms, the urban, younger and better educated significantly more often used anatomical terms as compared with traditional (Table 2B).

TABLE 2 - BRAIN AND MIND

A. Concepts of brain and mind: Izinyanga (N=14) vs. non-Izinyanga (N=96) belief that:-

		Agree	Disagree	Other responses	Significance
1) Brain is master organ of body	Izinyanga	14	0	0	-
	Non-Izinyanga	96	0	0	
2) Brain is divisible into four parts named traditionally.	Izinyanga	14	0	0	$X^2 = 3.71$ $p \leq 0.10$
	Non-Izinyanga	66	30	0	
3) Damage to part or whole brain leads to physical or psychological disability.	Izinyanga	14	0	0	-
	Non-Izinyanga	95	0	1	
4) Inadequate brain development results in mental deficiency.	Izinyanga	5	9	0	$X^2 = 58.93$ $p \leq 0.001$
	Non-Izinyanga	96	0	0	

B. Usage of anatomical terms among the laity (N=96)

Laity using anatomical terms		Laity using other, traditional terms		Significance
Rural:	4	Rural:	33	$X^2 = 11.46$ $p \leq 0.001$
Urban:	26	Urban:	33	
Male:	15	Male:	32	-
Female:	15	Female:	34	
13-35 years:	23	13-35 years:	23	$X^2 = 14.43$ $p \leq 0.001$
36 and above:	7	36 and above:	43	
No education to Std. VI:	0	No education to Std. VI:	57	$X^2 = 68.45$ $p \leq 0.001$
Std. VII and above:	30	Std. VII and above:	9	

Footnote: The data in Table 2A 4) were tabulated into two-by-two tables for statistical evaluation by chi-square. The "Agree" responses were those which agreed completely with the proposition (expressed in terms of the "sub-question"), and were compared with the "Disagree" responses, that is, those in partial or total disagreement with the proposition. "Other responses" (usually nil) were those unclassifiable or unascertainable and were not incorporated into the two-by-two table. Only where X^2 is 0.10 or $\leq$ 0.10 is the exact value recorded, and the method for evaluating X^2 is that described in Siegel (1956). Unless otherwise stated, all the data in this thesis have been treated as above.

Discussion:-

Informants were unanimous on the central importance of the brain, and none suggested that there was any other part of the body to rival its role and functions; the consensus was expressed by an inyanga who said that "the brain is the master of the whole body, it directs one to do anything and to think".

The traditional terms employed varied, possibly because of local dialectical variations, but most commonly the brain was said to be divided into three parts: (1) isiphongo or ubuchopo, corresponding to the forebrain; ukukhayi or ufukothi, corresponding to the midbrain; and (3) isiphundu or ingqondo, corresponding to the hindbrain. The word ingqondo is also used to describe the brain as a whole if one is talking about that part of the body known as the brain. The front part of the brain was said to have small importance if it be operating normally, but if it is injured very severely or there is an internal haemorrhage, the person may become mad. The midbrain is more sensitive than other parts and appears to be regarded as more important. It is soft at the birth of the child and gradually becomes stronger and harder; but while it is still soft the child is particularly vulnerable both to physical and magical harm. The parents must protect the baby against inhaling "bad air", i.e., evil medicines, because these will cause a depression in the ukhukhayi which could even lead to the child's death if the child were not treated. Besides this view, this part of the brain is also regarded as a bridge between the ubuchopho and the ingqondo through which the blood vessels ramify, and if an adult be injured in this part of his head he may be afflicted with a "falling sickness" and cannot withstand the heat of the sun. If an adult is affected with amafufunyane his ukhukhayi pulsates as does that of a small child. The ingqondo is also an important part of the brain; injury to it can cause madness or loss of speech, or paralysis of a particular limb or of a part of the body, and there is said to be no cure for this injury.

One of the izinyanga suggested that when a patient's head is too hot and he has a severe headache and is throbbing after having suffered a sharp blow, the cure is to make an opening on the area that was knocked, and when the bone is reached it should be scraped and the wound left to heal, by which time the headache will have subsided. This operation, similar to trepanning, is known as umhlahlo, and the author regrets not having been able to discover the frequency that it has been carried out by his informants, who were (perhaps understandably) reticent and evasive. The madness caused by a blow on the head is known as ukuphambana.

It is noteworthy that informants were clearer about the effects of injury to the brain (or parts of it) than they were about the normal functioning; the informants who gave the anatomical terms were the only informants to suggest a detailed exposition of normal functions and corresponding areas of the brain. This would suggest that the traditional beliefs have developed empirically, and are the observations of injured or dying humans and animals, which being pragmatic and empirical offer small scope for mystical or magical notions. On the other hand the seemingly rational view of the result of the inadequate development of the brain is seen to be modified by the traditional views of the causes of mental deficiency, which are less rational.

Conclusions:-

Not unexpectedly those informants who have had more education and, by living in towns have had more contact with "western" notions, tended to use "western" concepts. It is interesting that those who used "western" concepts, were often quite unable to give the traditional terms for parts of the brain even when they were prompted. It seems probable therefore, that the acceptance and absorption of "western" concepts is deep and replaces, rather than is additional to, traditional concepts.

Not unexpectedly the izinyanga were unanimous in their support of the traditional naming of the brain, and their strongest support from the laity was found among the rural, older and less educated informants who had less opportunity for their traditional beliefs to be influenced by modern concepts; the unanimity of the izinyanga in the other sub-questions suggests that traditional belief has incorporated some basic modern concepts about brain function and role. The laity's non-unanimity about the naming of the brain suggests they, more than the izinyanga, are in conflict about the respective validities of traditional and modern concepts of the brain.

Section Two: Conscious-Unconscious Determinants of Behaviour:-

Introduction:-

The general purpose of this section was to find out whether the informants believed (or rejected or modified the belief) that sometimes people behave without knowing fully (or understanding after the event) the immediate and effective reasons for their behaviour.

The section was divided into four sub-questions: (1) does unconscious motivation exist; (2) is it attributed solely to bewitching; (3) is it attributed to witchcraft as one of several causes; (4) is witchcraft not a cause? The major purpose of the section was to investigate the extent to which informants attributed unconscious motivation to irrational factors such as witchcraft, as distinct from other more rational causes, and therefore the responses of the non-izinyanga were analyzed to reveal the extent to which they used witchcraft as a cause.

The izinyanga and the laity were compared in the sub-questions, and the responses of the laity's belief in the causation by irrational factors was analyzed.

TABLE 3

UNCONSCIOUS MOTIVATION

A. Existence and Causation of Unconscious Motivation: Izinyanga (N=14) vs. Non-Izinyanga (N=96)

		Agree	Dis-agree	Other Responses	Significance
1) Unconscious motivation exists.	Izinyanga	14	0	0	-
	Non-Izinyanga	77	19	0	
2) Unconscious motivation caused by witchcraft solely.	Izinyanga	5	9	0	$X^2=28.16$ $p<0.001$
	Non-Izinyanga	0	96	0	
3) Unconscious motivation caused by irrational factors.	Izinyanga	10	4	0	-
	Non-Izinyanga	81	15	0	
4) Bewitching is not a cause.	Izinyanga	9	5	0	$X^2= 3.46$ $p<0.10$
	Non-Izinyanga	34	62	0	

B. Analysis of belief of laity that bewitching is not a cause (N=96)

Rural:	8	29	0	$X^2=45.57$ $p<0.001$
Urban:	54	5	0	
Male:	20	27	0	$X^2=17.69$ $p<0.001$
Female:	42	7	0	
13-35 years:	41	5	0	$X^2=21.25$ $p<0.001$
36 and above:	21	19	0	
No education to Std. VI:	25	32	0	$X^2=24.16$ $p<0.001$
Std. VII and above:	37	2	0	

Results:-

The izinyanga were unanimous in their belief that unconscious motivation existed, and were nearly unanimous in their belief that it be caused by irrational factors (Table 3A). The laity were nearly unanimous in their belief that unconscious motivation is caused by irrational forces, this view being most frequently held by the rural, male, older and less educated (Table 3B). The izinyanga and the laity differed significantly in the more frequent support of the former for the view that unconscious moti-

vation is exclusively cause by witchcraft; they differed nearly-significantly in the more frequent belief of izinyanga that unconscious motivation is caused by bewitching (Table 3A).

Discussion:-

The belief in the existence of unconscious motivation, substantially accepted by most informants, was denied by 20% of the laity whose views were that unless one is an imbecile or an immature child one cannot help but know what one is doing and one's reasons for doing it, and several informants suggested that to attribute such behaviour to bewitching or other irrational or magical causes, is an excuse by those with little self-control.

It was not easy to elucidate the opinions of the informants because of the difficulty of reducing the concept of unconscious motivation to a level of simplicity that was both comprehensible to the layman and yet a reasonably accurate rendering of the technical concept. The layman tends (in the author's experience) to interpret "unconscious motivation" as equivalent to that which is done impulsively or absentmindedly. On the other hand, if this section be read in conjunction with the sections on Projection and Obsession-Compulsion, the prima facie rejection of the concept by some informants is often a qualified acceptance. Where the concept was blankly denied, the interviewer gave a series of leading questions based upon a simple example of unconsciously motivated behaviour, in which a small child is described as behaving anti-socially in response to unconscious feelings of revenge for his neglect and illtreatment by his parents. This example aroused interest - even indignation - and proved to be an effective catalyst for conversation even with the reluctant informants.

The general proposition of those offering explanations in terms of witchcraft, is that unconscious motivation operates only if the individual

has been bewitched: either the individual is conscious and aware of the reasons for his behaviour and is in command of his thoughts, or he has been bewitched and his apparently motiveless behaviour is the result of his being directed by the will of a witch or wizard to carry out specific acts or to think about specific ideas and feel specific emotions, which otherwise would not have affected him. A person may therefore be the agent of a witch or a wizard, and may be bewitched against his will to behave in a way that is not explicable except in terms of witchcraft. One of the izinyanga, who referred solely to witchcraft, claimed that this behaviour is common and the behaviour resulting from this influence is a form of mental illness. The term ukuluthwa was used to describe the illness of an individual acting without his full conscious will. Another type of non-rational explanation was that children are sometimes "pushed" to behave against their will if their parent have failed to follow customs that should have been carried out when the child was very young. A child may, for example, be old enough to know that he should excrete outside the house, but he may nevertheless and for no good reason commit the enormity of excreting in the house: "It is said that the child is calling for uphawu": his behaviour is an appeal to the family to carry out the omitted ceremony or custom, and when this omission has been remedied his otherwise inexplicable behaviour will stop.

Amafufunyane is traditionally an emotional disturbance commonly caused by bewitching; this illness, mostly affecting young girls, is hysterical anxiety states with somatic symptoms, supposedly caused by "possession" by spirits that are sent by an enemy or by an unsuccessful and unrequited love. Lee (1950) holds the view that this disorder corresponds to the classical conversion hysterias. While the patient suffers from the disorder, she (or he) may cry and shout uncontrollably, rush wildly about, tear herself or her clothes, have mysterious pains or functional disturbances, and is to the lay observer, being "pushed" to have fears and to behave in a manner that is outside her control.

All of those informants who did not confine their explanations to witchcraft, differentiated between children and adults; motiveless behaviour is expected of children (although not of adults) because their minds are not fully developed: they, therefore, act without deliberation and on the impulse, but this waywardness gradually diminishes as the child becomes more mature.

The main causes other than witchcraft that affect adults are:-

a) "Beetles" in the brain, known as amabungane, which were never mentioned by the laity, and a small proportion only of the izinyanga. They are said to resemble the small white maggots found in cow-dung and are a natural phenomena curable by the use of an appropriate enema.

b) Other natural illnesses, physiogenic and psychogenic,were described: the informants recognized that conditions such as fevers, blows to the head, low intelligence and the mental confusion of old age are responsible for causing unconsciously determined behaviour and thoughts. Nearer to the psychoanalytic viewpoint was impulsive anger and aggressiveness: the situation was described in which a person acts beside himself with rage and frustration, and when taxed afterwards with his reasons for acting so erratically, he denies being aware of what he did and of why he did it. But not all informants accepted this explanation; one inyanga shrewdly objected that -

> "It does sometimes happen that a person say, assaults others, and claims that he did not know what he was doing. I cannot admit this. I say that such a person is insolent and cannot control his temper or himself, and though those related to him might give the excuse that he is bewitched, we all know that he is not .....".

The same informant continued by pointing out that even those who are bewitched to behave apparently against their will, are, in fact, willing to allow the bewitching to impel their behaviour; even bewitching can therefore be used as an excuse by those acting without prior thought,and who seek to justify their not wanting to control themselves.

Other causes were mentioned by informants but were not tabulated because of the infrequency of their mention, although they are worthy of note: the mental confusion consequent upon the call to become an *isangoma* (diviner), which is claimed to be a disturbance peculiar to Africans and therefore treatable solely by traditional medicine, and the mental confusions of *amafufunyane*.

Conclusions:-

In general in this section the *izinyanga* tended to be more traditional in their beliefs and readier to give explanations in terms of bewitching and other irrational factors than the laity, and among the laity, the better educated, younger, urban informants tended to give explanations more in keeping with "western" rational ideology.

Section Three: Memory:-

Introduction:-

The section consisted of five sub-questions on -

A - *loss of memory* as a result of (1) magical causes; (2) psychological causes; (3) physical illness or senility;

B - *distortion of memory* as the result of (4) magical causes; and (5) mental illness. (Appendix A).

The responses of *izinyanga* and non-*izinyanga* were compared (Table 4A and B). The responses of non-*izinyanga* were compared internally but only nearly-significant differences were shown.

Results:-

In the attribution of loss of memory to physical illness and to senility the *izinyanga* were evenly divided, and in the other sub-questions they were nearly unanimous. The laity were nearly unanimous in their rejection of magical causes of loss of memory and of distortion, and were

TABLE 4: MEMORY

A Causes of loss of memory: Izinyanga (N=14) vs. Non-Izinyanga (N=96)		Agree	Disagree	Other Responses	Significance
1) Loss of memory is caused by bewitching or other magical causes.	Izinyanga	3	11	0	-
	Non-Izinyanga	16	80	0	
2) Loss of memory is the result of psycho-social causes.	Izinyanga	3	11	0	$X^2=20.75$ $p<0.001$
	Non-Izinyanga	79	17	0	
3) Loss of memory is the result of physical illness or senility.	Izinyanga	7	7	0	-
	Non-Izinyanga	62	34	0	

B Causes of distortion of memory: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) Distortion of memory is the result of bewitching or magical causes.	Izinyanga	1	13	0	-
	Non-Izinyanga	4	92	0	
2) Distortion of memory is the result of mental illness.	Izinyanga	1	13	0	$X^2=14.78$ $p<0.001$
	Non-Izinyanga	58	38	0	

C Causes of loss of memory: Views of Non-Izinyanga (N=96)					
1) Loss of memory is caused by bewitching or other magical causes.	Rural:	8	29	0	-
	Urban:	8	51	0	
	Male :	9	38	0	-
	Female:	7	42	0	
	13-35 years:	5	41	0	-
	36 and above:	11	39	0	
	No education to Std.VI:	14	43	0	-
	Std. VII and above:	2	37	0	
2) Loss of memory is the result of psycho-social causes.	Rural:	31	6	0	-
	Urban:	48	11	0	
	Male:	37	10	0	-
	Female:	42	7	0	
	13-35 years:	39	7	0	-
	36 and above:	40	10	0	
	No education to Std. VI:	44	13	0	-
	Std. VII and above:	35	4	0	
3) Loss of memory is the result of physical illness or senility.	Rural:	28	9	0	-
	Urban:	34	25	0	
	Male:	28	19	0	-
	Female:	34	15	0	
	13-35 years:	28	18	0	-
	36 and above:	34	16	0	
	No education to Std. VI:	32	25	0	$X^2= 3.51$ $p<0.10$
	Std. VII and above:	30	9	0	

Table 4 continued next page.

Table 4 continued

D Causes of distortion of memory: Views of Non-Izinyanga (N=96)		Agree	Dis-agree	Other Responses	Significance
1) Distortion of memory is the result of bewitching.	Rural:	3	34	0	-
	Urban:	1	58	0	
	Male:	2	45	0	-
	Female:	2	47	0	
	13-35 years:	1	45	0	-
	36 and above:	3	47	0	
	No education to Std.VI:	4	53	0	-
	Std. VII and above:	0	39	0	
2) Distortion of memory is the result of mental illness.	Rural:	29	8	0	$X^2 = 3.47$ $p < 0.10$
	Urban:	29	30	0	
	Male:	28	19	0	-
	Female:	30	19	0	
	13-35 years:	28	18	0	-
	36 and above:	30	20	0	
	No education to Std.VI:	37	20	0	-
	Std. VII and above:	21	18	0	

otherwise divided. The izinyanga and the laity differed significantly in the laity's stronger support of the attribution of loss of memory to psychological causes, and of distortion to mental illness. Among themselves the laity differed no more than nearly-significantly: the attribution of loss of memory to bewitching was more frequently supported by the lower educated; the attribution of loss of memory to physical illness and senility was more frequently supported by the rural and the better educated; and the view that distortion is the result of mental illness was more frequently supported by the urban. There were no significant differences among the laity in the attribution of loss of memory to psychological causes, nor in the view that distortion is a result of mental illness; there were the following nearly-significant differences: a higher proportion of the better educated held that loss of memory is the result of senility or physical illness, and a higher proportion of the urban that distortion is the result of mental illness.

Discussion:-

In general, the explanations of the izinyanga tended to emphasize physical or physiological causes more than the psychological, and the emphasis of the laity was the converse, and of the physical-physiological causes specified, by far the most often mentioned was the deterioration of senility. Many informants went so far as to state that loss of memory is highly unusual among the young, but is common among the elderly. The mental deterioration of old age that was described as causing both loss and distortion of memory, was accepted as an inevitable and natural part of life by the informants who mentioned it, and they did not assert or imply that the condition could be either exacerbated or ameliorated by magical means. It was claimed that traditionally great toleration is shown to the senile; the phrase "in his second childhood" is used in Zulu as in English, and that someone is "in his second childhood" appears to be regarded as an adequate explanation and justification for tolerating the elderly person's distinctive behaviour. Moreover, according to many of the informants, traditionally the elderly are very much respected and their pronouncements and decisions are given much weight. However, when an elderly person shows signs that his memory is failing and that he is remembering confusedly, muddling events and forgetting that which he has recently done, although he will still be accorded the reverence due to his years, the nonsense that he speaks will be ignored and listeners will sift the sense from the nonsense in his conversation.

Other physical causes specified frequently were tumours, blows to the head and fevers. Informants agreed that loss of memory resulting from these causes should and could not be treated by the izinyanga but by the doctor, and it is noteworthy that the izinyanga were as aware of the limits to their abilities as were the laity.

The situations in which loss of memory was attributed to psychological causes, seem to be those in which the individual was absentminded or inattentive rather than having suffered a major loss of memory, but many informants distinguished between the loss of memory resulting from the confusion of mental illness and the temporary loss that is caused by worry, brooding about a problem or emotional strain. A sharp difference between the izinyanga and the non-izinyanga was the latter's specifying poverty and its frustrations, the preoccupation resulting from which "cannot be cured unless if you get what you want"; none of the izinyanga referred to this as a cause, whereas about half of the non-izinyanga made this reference.

Only the izinyanga specified "bettles" in the brain, which they stated brought about "stagnation" of the ingqondo; this though prima facie not a rational-medical explanation was, in fact, offered as a medical diagnosis, and although it was not made clear how these "beetles" enter the brain the izinyanga agreed that the treatment is to "spade" the sufferer, that is, to give him an enema that draws the "bettles" away from the brain and thereby relieves the stagnation of the ingqondo, allowing the memory to be restored.

The most commonly named magical cause was amafufunyane or ukuluthwa izilwane, the latter of which occurs when the sufferer is taken by a tikoloshe to a lonely spot. This condition is cured by the inyanga, who treats the sufferer with medicines to make him vomit, with inhalations and by steaming him. A less often mentioned magical cause, was the result of someone taking a love-philtre who so strongly dislikes the administrator of the philtre that he (or she) becomes mad and behaves in the hysterical manner known as hiveza. It will be recalled (although it was not mentioned by informants in their responses to this section), that one of the mental disturbances of the diviner in the early stages of his initiation is a "muddled mind", which partly takes the form of loss and distortion of

memory. One lay informant gave as a cause punishment by the amadlozi (the ancestors), who have been offended by the sufferer's having omitted to carry out a ritual or ceremony.

A class of causes given by four of the laity and included (after some hesitation) in the category "physical illness", is the belief that a person born into a family that once had an insane member might inherit loss of memory, not for magical reasons but in the same way that one might inherit bodybuild or colour of hair similar to that of an ancestor.

Distortion of memory was largely attributed to rational causes, and was more often than loss of memory held to be incurable - possibly because of its association with senility.

Of the category "psychological", fifty responses were to "inattention" or "naughtiness", but this should be qualified to modify the impression that the individual is necessarily wilful and blameworthy: this condition was very often qualified by the comment that the individual is suffering from a form of mental defect or mental illness, that is, he appears to be naughty or wilful, but is only partly responsible for his behaviour. As in the case of loss of memory, worry, strain and preoccupation, sometimes due to the difficulties of employment and the like, are mentioned as predisposing causes. One lay informant proposed an interesting relationship between distortion and educational level -

> "Education may be a cause. You cannot differentiate things, and you don't understand things if you aren't educated. This can be cured by educating the person, teaching him the difference between things and making him understand".

The informants' views on what is recalled and what is forgotten proved to be too varied to categorize, except so broadly as to make a comparizon between the non-izinyanga and izinyanga unilluminating. In general: informants claim to remember the bad or unpleasant things they have done and

the unpleasantness they have suffered, and the claim to forget the trivial, and surprisingly, the good and pleasant things. This somewhat un- Freudian view may have a reasonable pragmatic basis: it may be that the in- formants distinguished between forgetting the bad things that have happene(to them, i.e., repression of 'bad' happenings, but that one recalls the ba(things that one has done, i.e., the pangs of a guilty conscience are lively This interpretation has some support from an inyanga's reply to the author. The author asked the informant to consider the case of people who feared that they had done something bad, but who felt guilty although they tried hard to forget the wrong that they had done, and might not be immediately aware of what had aroused their feelings of guilt.

> "It does happen that a person suffers from guilty conscience. Others realize that this is so by his withdrawing and be- ing less active in what's going on, and before he was very active. People see that there is something worrying him ... and they get into a troubled state for him: they do not know whether the worry is for a little thing or if he's done a most horrible thing, and they try to find out by poking into his private life".

Later in the interview the informant implied that the sufferer himself might be unaware of the causes of his guilty conscience, and he might have quite "forgotten" that which he had done to upset him; this state was said to be peculiarly characteristic of children.

Conclusions:-

In general, both izinyanga and laity gave relatively few responses in terms of witchcraft or magical causes, and perhaps as a consequence of this there were few significant differences between izinyanga and laity. The laity, however, tended to be more environmentalistic in their views than the izinyanga, because the former are more likely to come into contact with the urban and industrial pressures that the layman might interpret as causing mental disturbances resulting in loss or distortion of memory; the izinyanga are, as it were, more insulated in their devotion to tradition. The laity

might further be expected to have more direct knowledge of the success of the hospital and doctor in relieving mental disturbances, including loss or distortion of memory, than the izinyanga.

Section Four: Heredity and Environment:-

Introduction:-

This section comprised three questions to obtain the opinions of the informants on (1) the effect of environment upon the developing character; (2) if both physical and psychological characteristics are inherited; (3) if "good" and "bad" environments can be defined and, if definable, are influential (Appendix A). The fundamental distinction that the author wished to find was whether the informants tended to be hereditarian or environmentalist in their views of the influences upon the personality. The views of the laity and the izinyanga were compared in the three sub-questions (Table 5A, B and C), and those of the laity in respect to the effects of environment.

TABLE 5

HEREDITY AND ENVIRONMENT

1. Izinyanga (N=14) vs. Non-Izinyanga (N=96)

		Agree	Dis-agree	Other Responses	Significance
A) The effect of environment on the individual is slight.	Izinyanga	6	8	0	-
	Non-Izinyanga	24	72	0	
B) Physical and psychological qualities are inherited.	Izinyanga	10	4	0	-
	Non-Izinyanga	94	2	0	
C) "Good" environment is definable and influential.	Izinyanga	8	6	0	$X^2=17.00$ $p<0.001$
	Non-Izinyanga	93	3	0	

2. Analysis of belief of laity of influence of environment (N=96)

	Slight Effect	Marked Effect	Significance
Rural:	11	26	-
Urban:	7	52	
Male:	8	39	-
Female:	11	38	
13-35 years:	5	41	$X^2= 6.99$ $p<0.01$
36 and above:	13	37	
No education to Std. VI:	16	41	$X^2= 6.56$ $p<0.02$
Std. VII and above:	2	37	

Results:-

In none of the three sub-questions was the izinyanga unanimous nor nearly-unanimous, and in only one sub-question were the laity nearly-unanimous: in their acceptance of the view that it is possible to define good and bad environments and that they are influential (Table 5A, B, C). The izinyanga differed significantly from the laity in one sub-question: the laity more frequently than the izinyanga supported the proposition that good and bad environments were definable and influential; the laity and the izinyanga differed non-significantly in the other sub-questions. Among

themselves the laity differed nearly-significantly as follows: the better educated and the younger holding that the effect of the environment upon the individual was marked (Table 5 2.).

Among the izinyanga the views of the informant appeared not to be related to age nor to rural-urban background, although the author had expected that the more rural and the older informants would tend to show an hereditarian bias and the younger an environmental. It may well be however that an unidentified variable is involved here: the more buoyant and optimistic izinyanga with a history of success behind them tending to take a more environmentalistic standpoint, than those with a more pessimistic and fatalistic view of life. The two contrasting opinions are illustrated in the following quotations. The environmentalistic inyanga was in his middle fifties, of rural background and had practised as an inspirational inyanga for some 20 years:-

> "A child's personality is shaped by his parents and other institutions which help the parent - like the school. But the most effective thing is the home ..... The environment is stronger than 'blood'. If 'blood' were strongest then ministers would give birth to other ministers! But this isn't what happens ..... Of course it's possible that a child is born to an aggressive father but takes absolutely nothing of the aggression of the father. You see, if the child is bad it's not because he's been born bad but because he's learned bad things from his family".

The contrary view of another inyanga, younger, urban and with less experience, emphasized that ufuzo (heredity) is the only way in which a child or adult may be influenced and that a child is born to be what he will be as an adult. The author attempted to suggest situations in which it might be thought by the layman that environment was influential, but the informant strongly disputed the author's arguments, and only grudgingly accepted the suggestion that there might be some truth in the traditional belief that if a child has been raised by his maternal grandmother he might be spoiled by her and his character affected.

An hereditarian member of the non-izinyanga appeared to be relying upon a fragment of folklore, saying:-

> "Heredity is stronger than environment. Look at two children of the same father. They don't behave in the same way, but not because their environments are different, but because they have different minds" (izigqondo zabo azifani).

Several factors might have tended to encourage informants to emphasize environment rather than heredity. Firstly: the informants live in a rapidly changing environment which impinges harshly upon them, and might expect from their everyday observation to appreciate how in their own lifetimes people have "changed" in many ways, and how little their personal qualities govern their destinies: i.e., that regardless of your personal qualities, regardless of your hereditary talents and temperaments, the role you will play and the personality that is expected of you is determined by the environment and the little that it offers. Secondly: traditionally (and probably only a little less in the towns), the Zulus tend to be much concerned with children and they pay the child more attention than is common among non-Africans. Even men may be lavish in affection and tenderness to an extent that would be regarded as highly unusual among non-Africans in this country.

This might be expected to suggest to a layman that influence upon the child centering about personal relationships, is more directly derived from environmental than from hereditary factors. The tendency of the izinyanga is to stress the traditional and the relatively constant; that of the laity to emphasize the changing, from which alone improvement of their conditions of life can come. As a class, the izinyanga are in a situation in which it is, perhaps, to their group advantage to emphasize the unchanging "nature" of people who are fundamentally unaffected by the whirl of change about them. On the other hand, the non-izinyanga's advantage lies with change - however painful the dislocations caused by change - to emphasize therefore the overriding importance of environment.

The characteristics of a good environment were so often described that they were almost stereotyped, and the buoyant optimistic belief in the influence of environment to change personality and ways of life was expressed by the youngest (and most educated) of the izinyanga:-

> "If you live among civilized people you also try and make your standard of living equal with theirs, so much so that even if you are illiterate, people cannot detect this because you become just like your civilized neighbours, too".

In general, the "good" environment was described as one that is settled and quiet, with little disorder, fighting and drinking, and with adequate facilities for decent living; Lamontville was often mentioned by contrast with Cato Manor and Kwa Mashu. A "bad" environment was described as a place in which there was violence, drinking, turmoil and unemployment and where children are tempted to learn evil ways despite the efforts of their parents. It is also described as a place with poor facilities: dirt, inadequate sanitation and inadequate transport, and again Cato Manor and Kwa Mashu were contrasted with Lamontville by both izinyanga and laity. It is interesting that a negligible number of the informants contrasted the country with the town as examples of good-bad environments, and even the few who made such a comparison, expressed it in terms that suggested strongly that the basic criteria were orderly government and reasonable social and public health facilities. The city was described as a "bad" environment, not by contrast with an idyllic countryside but because of the strains, crime, temptations and insecurity of urban life. There was no suggestion therefore by any informant of a nostalgic urge to return to the country, and (by implication) to the tribal way of life; on the contrary informants were well aware of the difficulties of urban life, and highly critical of many aspects of official "location" organization and policy, but were equally appreciative of its social and economic advantages.

The qualities that can be inherited can be divided into two broad categories: psychological and physical. Among the most commonly mentioned biological qualities are intelligence, aggressiveness, a specific talent or ability for a particular skill, ubusoka (possessing the quality of sexual attractiveness); the izinyanga mentioned less easily classifiable qualities such as the ability to heal, to do witchcraft and to divine. In general, the factors inherited correspond to the psychologists' classes of talents and temperaments together with intelligence. Physical qualities such as form of hair, build, colour were also frequently described.

Conclusions:-

The tendency for the izinyanga, the older, rural and less educated informants more frequently to give hereditarian responses, reflects the conservatism of the older and more traditionally minded person, that might be expected of those whose interests are harmed by the rapidly changing environment in which the informants live, in bringing them new and challenging values and eroding the old, traditional values.

Section Five: Personality:-

Introduction:-

The purpose of this section was to obtain the informants' descriptions and analyses of personality types in the broadest way. Krech and Crutchfield (1958) have suggested that when the man-in-the-street is asked to describe an acquaintance's personality, he strings together a set of trait-words, and the author's experience in this section was similar. But the author wanted to discover further if informants gave terms describing people as members of a class of personality types.

The section consisted of five sub-questions: (1) the relationship of physical and personality types; (2) the resemblance of mother and child; (3) the resemblance of father and child; (4) the resemblance of either parent and child; (5) the relation of "strong personality" to a combination of status and personal qualities (Appendix A).

The fundamental issue in this section seemed to be the extent to which the informants considered personality to be a function of social factors exclusively, that is status, or of social and individual and social determinants combined. The section in effect questions the views on the

TABLE 6 : PERSONALITY

Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
		Agree	Disagree	Other Responses	Significance
A) Physical and personality types are related.	Izinyanga	4	10	0	$X^2=59.60$ $p<0.001$
	Non-Izinyanga	95	1	0	
B) Resemblance of parent-child:-					
Mother resembles the child.	Izinyanga	3	11	0	-
	Non-Izinyanga	8	88	0	
Father resembles the child.	Izinyanga	1	13	0	-
	Non-Izinyanga	0	96	0	
Either parent may resemble the child.	Izinyanga	6	8	0	$X^2=19.65$ $p<0.001$
	Non-Izinyanga	88	8	0	
C) Strong personality is due to a combination of status and personal qualities.	Izinyanga	14	0	0	$X^2 = 9.60$ $p<0.001$
	Non-Izinyanga	59	37	0	
D) Views of Laity (N=96) that strong personality is due to a combination of status and personal qualities					
Rural:		24	13	0	-
Urban:		34	25	0	
Male:		35	12	0	-
Female:		28	21	0	
13-35 years:		24	22	0	-
36 and above:		34	16	0	
No education to Std. VI:		40	17	0	$X^2= 2.77$ $p<0.10$
Std. VII and above:		20	19	0	

role of heredity as compared with environment, in relation to a more specific issue than was dealt with in the earlier and more general section on Heredity and Environment. It was therefore not felt necessary to carry out an analysis of all the laity responses, because this would in effect be repeating the investigation of the earlier section. The comparison of the laity was confined, therefore, to their views on the psycho-social causation of 'strong' personality (Table 6 D). The responses of izinyanga and non-izinyanga were throughout compared (Table 6 A, B, C).

Results:-

Izinyanga were unanimous in their support of the view that strong personality is caused by a combination of psychological and social factors, and were nearly-unanimous in their views of the relationship of physical to personality types, the resemblance of mother to child and father to child (in none of which did they support the proposition) (Table 6 A, B, C). The laity were unanimous in their rejection of the view that the father resembles the child, and nearly-unanimous in their support of the views that personality and physical types are related and that either parent might resemble the child; they were nearly-unanimous in their rejection of the proposition that the mother resembles the child (Table 6 A, B, C).

The izinyanga and the laity differed significantly as follows: the laity more frequently supported the view that physical and personality types are related, that either parent might resemble the child and less frequently supported the view that strong personality is the result of social and psychological factors (Table 6 A, B, C). The less-educated laity supported more frequently (near-significantly) the view that strong personality is due to a combination of psychological and social causes (Table 6D).

Discussion:-

The informants agreed that people can be described in general terms so that a person can be contrasted with or compared to another, as by saying that he has a distinctive build, features, mannerisms, oddities of expression and predictable moods and reactions in given situations. The most general term collected was ubuvena (or ubuwena), which was defined by an informant as -

> "some thing that spells out a person so that you can identify him whenever something is said about him without his name being mentioned. So you could imitate his voice, or show how he walks or some other thing that he does, or say that he is known to be very irritable or very good natured. It is almost like creating a picture in words of the person".

This well fits the definition of personality of most non-psychologists: a concrete description of the physique and characteristics of the individual and an attempt to evaluate "what sort of a person he is", that is, to describe his social-stimulus value as, for example, irritable or unreliable.

The agreement among the laity was on a level similar to such English saws as that a redheaded person is irritable or that fat people are good-natured. A commonly mentioned opinion was that people with reddish eyes are aggressive and hostile, and therefore referred to as isigebengu (a ruffian or dagga-smoker); another description was that people with sleepy, hooded eyes are referred to drunkards (isidakwa) because drunkards look sleepy, behave sleepily and have puffy eyes. From data collected in other parts of this section, a large and upstanding man is more likely to be described as a man with an outstanding personality than is a small man.

The author finds it curious that in a traditionally patriarchal society in which the woman was given a role in many ways subordinate to that of the man, the stereotype should be to relate the child to the mother,

i.e., to imply that it is the belief that the influence of the female is greater than that of the male. This is made more paradoxical by the qualification made by informants, that although the boy-child might resemble his mother, he would be displeased and embarrassed to be told of this resemblance. There is also a traditional belief (related as such by one of the izinyanga), that if a small boy is unusually naughty he "gets the naughtiness from his mother's side of the family".

To interpret this complex of relationships of mother to child, might perhaps be partly resolved if one assumes a strong ambivalence in the relationship of mother and son, because even if the informants were reporting on the basis of their observations in their own family or neighbourhood, probability would be highly unlikely to make this situation more observable than the closeness of resemblance of a father to his children. The conflicting tendency of the powerful attachment of mother and son to one another, and the emphasis upon masculinity in traditional society, is reflected in the informants' conflict: it is believed that the son resembles the mother and that this must be concealed from the son who would be offended, hurt and indignant if the resemblance were pointed out. Femininity in a boy is resented by him, yet society appears to assume that it exists. That a child's unusual naughtiness is attributed to what he gets from his mother's family is probably derived from the observation that the young child's upbringing is traditionally largely in the hands of the mother and her mother and aunts, who are therefore more obviously influential in the formation of the boy's character in his early years.

It should be noted, however, that the informants as a whole were moderate in their opinions, and many pointed out that altough a child might resemble his parent in looks he might nevertheless be unlike his parent in mannerisms and character; an aggressive father might for example have an exceptionally timid son who yet looks like him.

Laity and izinyanga differ significantly in the ascription of strong and striking personality to a combination of status and personal qualities (Table 6 C). Over one-third of the laity attributed striking personality to status alone or to personal qualities alone, of which only 9% favoured status alone. All nine non-izinyanga who explained strong personality exclusively in terms of status were rural and from the older age groups. The comment of an eighty-year old informant expresses the views of his protagonists succintly:-

> "Strong or powerful personality is due to status, of course. A chief is feared and respected because of his power to make the laws and to punish when he thinks it is necessary" -

a strangely old-fashioned picture of the modern political-appointee chief.

On the other hand, others denied that if a man is a celebrated inyanga or chief this would in itself suffice to give him a respected and commanding personality: he must in addition to his status have outstanding personal qualities. An extension of this argument was that if a man occupies an admired position, and has therefore a corresponding status, he is more readily able to acquire personality characteristics that would make him become a commanding and strong personality even were he to lose his position. The Paramount Chief of the Zulus was an example given of a man who, although occupying a position that was traditionally most exalted, yet is despised by many Zulus; his occupying his notionally-exalted position has done nothing to imbue him with an outstanding and respected personality.

Those non-izinyanga who ascribed a striking personality to personal qualities exclusively, mostly argued that this was an inborn quality, and depends on the manner in which the individual carries himself and relates to other people. If he respects others and is dignified, kindly and sincere, he is respected and considered to have a striking personality. It is clear that this is not related to the notional awe of the occupant of a

high office: Chief Lutuli was mentioned as an example of one whose personal qualities are such, that although he has been formally stripped of his Chieftainship by the government, he retains a dignified bearing that makes his personality striking and powerful for his personal qualities alone.

Various terms were used to describe personality characteristics: ubuvena or ubuwena has already been described. Isithunzi describes a person with an imposing or commanding presence, often also intimidating and overbearing: "He is tall and hefty. You think that he practises witchcraft. He is feared by everybody". Isigqi also describes forceful personality, but the person endowed with isigqi is admired rather than feared, respected for being a "self-made man" and worthy of honour for his efforts; this quality may also result from the way he carries himself, people tending to like and admire him for being so impressive and charming: "You can improve your personality in this way, but these qualities are really inborn". Ithwazi (probably a local word and not known by all informants, who used more often irata) describes an impulsive person, who acts hastily without much consideration. Eccentricity was distinguished from madness, the term isixhwayixhwayi corresponds to being odd, strange, peculiar, unnecessarily aggressive, not mad but not far from madness. Informants described various manifestations of eccentricity, such as wearing outlandish or inappropriate clothes unnecessarily, collecting rubbish on the streets, being easily excited or depressed. This behaviour was said to be "merely bad habits" that the individual had developed and that he was too weak to break. In general, the states described seemed to be mildly manic-depressive or senile.

Conclusions:-

The informants in general tended to be interested in personality characteristics and their formation in a pragmatic way, concentrating the major part of their discussions on "social stimulus value" rather than on

specific trait description or characterology. The izinyanga, unusually, were more sympathetic to environmentalistic explanations than to hereditarian: this might be because in this section they were dealing with specific issues of causation, whereas earlier in the section on heredity and environment general principles were being discussed.

Overall Conclusions:-

In general therefore on basic psychological questions, the izinyanga differed from the laity in their more frequent reliance on explanations that depended upon traditional ideas and values, and magical or irrational beliefs and practices. The laity in general tended to rely less than the izinyanga on traditional and irrational explanations, and among themselves there was an almost constant tendency for the younger, urban, and better educated informants to give explanations in agreement with modern ideas and values, and implicitly to reject traditional ideas and values. Biesheuvel (1954, 1958) has also found that there is a significant relationship between age and education and the extent to which modern attitudes are accepted.

CHAPTER FIVE

PSYCHODYAMICS

Introduction:-

This chapter consists of seven sections about: Dreams and Daydreams, Sleepwalking, Projection, Obsessional-Compulsive behaviour, Illusions, Fears and Aggressive behaviour. Broadly, the material is analyzed to indicate the informants' opinions on motivational and psychodynamic questions, except for the possibly anomalous case of sleepwalking.

Section One: Dreams and Daydreams:-

Introduction:-

This section comprised four sub-questions about dreams and three about daydreams: (1) are dreams natural events; (2) what is the cause of 'bad' dreams; (3) what is the whereabouts of the 'soul' during dreaming; (4) do dreams foretell the future; (5) and (6) what are the causes of dreams; (7) what sort of people have daydreams? (Appendix A).

The responses of izinyanga and non-izinyanga were compared, and those of the laity were compared internally in four issues: that dreams are natural events, that witchcraft causes bad dreams, that the 'soul' stays in the body during dreaming and that daydreams are caused by the day's events (Table 7). No analysis of the laity's responses was carried out in the other three sub-questions, because of the near-unanimity of the laity in those sub-questions (other than in question 7B3 in which there were no lay responses).

TABLE 7

DREAMS AND DAYDREAMS

			Agree	Dis-agree	Other Responses	Significance
A. Causes and nature of dreams: Izinyanga (N=14) vs. Non-Izinyanga (N=96)						
1)	Dreams are natural events.	Izinyanga	5	9	0	$X^2=31.15$ $p<0.001$
		Non-Izinyanga	84	12	0	
2)	Witchcraft causes bad dreams.	Izinyanga	4	10	0	-
		Non-Izinyanga	23	73	0	
3)	The 'soul' stays in the body during dreaming.	Izinyanga	9	5	0	$X^2=13.29$ $p<0.001$
		Non-Izinyanga	89	7	0	
4)	Dreams foretell the future.	Izinyanga	No information			-
		Non-Izinyanga	10	86	0	
B. Causes of daydreams: Izinyanga (N=14) vs. Non-Izinyanga (N=96)						
1)	Day's events, worries.	Izinyanga	3	11	0	$X^2=13.02$ $p<0.001$
		Non-Izinyanga	71	25	0	
2)	Ancestors, worries.	Izinyanga	2	12	0	-
		Non-Izinyanga	8	88	0	
3)	Mentally unbalanced and simpletons have these.	Izinyanga	9	5	0	No comparison possible
		Non-Izinyanga	0	0	0	
C. Dreams are natural events: Views of Non-Izinyanga (N=96)						
	Rural:		37	0	0	$X^2=6.84$ $p<0.01$
	Urban:		47	12	0	
	Male:					-
	Female:					
	13-35 years:		42	4	0	-
	36 and above:		42	8	0	
	No education to Std. VI:		47	10	0	-
	Std. VII and above:		37	2	0	
D. Witchcraft causes bad dreams: Views of Non-Izinyanga (N=96)						
	Rural:		13	24	0	$X^2=3.19$ $p<0.10$
	Urban:		10	49	0	
	Male:		13	34	0	-
	Female:		10	39	0	
	13-35 years:		6	40	0	$X^2=8.09$ $p<0.01$
	36 and above:		17	33	0	
	No education to Std. VI:		20	37	0	$X^2=67.5$ $p<0.001$
	Std. VII and above:		3	36	0	

Table 7 continued next page.

Continuation of Table 7

E. The 'Soul' stays in the body during dreaming: Views of Non-Izinyanga (N=96)				
	Agree	Dis-Agree	Other Responses	Significances
Rural:	37	0	0	$X^2=3.14$ $p<0.10$
Urban:	52	7	0	
Male:	41	6	0	-
Female:	46	1	0	
13-35 years:	42	4	0	-
36 and above:	47	3	0	
No education to Std. VI:	50	7	0	$X^2=3.51$ $p<0.10$
Std. VII and above:	39	0	0	
F. Daydreams are caused by the day's worries: Views of Non-Izinyanga (N=96)				
Rural:	27	10	0	-
Urban:	44	15	0	
Male:	34	13	0	-
Female:	37	12	0	
13-35 years:	41	5	0	$X^2=9.09$ $P<0.01$
36 and above:	30	20	0	
No education to Std. VI:	36	21	0	$X^2=7.17$ $p<0.01$
Std. VII and above:	35	4	0	

Results:-

The izinyanga were never unanimous, but were nearly unanimous in their rejection of the views that daydreams are caused by thinking about the day's events and difficulties, or by witchcraft and the intervention of the ancestors. They were divided in their views of whether dreams are natural events, whether witchcraft causes bad dreams, on the whereabouts of the 'soul' during dreaming, and whether only simpletons have daydreams (Table 7 A and B). They laity were never unanimous but were nearly-unanimous as follows: in their support of the views that dreams are natural events, that the 'soul' stays in the body during dreaming, that daydreams are caused by the day's events, and in their rejection of the views that bad dreams are caused by witchcraft, that dreams foretell the future, and that daydreams are caused by the intervention of the ancestors or by witchcraft (Table 7 A and B) The laity differed significantly from the

izinyanga as follows: a higher proportion of the former rejected the views that dreams are natural events, that the 'soul' stays in the body during dreaming and that the causes of daydreams are the day's events and worries; there were no other significant differences between laity and izinyanga (Table 7 A and B). Among themselves the laity differed significantly as follows: the rural more frequently than the urban supported the view that dreams are natural events, the older and the less educated more frequently supported the view that bewitching causes bad dreams, a higher proportion of the younger and better educated supported the view that daydreams are caused by the day's events. Among the laity there were the following near-significant trends: the rural supported the view that witchcraft causes bad dreams, the rural and better educated supported the view that the 'soul' stays in the body during dreaming (Table 7 C, D, E and F).

Discussion:-

Like most peoples, the Zulu are frequently intrigued by the waywardness of the dream (and related activities), and according to Lee (1958):

> "to the Zulu, as to depth psychologists, dreams are of great importance. They can greatly influence the life of the individual Zulu ..... mainly because it is held by the people that dreams are, to parody Freud, "the royal road to the ancestors".

Callaway (1884) devoted much of his work on Zulu religion to a study of the dreams of his informants, and the author was much interested to learn that unlike Callaway's informants, his made few references to ancestors and few to witchcraft as determining the nature and quality of dreams.

A main purpose of Lee's study was to relate the manifest content of dreams to social conditions, but the author on the contrary was not concerned to replicate Lee's thorough and competent study, nor to compare the local interpretations of dreams with those of Freud et al.. The author

sought the informants' accounts of what they thought caused dreams and day-dreams, and (in particular) the extent to which they spontaneously volunteered explanations in terms of wish-fulfilment; the material revealed beliefs about the power of dreams to foretell the future and the whereabouts of the 'soul' during the dream.

Of the natural events causing dreams, there were about ten references to physical discomfort or irritations, such as indigestion or lying uncomfortably in bed, but by far the majority of explanations were in terms of wish-fulfilments, the day's events and excitements, or the dreamer's problems.

The significantly higher proportion of laity than of izinyanga who supported the view that dreams are natural events (Table 7 A), is possibly related to the izinyanga's acceptance of traditional explanations of psychological phenomena, such as the intervention of the ancestors or bewitching, and is in keeping with their general tendency to reject psychological explanations.

One informant, for example, described his dreaming as typical of most dreamers:-

> "Dreams are caused by revising your thoughts, and for wish-fulfilment. Dreams come after you have been thinking about something. They may also be because you are troubled or frightened about something".

The interpretation of dreams (particularly bad dreams) in terms of witchcraft and magical causes (Table 7 A), covered a virtually unclassifiable range of causes from nocturnal visits from the ancestors to the evil effects of love-charms, but these non-rational causes were by no means exclusively harmful or unpleasant. Several informants were visited nocturnally by their ancestors who thoughtfully gave them advice on the horses to back at the races, and several had other advice from their ancestors.

The majority of those who attributed bad dreams to witchcraft, mentioned somatic accompaniments to the unpleasant thoughts of the dream: stabbing pains in the body, sweating, restlessness, and one informant even attributed sterility to witchcraft-induced nightmares: the dream "settling" in the womb and rendering the woman sterile. Several informants gave dreaming of snakes as a warning against enemies (cf. Lee, 1958), and it is interesting that Callaway (1884) in his account of dreams, states that his informants associated dreaming about snakes with the visitation of the spirit of divination to a man who does not understand that he is dreaming about becoming a diviner; he dreams continually that snakes are encircled about his body while he is in a pool and that he leaves the water heavy with snakes. If the informants' information is any indication of changing social interpretations of dreams, then it would appear that whereas the dreams of snakes and ancestors were directly attributed to non-rational forces and the meditation of non-rational beings, there is now a marked shift towards explanations in terms not of simple traditional myth but in terms not dissimilar from modern psychosomatic explanations. Lee (1958) found that among his rural informants snakes were dreamed about mainly by women, who coupled them with a traditional priapic figure, the tikoloshe, and whose snake-tikoloshe dreams "are frankly sexual in character - and are often of violent sexual attack by either of them". The author did not explore the latent content of his informants' dreams, but would not be surprised to find confirmation of Lee's parallel with Freudian views of dreams.

Surprisingly few of the informants claimed that dreams can foretell the future, but it seems that those who believed that the ancestors come in dreams to give advice or utter warnings, are in effect admitting to a belief in the prophetic character of dreams.

Few informants believed that the 'soul' wanders during dreaming (Table 7 A), and many informants who denied this belief tended to refer to

the reasons that they had given already to explain dreams, and said how it was impossible for the 'soul' to leave the body. One informant who agreed with the belief gave as an example that if he dreams that he is tilling his plot of land his 'soul' travels to the plot.

Informants were less certain of their opinions about daydreams than about dreams, and twenty-five informants denied having them, arguing that they were only indulged in by the idle, who have nothing better to do with their time than to dream. But the explanations supported the view that daydreams were largely concerned with the worries and preoccupations of the day and are a form of wishfulfilment (Table 7 B).

The izinyanga tended on the whole to support less pragmatic and more traditional explanations of dreams and daydreams than the laity, who were readier to give explanations in terms of day-to-day environmental, or psychological factors (Table 7 A, B, C). It is noteworthy that the izinyanga and laity were divided on all issues, and that the laity were slightly more often nearly-unanimous than the izinyanga: it may be that in this section the topic is one that lends itself to explanations in which western and traditional elements conflict, and the division among the informants is a reflection of this conflict.

Conclusions:-

In general the laity were divided along the now familiar lines of education, age and rural-urban background, but there was an unexpected and inexplicable tendency for the rural to support the view that dreams are natural events.

Section Two: Sleepwalking:-

Introduction:-

This section comprised four sub-questions:- (1) are the causes of sleepwalking natural, for example, caused by physical restlessness or discomfort?; (2) are the causes magical or otherwise irrational?; (3) is this condition to be treated medically?; (4) is this condition to be treated by an *inyanga* traditionally? (Appendix A).

Results:-

The *izinyanga* were only unanimous in their lack of support for the proposition that the treatment for sleepwalking is medical, and were divided in all other sub-questions. The laity were divided in all sub-questions (Table 8 A, B). The *izinyanga* did not differ significantly from the laity in their views on the causes of sleepwalking, but in their views of the treatment they differed significantly as follows: a higher proportion of the laity than the *izinyanga* held the view that the treatment for sleepwalking is medical and a smaller proportion than the *izinyanga* that the appropriate treatment is by an *inyanga* (Table 8 A, B). Among themselves the laity differed significantly as follows: the male, and better educated more frequently held the view that the causes of sleepwalking were natural. The laity differed significantly in their rejection of the view that witchcraft or magic causes sleepwalking: a higher proportion of the urban, younger and better educated rejected the view (Table 8 C). The better educated significantly more frequently supported the view that the treatment appropriate for sleepwalking is medical (Table 8 D). The view that the appropriate treatment is by an *inyanga* was nearly-significantly more frequently supported by the rural and the less educated (Table 8 D).

TABLE 8

		Agree	Dis-agree	Other Responses	Significance
A. Causes of Sleepwalking: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) Causes of sleepwalking are natural.	Izinyanga	9	5	0	-
	Non-Izinyanga	54	42	0	
2) Causes of sleepwalking are witchcraft, magic.	Izinyanga	5	9	0	-
	Non-Izinyanga	30	66	0	
B. Treatment of Sleepwalking: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) Treatment is medical.	Izinyanga	0	14	0	$X^2=22.26$ $p<0.001$
	Non-Izinyanga	21	75	0	
2) Treatment is by an inyanga.	Izinyanga	10	4	0	$X^2=13.22$ $p<0.001$
	Non-Izinyanga	20	76	0	
C. Causes of Sleepwalking: Views of Non-Izinyanga (N=96)					
1) Causes are natural.	Rural:	19	18	0	-
	Urban:	35	24	0	
	Male:	32	15	0	$X^2=4.34$ $p<0.05$
	Female:	22	27	0	
	13-35 years:	30	16	0	-
	36 and above:	24	26	0	
	No education to Std. VI:	23	34	0	$X^2=12.86$ $p<0.001$
	Std. VII and above:	31	8	0	
2) Causes are witchcraft, magic.	Rural	18	19	0	$X^2=7.22$ $p<0.01$
	Urban:	12	47	0	
	Male:	15	32	0	-
	Female:	15	34	0	
	13-35 years:	7	39	0	$X^2=7.34$ $p<0.01$
	36 and above:	23	27	0	
	No education to Std. VI:	27	30	0	$X^2=5.06$ $p<0.05$
	Std. VII and above:	3	36	0	
D. Treatment of Sleepwalking: Views of Non-Izinyanga (N=96)					
1) Treatment is medical.	Rural:	7	30	0	-
	Urban:	14	45	0	
	Male:	12	35	0	-
	Female:	9	40	0	
	13-35 years:	12	34	0	-
	36 and above:	9	41	0	
	No education to Std. VI:	6	51	0	$X^2=9.00$ $p<0.01$
	Std. VII and above:	15	24	0	
2) Treatment is by an inyanga.	Rural:	12	25	0	$X^2=3.69$ $p<0.10$
	Urban:	8	51	0	
	Male:	9	28	0	-
	Female:	11	48	0	
	13-35 years:	6	40	0	-
	36 and above:	14	36	0	
	No education to Std. VI:	16	41	0	$X^2=3.51$ $p<0.10$
	Std. VII and above:	4	35	0	

Discussion:-

Adults who sleepwalk habitually are known as indlu yobuthongo (literally: house of sleep; that is, those who are fond of sleeping), but this description conceals the anxiety that is reported about adults sleepwalking. Someone who habitually sleepwalks (according to an inyanga), is in danger from the witches who are abroad at nights.

The causes of sleepwalking can be divided into two broad groups: those which attribute it to natural causes such as worry, sickness of mind, restlessness, indigestion or other physical discomforts; and those which attribute it to witchcraft and to witchcraft-induced sickness of mind. About the same proportion of izinyanga and non-izinyanga attribute sleepwalking to natural causes (Table 8 B): a remarkably high proportion of about 65%. Of the natural causes worry and "mental disturbances" were the most commonly given. The informants who attributed sleepwalking to witchcraft and similar causes, suggested a wide range of causes, the most common of which was the use of a herb known as "abaphaphi" which compels the person to walk. It is significant that most of the accounts spoke of a girl being compelled to sleepwalk, even if the informant were a man. An account by a non-izinyanga (aged 26 and with a J.C.) illustrates a mingling of traditional and more sophisticated beliefs:-

> "Sleepwalking is a mental illness or the loss of memory which may be due to thinking and worrying too much. But it may also be because of bewitching-ufufunyane. You walk in your sleep and return again. Sometimes a lovecharm is used: your name is called into the bottle ("ukukhafula") and the girl walks in sleep to the man and then she tells him that she loves him. But this is a sign of mental illness and has to be cured by the inyanga".

The izinyanga more often than the non-izinyanga stressed the extreme danger of sleepwalking if it be induced by witchcraft, because not only may the sleepwalker be harmed by witches but he may be seized by an

umkhovu or the spirits known as isinhlanga and be compelled to do evil. Children might be bewitched to go to the woods to meet a tikoloshe.

There was one reference made to a medicine made of a mixture including owl's faeces (umuthi wezikhova) in a context that suggested that this be a dimly remembered fragment of some long vanished folklore; the element of magic by similarity is interesting.

Conclusions:-

In general the informants were divided in their opinions of the causes and treatment of sleepwalking, but as might be expected the izinyanga tended to support the less western view. There might be an element of business acumen in the izinyanga's support of the view that sleepwalking is to be treated by them, but their views should not be lightly interpreted as evidence of cupidity: it must be remembered that in this section (and in others) the views even of the izinyanga tend to be divided and to reflect a conflict between traditional and modern beliefs. Further, their society traditionally attributes the dangerous condition of sleepwalking to bewitching or magical causes, and it is their function to remedy the bewitching. Again not unexpectedly, the rural, elder, and less educated tend to support the more traditional beliefs and, by implication to reject aspects of modern thought.

Section Three: Projection:-

Introduction:-

This section comprised three sub-questions on the causes of Projection (Appendix A), and the material was analyzed as follows:- (1) whether causation is analogous to Freudian projection; (2) whether the causation was explained in terms of conscious explanations; (3) whether projection was said to be a symptom of mental illness.

The views of the laity and the izinyanga were compared (Table 9 A) and the views of the laity were compared internally (Table 9 B).

TABLE 9

PROJECTION

			Agree	Dis-agree	Other Responses	Significance
A.	Causation: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1)	Causation is "Freudian".	Izinyanga	10	4	0	-
		Non-Izinyanga	69	27	0	
2)	Causation is 'conscious', deliberate will.	Izinyanga	3	11	0	$X^2=22.6$ $p<0.001$
		Non-Izinyanga	79	17	0	
3)	Causation is mental illness.	Izinyanga	4	10	0	-
		Non-Izinyanga	22	74	0	
B.	Analysis of views of Non-Izinyanga (N=96)					
1)	Causation is "Freudian".	Rural:	30	7	0	-
		Urban:	39	20	0	
		Male:	29	18	0	-
		Female:	40	9	0	
		13-35 years:	32	14	0	-
		36 and above:	37	13	0	
		No education to Std. VI:	43	14	0	-
		Std. VII and above:	26	13	0	
2)	Causation is 'conscious', deliberate will.	Rural:	36	1	0	$X^2=7.08$ $p<0.01$
		Urban:	43	16	0	
		Male:	37	10	0	-
		Female:	42	9	0	
		13-35 years:	38	8	0	-
		36 and above:	41	9	0	
		No education to Std. VI:	48	9	0	-
		Std. VII and above:	31	8	0	
3)	Causation is mental illness.	Rural:	11	26	0	-
		Urban:	11	48	0	
		Male:	14	33	0	-
		Female:	8	41	0	
		13-35 years:	10	36	0	-
		36 and above:	12	38	0	
		No education to Std. VI:	16	41	0	-
		Std. VII and above:	6	39	0	

In this section the author found great difficulty in making clear to the informants the precise nature of information that he required, and after several attempts (not included in the material analyzed) he adapted the concept of "eccentric projection" of English and English (1958), that is, "the process of unwittingly attributing one's own traits, attitudes, or subjective processes to others". The author based upon this simple definition a simple example of a person who says that others hate him when, in truth, it is he who hates other people and makes them hate him, but who wants others to think that it is not he who hates; the author gave a second example to suggest that the projector may not be conscious of the projection onto others of what he feels and of the result of his behaviour.

In this form and presentation all informants appeared to understand the question, and many gave examples of "eccentric projection" from their own experiences. The general description (without the assertions about Christianity) is illustrated by an inyanga who said that -

> "This is something very new; it came about with Christianity. Christians are in the habit of saying that other people hate them when in fact they hate those people. When you ask "why does so-and-so hate you?, the usual answer is "I don't know, but so-and-so always looks at me with a wicked eye". But it's their eyes that are really wicked".

Results:-

The izinyanga were never unanimous, but were nearly-unanimous in their rejection of the view that projection is 'conscious' and deliberate. The laity were never unanimous but were nearly-unanimous in their support of the belief that projection is conscious and that it is caused by mental illness (Table 9 A). The izinyanga and the laity differed significantly as follows: a higher proportion of the laity than the izinyanga supported the view that the causation of projection was the conscious deliberation of the individual (Table 9 A). Among themselves the laity differed signifi-

cantly as follows: a higher proportion of the rural than of the urban laity supported the view that the causation is conscious will (Table 9 B2); they did not differ in any sub-question.

The explanations for projection were clearly given: (1) a simple, quasi-Freudian explanation that the projector is unwittingly covering his weakness or fault or relieving his guilty conscience by blaming others; (2) a conscious projection for mischief or evil-doing, that was often said to be the result of jealousy; and (3) mental illness, which included a few references to the magically induced illness of amafufunyane. Several of the informants who thought projection was a sign of mental illness gave as the grounds for their belief that "when you trace back, you always find that there is no reason for such behaviour", and a few referred to ukuzeya ("inferiority complex", as used in a loose, popular sense), which was not regarded as a symptom of mental illness. It is noteworthy that despite the informants' reluctance earlier (Chapter 4, Table 3) to admit to the reality of unconscious determinants of behaviour, they here support a quasi-Freudian explanation. A possible explanation might be that although the informants do not accept such an explanation for behaviour in general, they accept it for the specific behaviour of Projection. In this section a linguistic distinction emerged between the two terms Amafufunyane and ufufunyane: the former is according to informants, a "townish" and contemptuous expression that would not be used by those who believe that this disorder is a specifically African illness. On the contrary the term ufufunyane is the more correct term, used by the izinyanga and those with a sympathy for the traditional terms and ideas.

Conclusions:-

In general there were few marked divergences among the informants, who were broadly in sympathy with rational, western accounts of

Projection and not with the traditional and magical accounts. But the izinyanga, the rural and the less educated tended more frequently to give traditional responses. The lack of unanimity among both izinyanga and laity again suggests that there has developed a cleavage among the informants, between those influenced by modern education and ideals and those who are still clinging to traditional views.

Section Four: Obsessional-Compulsive Behaviour and Thought:-

Introduction:-

This section was divided into two parts: (A) Obsessional-Compulsive behaviour, and (B) Obsessional-Compulsive Thought and Feeling, and each part was analyzed into 4 sub-questions concerning (1) whether compulsive behaviour or thought exists; (2) whether the causes are psychological; (3) whether causes are magical; (4) whether causes are mental illness (Appendix A).

The views of izinyanga and laity were compared, and the views of the laity were compared on whether they thought the causes of obsessional behaviour and thought were psychological; no other enquiry into the views of the laity was carried out because they were nearly unanimous in response to the other sub-questions.

Results:-

The izinyanga were unanimous in their support of the view that compulsive thought and behaviour exists, and nearly-unanimous in their support of the view that they are caused by mental illness; they were divided in their other views, tending to support the view that the causes are magical and to reject the view that the causes are psychological (Table 10 A and C). The laity were nearly-unanimous in their support of the view that compulsive behaviour and thought exists, that they be caused

by psychological factors, and they were nearly-unanimous in their rejection of the view that compulsive behaviour and thought are caused by magic and mental illness (Table 10 A and C). The izinyanga and the laity differed significantly as follows. In respect of Obsessional-Compulsive behaviour a higher proportion of the laity held the view that this behaviour is caused by psychological factors, and a higher proportion of the izinyanga held the view that this behaviour is caused by magic (Table 10 A). Similar views were held in respect of Obsessional-Compulsive thought (Table 10 C). Among themselves the laity differed significantly as follows: the views that there were psychological causes for compulsive behaviour was supported by a higher proportion of the younger and the better educated, and was nearly-significantly more often supported by the urban (Table 10 B). The view that there were psychological causes for compulsive thought and feelings was supported by a significantly higher proportion of the male and younger of the laity (Table 10 D).

Discussion:-

(A) Behaviour:-

Various terms were offered to describe compulsive behaviour: isiphakaphaka and ukuphakazela were said to correspond to acting impulsively and without thinking first; igungo was said to correspond to "bloodlust" or an action carried out while the person is besides himself with agitation; and ithuko was said to correspond to a "mad restlessness", impulsiveness or frenzy.

Only five dissentients (all non-izinyanga) appeared to be unclear and undecided about the behaviour, arguing that a man is never compelled to do things without his willing to do them, because the individual always directs his behaviour and thought. However, as the informants appeared to accept magical direction of behaviour and thought, their respon-

ses were included in the category 'Disagree'. It is noteworthy that as in the last section informants tacitly accept unconscious determinants of behaviour and similar reasons can be surmised.

TABLE 10

OBSESSIONAL AND COMPULSIVE BEHAVIOUR AND THOUGHT

		Agree	Dis-agree	Other Responses	Significance
A. Obsessional-Compulsive Behaviour: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) Compulsive behaviour exists.	Izinyanga	14	0	0	-
	Non-Izinyanga	91	5	0	
2) Causes are psychological.	Izinyanga	5	9	0	$X^2=12.22$ $p<0.001$
	Non-Izinyanga	79	17	0	
3) Causes are magical.	Izinyanga	9	5	0	$X^2=36.80$ $p<0.001$
	Non-Izinyanga	4	92	0	
4) Causes are mental illness.	Izinyanga	2	12	0	-
	Non-Izinyanga	20	76	0	
B. Causes are psychological: Views of Non-Izinyanga (N=96)					
Rural:		29	8	0	$X^2=2.71$ $p<0.10$
Urban:		50	9	0	
Male:		39	8	0	-
Female:		40	9	0	
13-35 years:		44	2	0	$X^2=9.13$ $p<0.01$
36 and above:		35	15	0	
No education to Std. VI:		42	15	0	$X^2=5.75$ $p<0.02$
Std. VII and above:		37	2	0	
C. Obsessional-Compulsive Thinking and Feeling: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) Compulsive thought exists.	Izinyanga	14	0	0	-
	Non-Izinyanga	85	11	0	
2) Causes are psychological.	Izinyanga	5	9	0	$X^2=4.33$ $p<0.05$
	Non-Izinyanga	65	11	0	
3) Causes are magical.	Izinyanga	9	5	0	$X^2=27.51$ $p<0.001$
	Non-Izinyanga	7	89	0	
4) Causes are mental illness.	Izinyanga	2	12	0	-
	Non-Izinyanga	17	79	0	

Table 10 continued next page.

Continuation of Table 10 -

D. Causes are psychological: Views of Non-Izinyanga (N=96)				
	Agree	Dis-agree	Other Responses	Significance
Rural:	23	14	0	-
Urban:	42	17	0	
Male:	38	9	0	$X^2=6.14$ $p < 0.02$
Female:	27	22	0	
13-35 years:	37	9	0	$X^2=5.47$ $p < 0.02$
36 and above:	28	22	0	
No education to Std. VI:	40	17	0	-
Std. VII and above:	25	14	0	

The non-izinyanga who agreed with the izinyanga were all over 46, only one has reached Std. IV and the other three were illiterate, only one was urban and only one was male.

The explanations of the izinyanga who did not accept witchcraft were in psychological terms, and these izinyanga held strongly that this behaviour was caused by psychological factors, though it was not necessarily a sign of mental illness. The izinyanga who gave an account in terms of witchcraft, pointed out that similar considerations applied to compulsive thought.

The general term used was ukudlulisa, that is, to cause a person to do against his will that which is socially disapproved; the author was unable to get a clear account if such a compulsive behaviour could be socially neutral. There seem to be four distinct ways in which a compulsion could be caused by witchcraft or other magical means, and in some of these the term witchcraft is to be loosely understood to describe a magical determination: (1) a child may defy his parents continuously, and then the ancestral spirits will punish him by making him do wrongful and naughty acts, even against his will and despite his efforts to stop himself. This is known as ukudlebeleka. (2) When a relative close to a

person has died and before the funeral the person does not respect the appropriate conventions, even though he has not done anything to offend the spirit of the dead relative he may be compelled to behave in some objectionable way. For example, you ought not to be remarkably quiet at the time nor do anything to the extreme lest you are compelled to continue to behave in this way throughout life (ukudlebeleka). A saying was reported that when someone behaves extravagantly or in an extreme fashion, it is said that "He did it when there was a death". (3) Medicines may be used to cause a person to continue to steal or behave anti-socially even when he no longer wishes to steal or behave anti-socially. The belief appears to be that this situation would arise if the bewitched individual did some wrong to the bewitcher; the bewitcher bewitches him so that the bewitched person no longer commits wrong by his own will but because of the bewitchment. (4) In general, a witch who has a grudge against another person may bewitch that other or his or her children, by making incisions into which medicines are inserted, which will compel the person to behave anti-socially; a child may as a result of this bewitching wake during the night and move about nakedly as a witch does. These incisions are known as izinhlanga.

The general view of the role of psychological causes was that when such psychological causes as preoccupation and worry are responsible, this is something that happens to all people and therefore cannot be regarded as sufficiently abnormal to indicate mental illness; moreover, many informants argued that this behaviour can result often from lack of self-control which is not a sign of mental illness.

Conclusions:-

In general there were few marked divergences among informants, who tended broadly to accept rational rather than magical causation. But

the izinyanga, the older and less educated and the rural tended more frequently to cleave to traditional, non-rational explanations.

(B) Thought:-

As in part A of this section the general tenor of informants' views was more rational than traditional, and the essentially pragmatic view of many informants is trenchantly expressed by a male informant of 36 with Standard VI education and an urban background: "This is nonsense! A human being controls the brain as far as thinking is concerned. One cannot think what he does not want to think about". In the attribution of causes to psychological factors, there is again demonstrated the tendency of the non-izinyanga to offer explanations in terms of psychological factors, and of the izinyanga to reject or minimize these factors. A typical psychological explanation is that of a young man with Standard VII, who attributed compulsive thinking to thinking about things that concern you very deeply, that is, to preoccupation about a problem, and ended his account with a remark that Skinner and Watson could hardly have bettered: "After all, thinking is more of a habit than any other thing". Of the problems that tend to perseverate, besides domestic problems and the common worries of uncertain urban life, there was frequent reference to fears concerned with violence: murder, death, funerals, which the author believes is a reflection of the extreme uncertainty and violence in which even the most law abiding African lives today. Only three informants mentioned obsessive thoughts about sex-temptations and the like, and of these one young rural girl mentioned the power of love charms to make you think compulsively of someone you do not wish to love.

Conclusions:-

In this, as in the previous part of this section, there were few divergencies between informants, but the general sympathy was towards rati-

onal rather than magical or traditional explanations. Again, a higher proportion of izinyanga, the older and the less educated supported the traditional ideas and explanations than modern, psycho-social explanations.

In this section in general, psycho-social explanations were proportionately more often held than were traditional and magical, which suggests that in the field of understanding unusual - if not abnormal - behaviour there is a pragmatic attitude rather than an irrational one, which has probably developed through the pressures of psycho-social factors in a rapidly changing environment,and through the anti-magical implications of much of modern education and social practice.

Section Five: Illusions:-

Introduction:-

In this section the author did not attempt to distinguish between illusions, hallucinations, but accepted the informants' descriptions and explanations of these and similar phenomena as a broad category more or less corresponding to supernatural. The material was analyzable into seven sub-questions: (1) Do illusions exists; (2) are they "natural" phenomena; (3) are they harmful or may they be beneficial (Table 11 A); (4) are illusions treatable; (5) are illusions treatable solely by an inyanga; (6) are illusions treatable solely by a doctor; (7) are illusions treatable by either an inyanga or a doctor (Table 11 B) (Appendix A).

The responses of izinyanga and laity were compared, and those of the laity were compared in three issues: that illusions are natural, that illusions are treatable solely by an inyanga,and that they are treatable solely by a doctor. The laity's responses were not compared in the other four sub-questions, because the author considered that the general purpose of the section: the informants' views of the natural or supernatural cusation of these phenomena was adequately demonstrated in answer to these sub-questions.

TABLE 11

ILLUSIONS

			Agree	Disagree	Other Responses	Significance
A.	**Nature of Illusions: Izinyanga (N=14) vs. Non-Izinyanga (N=96)**					
1)	Illusions exist.	Izinyanga	14	0	0	-
		Non-Izinyanga	90	6	0	
2)	Illusions are "Natural".	Izinyanga	3	11	0	$X^2=4.57$ $p<0.05$
		Non-Izinyanga	44	52	0	
3)	Illusions may be harmful or beneficial.	Izinyanga	14	0	0	$X^2=4.65$ $p<0.05$
		Non-Izinyanga	66	30	0	
B.	**Treatment of Illusions: Izinyanga vs. Non-Izinyanga**					
1)	Illusions are treatable.	Izinyanga (N=14)	11	3	0	$X^2=1.83$ $p<0.10$
		Non-Izinyanga (N=96)	53	43	0	
2)	Treatable solely by an inyanga.	Izinyanga (N=11)	9	2	0	$X^2=5.48$ $p<0.02$
		Non-Izinyanga (N=53)	20	33	0	
3)	Treatable solely by a doctor.	Izinyanga (N=11)	0	11	0	$X^2=5.24$ $p<0.05$
		Non-Izinyanga (N=53)	22	31	0	
4)	Treatable by inyanga or a doctor.	Izinyanga (N=11)	2	9	0	-
		Non-Izinyanga (N=53)	9	44	0	
C.	**Views of Non-Izinyanga**					
1)	Illusions are "Natural". (N=96)	Rural:	17	20	0	-
		Urban:	27	32	0	
		Male:	22	20	0	-
		Female:	22	27	0	
		13-35 years:	25	21	0	-
		36 and above:	19	31	0	
		No education to Std. VI:	14	43	0	$X^2=25.31$ $p<0.001$
		Std. VII and above:	30	9	0	
2)	Treatable solely by an inyanga. (N=53)	Rural:	11	9	0	$X^2=2.96$ $p<0.01$
		Urban:	9	24	0	
		Male:	9	16	0	-
		Female:	11	17	0	
		13-35 years:	8	19	0	-
		36 and above:	12	14	0	
		No education to Std. VI:	18	7	0	$X^2=21.90$ $p<0.001$
		Std. VII and above:	2	26	0	
3)	Treatable solely by a doctor. (N=53)	Rural:	4	19	0	$X^2=5.58$ $p<0.02$
		Urban:	16	14	0	
		Male:	10	15	0	-
		Female:	10	18	0	
		13-35 years:	13	14	0	-
		36 and above:	7	19	0	
		No education to Std. VI:	5	20	0	$X^2=4.96$ $p<0.05$
		Std. VII and above:	15	13	0	

Results:-

The izinyanga were unanimous in their support of the views that illusions exist and that they may be harmful or beneficial according to the circumstances in which they are perceived, and they were unanimous in their failure to accept the view that these are treatable solely by a doctor. They were nearly-unanimous in their failure to support the view that illusions are "natural", and that they are treatable by an inyanga or by a doctor, and were nearly-unanimous in their support of the view that illusions are treatable, and are treatable solely by an inyanga (Table 11 A and B). The laity were never unanimous, but were nearly-unanimous in their support of the view that illusions exist; in all other issues they were divided (Table 11 A and B).

The laity and the izinyanga differed significantly as follows: a higher proportion of the laity than the izinyanga supported the view that illusions are natural, and that they are treatable solely by a doctor; the izinyanga more frequently than the laity supported the view that illusions may be harmful or beneficial, that illusions are treatable (nearly-significant), that illusions are treatable solely by an inyanga (Table 11 A and B). Among themselves the laity differed significantly as follows: a higher proportion of the better educated supported the view that illusions are natural, the rural and less educated more frequently supported the view that illusions are treatable solely by an inyanga, the urban and better educated more frequently supported the view that illusions are treatable solely by a doctor (Table 11 C).

Discussion:-

Traditionally, Zulu culture paid much attention to illusions, hallucinations and the like: the ancestors were reported to visit dreamers, children saw creatures corresponding to the hobgoblins and fairies and

ogres of the folklore of western Europe, and the novitiate diviner is commonly known to experience hallucinations and visions before he enters into his initiation.

That illusions can be seen was agreed by substantially all the informants, only six non-izinyanga denying their existence. Among the informants who denied their existence was a young man of urban background who stated "there is nothing like that. I've never heard of such a thing happening in these days, but in ancient times and in bible stories we heard of such things, and we see them in the bioscope". However, a further twelve informants although agreeing that illusions existed, qualified their answers by emphasizing that if you believe in illusions then you may see or hear them; it was clear that these informants were sceptical of the truth of traditional accounts, but openminded enough to allow that there might be something in what was said. Typical of the sceptical accounts was that of an elderly informant, who commented "Some people do say that they see illusions, but I'm not sure whether it really does happen. I think that it may be happening if you have a belief in these things".

An account that completely accepts illusions is that of an inyanga who said of illusions:-

> "This is caused by supernatural powers. With me for example, the ancestors have the power to come and I was visited by Chaka in a vision who advised me to become an inyanga. Western civilization cannot treat this as it is not an illness, but a gift ..... It's a gift. It's not everybody that gets it".

Illusions may be caused by (1) natural and (2) supernatural causes; the author is aware that this distinction is based upon the tacit assumption of a particular system of metaphysical assumptions. To a person having the given system of assumptions common to his society or his educational level, the appearance of a fairy or an angel or a mythical beast may be a "natural" event; in another society or to a person of another educational

level this appearance may be considered to be "irrational" or the result of mental disease or superstitious beliefs. The author was therefore hesitant in classifying the informants' responses, but included as "natural" such determinants as imagination, senility and acute illness, and included as "supernatural" such determinants as visitations from the ancestors; mental illness was sometimes offered as an explanation and was classified as "natural" if it appeared from the context that the informant was excluding mental illness caused by magic or witchcraft.

The supernatural explanations of illusions and hallucinations fell into three broad classes: (1) traditionally defined forms of mental disturbance, particularly that known as amafufunyane, and states of mind and situations that are traditionally considered conducive to the appearance of these phenomena, for example the initiation period of an aspiring diviner and the appearance of the ancestors; (2) bewitching, especially the administration of love magic to an unwilling party; (3) that this is a gift from God and is, therefore, particularly enjoyed by Christians (seven informants), one informant explaining that "it is possible for Christians to see visions. This is caused by your belief in Christ, and you become God's messenger. See Hebrew 11"; (4) traditionally children can see mythical creatures such as the tikoloshe and umkhovu, which are regarded as important sources of illusions.

The tikoloshe appears to have elements of the nature of Robin Goodfellow or Puck or the Leprechauns, being able to take different forms and behaving in a friendly or a hostile manner according to the way he is treated. According to an inyanga, the tikoloshe is an animal in human form who lives in or near rivers, near a particular spot on dry land where he likes to hide. Normally he is only seen by small boys, to whom he is generally friendly because they can give him milk, in return for which he teaches them tricks. Occasionally he appears to an adult as the result of

bewitching, and this is regarded as a baleful event. The umkhovu is a human being who, by the use of bad medicines, was almost killed, and after being buried for dead was rescuciated by a witchdoctor who slits its tongue (to prevent it from communicating) and places a peg on its head to keep it small. The same informant asserted that neither tikoloshe nor umkhuvo are common, and that many people who report having seen them are in fact seeing a "made-up" tikoloshe or umkhuvo, that is, imaginary creatures, created by the use of a strong and specific medicine called amakubalo, which has the power to convert the impossible into the possible. The distinction must therefore be drawn between imaginary tikoloshe and umkhuvo and those caused by the use of amakhubalo (see Hunter, 1961, for an extended account of similar beings among the Pondo).

The weight of izinyanga opinion was, however, that the most important and common cause of illusions was the group of emotional disturbances known as amafufunyane which gives rise to a clearly recognized form of mental illness akin to classical hysteria, manifested in the behaviour described as hyeza.

Visitations from the ancestors (amadlozi), make their presence known by uttering noises like the wind whistling through telephone wires, and were considered to be common.

One informant with knowledge of the traditional ways of more than one tribe, suggested that the character of the illusion is determined by what is known to the particular tribe. It was suggested as examples, that tribal Pondo or Xhosa might see impundulu (a magical bird that is able to take any form, animal or human), and that the tribal Zulu would be more likely to see umkhovu.

It is perhaps reasonable that the izinyanga whose professional life is much concerned with the supernatural, should agree that illusions might be either harmful or beneficial according to the circumstances in which they appear, but that the laity tended to say that these appearances are frightening and disturbing even if the ancestors or other spirits are bringing good news or advice. This unwillingness of the laity to regard illusions as possibly beneficial is probably a reflection of their tendency to consider illusions as naturally caused phenomena that appear when the individual is mentally or physically ill, or that even presage mental disturbance.

Conclusions:-

Once more we find that a higher proportion of the izinyanga, the older, less educated and rural support the traditional, less rational view of the phenomena, and the urban, better educated and younger support the modern view. It seems from the frequent cleavage between laity and izinyanga and that among the laity, that beliefs about illusions are more resistant to the influence of modern education and ideas than other beliefs have proved to be. It is interesting that this view is partly supported by the findings of Marwick (1948 and 1958) that in the towns there is no tendency for belief in the supernatural to dwindle sharply, but rather that the insecurity of the towns increases the belief, although the findings of this thesis do not entirely support Marwick's findings.

Section Six: Fears:-

Introduction:-

This section comprised five sub-questions (Appendix A) on the causes of fears (Table 12 A) and the relation of education to fear (Table 12 B): are fears caused (1) by natural forces, (2) by psychosocial forces,

(3) by supernatural forces, (4) are the educated less fearful than the uneducated, (5) do the educated fear shame more than the uneducated?

The responses of izinyanga and non-izinyanga were compared (Table 12 A, B) and the views of the laity of the causes of fears were compared (Table 12 D, E).

TABLE 12

FEARS

		Agree	Disagree	Other Responses	Significance
A. Causes of Fear: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) Fear caused by natural forces.	Izinyanga	14	0	0	-
	Non-Izinyanga	82	14	0	
2) Fear caused by psychosocial forces.	Izinyanga	2	12	0	$X^2 = 7.83$ $p < 0.01$
	Non-Izinyanga	56	40	0	
3) Fear caused by supernatural forces.	Izinyanga	9	5	0	$X^2 = 16.62$ $p < 0.001$
	Non-Izinyanga	13	83	0	
B. Education and fear: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) The educated are less fearful than the uneducated.	Izinyanga	5	9	0	-
	Non-Izinyanga	21	75	0	
2) The educated fear shame more than the uneducated.	Izinyanga	5	9	0	-
	Non-Izinyanga	40	56	0	
C. Composition of children's fears: Views of Non-Izinyanga (N=127)					
Natural	72				
Ghosts and supernatural	2				
Psychosocial	53				
D. Causation of fears is psychosocial: Views of Non-Izinyanga (N=96)					
Rural:		31	6	0	-
Urban:		51	8	0	
Male:		41	6	0	-
Female:		41	8	0	
13-35 years:		45	1	0	$X^2 = 9.09$ $p < 0.01$
36 and above:		37	13	0	
No education to Std. VI:		46	11	0	-
Std. VII and above:		36	3	0	

Results:-

The izinyanga were unanimous in their agreement with the view that fears may be caused by natural forces, and were nearly-unanimous in their rejection of the view that they are caused by psychosocial forces (Table 12 A). The laity were nearly-unanimous in their support of the view that fears are caused by natural forces, and in their rejection of the views that they are caused supernaturally and that the educated are less fearful than the less educated (Table 12 A and B). The izinyanga and the laity differed significantly as follows: a higher proportion of the laity than the izinyanga supported the view that fears are caused by psychosocial forces and more frequently than the izinyanga failed to support the view that fears are caused supernaturally. Among themselves the laity differed significantly as follows: the younger more frequently than the older supported the view that fears are caused by psychosocial factors (Table 12D). There were no significant differences among the laity on the supernatural causation of fears.

Discussion:-

The general nature of things feared was divisible into three: (1) natural such as falling ill or being struck by lightning, where such happenings occurred without the intervention of bewitching; (2) psychosocial such as shame, loneliness, becoming unemployed or being evicted from one's home; and (3) supernatural such as seeing a ghost or a tikoloshe or being bewitched.

The non-izinyanga's description of the psychosocial fears suggest the many pressures that they have to resist or to which they must accommodate themselves: twenty of the laity directly referred to situations more likely to arise in the town than in the country such as evictions, civil unrest, imprisonment, arrest and punishment for offending against the

"Pass Laws", and another informant spoke at length about her fear of "Europeans". Six lay informants spoke exclusively of their fears of shyness, isolation and loneliness, and another six of their feelings of guilt arising from sin.

The izinyanga described the supernatural fears in much greater detail than the non-izinyanga, of whose accounts an example is that of a rural inyanga who makes no mention of causes other than the supernatural:-

> "No normal person fears nothing. Everyone fears. When people fear it is because they are visited by a wizard's bird (impundulu) or a ghost; these of course are not illusions but real things to fear, and they only come to visit a particular person. Such a person needs immediate attention, and the house that he lives in that is haunted must be treated by the inyanga".

A more balanced account including both natural and supernatural causes is that of an inyanga who has spent about half of his fifty-five years in the town:-

> "Fear is something that is found everywhere. People often fear in the dark, and this is because they don't know what is in the darkness ..... It's more in the rural areas, of course, because there are snakes and if you don't fear then you are heading for trouble: we live by fear to keep safe from things that are dangerous ..... Children do not fear, on the whole, except when they see things that adults can't see such as tikoloshe and isithunzela [dead people brought to life with the aid of magic], and when a child sees these things it might even refuse to suckle from its own mother. The only way to stop these fears is to chase away the causes of the fears by use of medicine".

Conclusions:-

Again it was found that the izinyanga, the older, rural and less educated informants support the less rational, psychosocial explanations, more frequently supporting explanations in terms of magical or traditional forces. Laity and izinyanga were infrequently unanimous or nearly-unanimous, suggesting again that there is conflict between the persistence of

traditional beliefs and the growing influence of modern beliefs. It is noteworthy that even among the more traditional informants the influence of modern beliefs is apparent.

Section Seven: Aggressive Behaviour:-

Introduction:-

This section was composed of seven sub-questions: the causes of aggressive behaviour are (1) psychosocial, (2) biological, (3) magical (Table 13 A); the treatment of aggressive behaviour is (1) educational and environmental, (2) by an inyanga (Table 13 B), (3) there is no appropriate treatment (Table 13 B), (4) aggression may be a symptom of mental illness (Table 13 C).

The views of izinyanga and laity were compared (Table 13 A, B and C), and those of the laity were compared internally (Table 13 D, E, G, H and I) except in the case (Table 13 F) where the laity were almost unanimous.

Results:-

The izinyanga were nearly-unanimous in their support of the views that treatment is educational and environmental, and in their failure to support the views that causes are magical, that threatment should be by an inyanga, that no treatment is appropriate and that aggression may be a symptom of mental illness (Table 13 A, B and C). The laity were nearly-unanimous in the support of the views that aggressive behaviour is psychosocial, and were nearly-unanimous in their failure to support the views that causes are magical, that treatment should be by an inyanga and that aggression may be a symptom of mental illness (Table 13 A, B and C). The izinyanga and the laity differed significantly as follows: a higher proportion of the laity than the izinyanga supported the views that aggressive

TABLE 13

AGGRESSIVE BEHAVIOUR

			Agree	Dis-agree	Other Responses	Significance
A.	Causes of Aggression: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1)	Aggressive behaviour is psychosocial.	Izinyanga	6	8	0	$X^2=43.99$ $p<0.001$
		Non-Izinyanga	95	1	0	
2)	Causes are biological.	Izinyanga	7	7	0	-
		Non-Izinyanga	61	35	0	
3)	Causes are magical.	Izinyanga	2	12	0	-
		Non-Izinyanga	3	93	0	
B.	Treatment of Aggression: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1)	Treatment is educational & environmental.	Izinyanga	12	2	0	$X^2=13.82$ $p<0.001$
		Non-Izinyanga	29	67	0	
2)	Treatment should be by an inyanga.	Izinyanga	3	11	0	$X^2=4.78$ $p<0.05$
		Non-Izinyanga	3	93	0	
3)	There is no appropriate treatment.	Izinyanga	1	13	0	$X^2=11.88$ $p<0.001$
		Non-Izinyanga	58	38	0	
C.	Aggression may be a symptom of mental illness: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
		Izinyanga	3	11	0	-
		Non-Izinyanga	23	73	0	
D.	Causes of aggression are psychosocial: Views of Non-Izinyanga (N=96) Not analyzed: Non-Izinyanga nearly-unanimous					
E.	Causes of aggression are biological: Views of Non-Izinyanga (N=96)					
	Rural:		22	15	0	-
	Urban:		39	20	0	
	Male:		33	14	0	-
	Female:		28	21	0	
	13-35 years:		36	10	0	$X^2=6.17$ $p<0.02$
	36 and above:		25	25	0	
	No education to Std. VI:		30	27	0	$X^2=6.09$ $p<0.02$
	Std. VII and above:		31	2	0	
F.	Causes of aggression are magical: Views of Non-Izinyanga (N=96) Not analyzed: Non-Izinyanga nearly-unanimous					

Table 13 continued on next page.

Table 13 continued -

	Agree	Dis-agree	Other Responses	Significance
G. There is no appropriate treatment: Views of Non-Izinyanga (N=96)				
Rural:	25	12	0	-
Urban:	33	26	0	
Male:	28	19	0	-
Female:	30	19	0	
13-35 years:	29	17	0	-
36 and above:	29	21	0	
No education to Std. VI:	42	16	0	$X^2=9.01$ $p<0.01$
Std. VII and above:	16	23	0	
H. Aggression may be a symptom of mental illness: Views of Non-Izinyanga (N=96)				
Rural:	10	27	0	-
Urban:	13	46	0	
Male:	10	37	0	-
Female:	13	36	0	
13-35 years:	17	29	0	$X^2=4.51$ $p<0.05$
36 and above:	6	44	0	
No education to Std. VI:	9	48	0	$X^2=4.09$ $p<0.05$
Std. VII and above:	14	25	0	

behaviour is psychosocial, and a smaller proportion than the izinyanga supported the views that treatment is educational and environmental, that treatment should be by an inyanga, and that there is no appropriate treatment (Table 13 A, B and C). Among themselves the laity differed significantly as follows: a higher proportion of the younger and better educated supported the view that the causes of aggression are biological, the less educated more frequently supported the view that there is no appropriate treatment, a higher proportion of the younger and better educated supported the view that aggression might be a symptom of mental illness (Table 13 E, F, G, H). There were no sifnificant differences among the laity in their views that the treatment of aggression is educational.

Discussion:-

The causes of aggression were divisible into three: (1) psycho-social, such as the strain of living in an unhappy environment, poverty, frustration or an unhappy and unsettled childhood; (2) biological, such as sexual frustration, illness and senility; and (3) magical causes, such as the baleful effects of love-charms upon an unwilling recipient and the non-observance of customary rules and prohibitions. It was said, for example, that the ancestors cry for the custom to be performed, and show their displeasure and distress until the omission be rectified by causing the defaulting child or adult to behave aggressively and to commit anti-social acts. The treatment of aggressive behaviour was of three types:- (1) the education and encouragement of the aggressive person, and sheltering him from provocation, (2) the treatment of the aggressive person in a traditional, quasi-magical way by the inyanga, (3) steering clear of the aggressive person so that he cannot vent his aggression onto anyone, and, therefore, his aggression gradually dwindles. This view implies that nothing can modify the aggressive person's behaviour; all that one can do is to avoid him. In the first type of treatment a deliberate attempt is made to help the aggressive person to curb his impulses.

Two terms were given to describe aggression or an aggressive person: (1) gcweleza is a general personality term applied to a person who is temperamentally aggressive and often threatens violence. He is not an abnormal or mentally disturbed person, but finds himself responding aggressively, impulsively and without choosing the occasion; (2) chwenza is a term to describe aggressive behaviour such as teasing or shouting angrily in a specific situation. Thus an habitually placid person might be provoked into acting aggressively and the term chwenza would be used to describe his behaviour on this occasion. This term therefore also applies to persons who are not regarded as mentally disturbed.

Conclusions:-

Again we find that the izinyanga and the older, less educated and rural informants tend to support more traditional views or explanations, and that the younger, urban and better educated informants tend to favour explanations in psychosocial terms. In other words, the izinyanga and their supporters tend to support the more rigid and inflexible explanations of behaviour.

Overall Conclusions:-

In this chapter the author analysed the informants' views on seven topics that are broadly definable as motivational. Throughout there was a marked tendency for the izinyanga, the older, less educated and the rural to favour explanations that presupposed traditional values and ideas, and that minimized the psychosocial (as contrasted with the magical) determinants of behaviour. However, it was noteworthy that even the supporters of tradition were influenced by modern concepts, transmitted possibly by education.

CHAPTER SIX

ANTI-SOCIAL BEHAVIOUR, MENTAL DEFICIENCY AND MENTAL ILLNESS

Introduction:-

This chapter analyzes the material obtained from the informants about stealing, dagga-smoking, "drinking", suicide, sexually anomalous behaviour, mental deficiency and mental illness. The author anticipated that the discussion of the topics of this chapter would indicate the general views of informants about behaviour - anti-social and otherwise deviant - and in particular, whether there is any contrast between the traditional and the modern points of view. The informants tended to become even more highly involved in the discussions than in the other (perhaps more emotionally neutral) topics of the other chapters, and it was found necessary to confine the analysis to a selection of questions. It was also found that discussions ranged widely and in such detail that a remarkably few responses were unclassifiable and few questions remained unanswered.

Section One: Stealing:-

This section is divided into nine sub-questions on the causes (Table 14 A), the treatment (Table 14 B), and the incidence (Table 14 C) of stealing. The sub-questions are: that stealing is caused by (1) poverty and need, (2) bad company, (3) mental illness, (4) bewitchment (Table 14 A); that stealing is treated by (1) the relief of poverty, (2) advice, counselling and training, (3) punishment, (4) magical-traditional means (Table 14 B); stealing is commoner in the towns than in the country (Table 14 C) (Appendix A).

TABLE 14

STEALING

		Agree	Disagree	Other Responses	Significance
A. Causes of Stealing: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) Stealing is caused by poverty and need.	Izinyanga	6	8	0	X^2= 5.59 p< 0.02
	Non-Izinyanga	74	22	0	
2) Stealing is caused by bad company, temptation.	Izinyanga	6	8	0	X^2=26.83 p < 0.001
	Non-Izinyanga	91	5	0	
3) Stealing is caused by mental disturbance.	Izinyanga	0	14	0	X^2= 4.46 p< 0.05
	Non-Izinyanga	27	69	0	
4) Stealing is caused by bewitching.	Izinyanga	1	13	0	-
	Non-Izinyanga	17	79	0	
B. Treatment of Stealing: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) Stealing is cured by relieving poverty.	Izinyanga	3	11	0	-
	Non-Izinyanga	18	78	0	
2) Stealing is cured by advice, counsel, training.	Izinyanga	2	12	0	-
	Non-Izinyanga	15	81	0	
3) Stealing is cured by punishment.	Izinyanga	1	13	0	-
	Non-Izinyanga	12	82	2	
4) Stealing is cured magically, traditionally.	Izinyanga	2	12	0	-
	Non-Izinyanga	8	88	0	
C. Incidence of Stealing: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) Stealing is commoner in towns than country.	Izinyanga	5	9	0	X^2=16.62 p < 0.001
	Non-Izinyanga	83	13	0	
D. Stealing is caused by poverty and need: Views of Non-Izinyanga (N=96)					
Rural:		29	8	0	-
Urban:		45	14	0	
Male:		37	10	0	-
Female:		37	12	0	
13-35 years:		39	7	0	-
36 and above:		35	15	0	
No education to Std. VI:		40	17	0	-
Std. VII and above:		34	5	0	

Table 14 continued on next page.

Continuation of Table 14

E. Stealing is caused by mental disturbance: Views of Non-Izinyanga (N=96)				
	Agree	Dis-agree	Other Responses	Significance
Rural:	10	27	0	-
Urban:	17	42	0	
Male:	16	31	0	-
Female:	11	38	0	
13-35 years:	16	30	0	-
36 and above:	11	39	0	
No education to Std. VI:	14	43	0	-
Std. VII and above:	13	26	0	

The views of izinyanga and non-izinyanga were compared, and those of the non-izinyanga were compared (by age, sex, etc.) in the two cases where there was a large enough group to warrant analysis: that stealing is caused by poverty and that stealing is caused by mental disturbance.

Results:-

The izinyanga were nearly-unanimous as follows: in their failure to support the belief that stealing is caused by mental disturbance and bewitching, and is cured by the relief of poverty, by advice, by punishment and by traditional methods (Table 14 A and B). The laity were nearly-unanimous in their support of the opinion that stealing is caused by poverty and bad company, and in their failure to support the views that it is caused by mental disturbance and bewitching or cured by the relief of poverty, advice, punishment or magical means (Table 14 A and B). The laity are also nearly-unanimous in their support of the belief that stealing is commoner in the town than in the country.(Table 14 C). The izinyanga and the laity differed significantly as follows: a higher proportion of laity than izinyanga supported the opinion that stealing is caused by poverty, by bad company and by mental disturbance, and that stealing is commoner in the town

than in the country (Table 14 A, B and C). The internal analysis of the responses of the non-izinyanga revealed no significant difference throughout.

Discussion:-

The comparatively few issues that significantly divided the izinyanga from the laity possibly reflect the tendency of informants to find the topic difficult to analyze in other than conventional terms; informants made conventional comments on the immorality of stealing, but tended to be uncertain about the means to handle it. Unexpectedly few informants suggested that punitive measures were the appropriate treatment, and more suggested that the treatment is environmental, or in some way non-punitive.

It is also possible that the tendency to minimize punitive treatment is related to the high proportion of informants who attributed stealing to poverty and need, and to living in a bad environment such as Cato Manor where there is abundant temptation, bad influence and the spur of poverty. But reference was also made to the needs generated by a rising urban standard of living that are frustrated by low wages and high unemployment: one elderly informant who had spent about equal parts of her life in the town and in the country said:-

> "Some people steal because they are in need ..... but due to the strain of urban life, there is more stealing in the towns. The influence of western civilization, bioscopes, wanting to live a better life in modern ways, unemployment, all encourage people to steal".

Only the laity attributed stealing to mental disturbances, which again confirms the tendency of the laity to support more rational explanations than the izinyanga. Informants seemed to have in mind the pointless magpie stealing of defectives, though there were a few accounts of a form of bewitching that gives rise to behaviour that appeared to the author (and was said to be by informants) that of a mentally disturbed person. The

terms ukuhungulwa and ukudluliswa were given and interpreted as "stealing when there is no need to steal", such as "taking an old basin that's only fit to carry coal in"; the former term is usually associated with stealing something that is sacred or that has been bewitched, and for the rest of his life the thief will be marked by an unbreakable habit of stealing senselessly. Many of the informants doubted if this aberrant behaviour could properly be called stealing, because the individual was not in command of his will, which confirms the earlier reluctance of the informants to accept unconsciously determined behaviour.

Stealing caused by bewitching was also said to come from stealing during a period of mourning because acts done then often persist thereafter. In the section on Obsessions-Compulsions the author described the belief that offenses against the ancestors can result in the offender (or his children) being compelled to steal or carry out other anti-social behaviour.

Several informants gave a plurality of causes, and emphasized that if you are to understand why a particular person is stealing you must look carefully at his way of life. Thus, a non-izinyanga -

> "You may steal because you are too lazy to work, but you want money. Others steal because they are in need - they are poor and cannot afford food and things. This [stealing] may be due to naughtiness; they may be compelled by impulses upon themselves. Through being bewitched you may steal ... It all depends .....".

A defective child or adult who steals is not considered responsible for his actions and is not punished; several informants suggested that a child might steal if he were unhappy at home, felt rejected or neglected by his parents, both because he might tend to wander about hungry and neglected, and because he might have feelings of revenge.

Many informants (about 80%) (Table 14 C) held that stealing was worse in the town than in the country, but whereas the views of the laity were generally that there were greater pressures and temptations in the city, the izinyanga tended to hold traditional values and views and seemed often to be exaggerating the disadvantages of the town and the advantages of the country; the non-izinyanga did not seem to the author to contrast town and country in a noticeably unrealistic and sentimental way. The traditional view was a strictly moralistic condemnation of adult stealing, which was said formerly to be a capital offence. A child who stole was first punished severely, and would if he broke a taboo suffer thereby, but the petty theft of fowls, fruit and sugar cane by small boys was condoned as the normal mischievousness of boys much as fruit "scrumping" is still regarded in rural England. On passing boyhood, however, even this mildly naughty stealing had to stop or the boy would be severely punished, and if the stealing persisted despite the infliction of punishment, the boy was regarded as bewitched and considered to be in need of treatment by the inyanga. Informants insisted that even today parents are much concerned if their children steal, because of the disgrace to the family and the danger to the child that this behaviour brings.

Conclusions:-

Again the author found the tendency of the informants to dichotomize: the izinyanga taking the traditional views, and minimizing the environmental and psychosocial explanations, and the laity tending to emphasize the psychosocial and "modern" views. Informants tended to be unable to suggest the treatment of stealing: possibly they were in a similar position to most laymen vis à vis professional workers or students of anti-social behaviour: the traditionally repressive methods have been shown to be impractical and psychosocial principles have not yet been fully grasped by the laity nor put into practise. The relatively more "insulated" izinyanga

were less ready than the laity to attribute stealing to environmental strain and poverty, but that the izinyanga's traditionalism is possibly being eroded in this as in other sections is seen in the relatively few explanations in terms of bewitching.

Section Two: Taking Alcohol and Dagga:-

Introduction:-

This topic was confined to discussion of people who smoke dagga or who "drink" to excess, and are therefore condemned as "anti-social" or regarded popularly as "abnormal". The author anticipated that in this marginally deviant behaviour there might be sharp contrasts between a stricter and more disapproving elder generation (or those upholding stricter traditions) and those whose views are more modern and liberal.

This section was divisible into two parts: (1) on the reasons why people indulge in taking alcohol and dagga (Table 15 A) and (2) on the comparative extent of excess in town and country, and the causes of any difference (Table 15 B). There are six sub-questions: (1) are alcohol and dagga taken for pleasure, entertainment, pure enjoyment, (2) because "dagga" clears the mind, (3) to escape frustrations, to stimulate courage, (4) is there more indulgence in towns, (5) does the strain of urban life encourage indulgence, (6) does the breakdown of traditional curbs encourage indulgence (Appendix A)?

The views of izinyanga and non-izinyanga were compared (Table 15 A and B), and those of the non-izinyanga were compared internally (by age, sex, etc.) (Table 15 C) in their discussion of whether the strain of urban life encourages indulgence. The major issue in the section on incidence was the relative indulgence in town and country, and the views of the izinyanga were analyzed only in relation to this issue; it should be noted that

in all other issues the non-izinyanga were so nearly-unanimous that analysis would have been unprofitable.

TABLE 15

TAKING ALCOHOL AND DAGGA

		Agree	Disagree	Other Responses	Significance
A. Why Dagga and Alcohol are taken: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) For pleasure, entertainment.	Izinyanga	4	10	0	$X^2=10.95$ $p < 0.001$
	Non-Izinyanga	73	23	0	
2) Dagga "clears the mind".	Izinyanga	3	11	0	-
	Non-Izinyanga	29	67	0	
3) To escape frustrations.	Izinyanga	7	7	0	$X^2=11.78$ $p < 0.001$
	Non-Izinyanga	86	10	0	
B. Incidence and Causes thereof: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) More indulgence in towns.	Izinyanga	14	0	0	-
	Non-Izinyanga	82	14	0	
2) Strain of urban life encourages indulgence.	Izinyanga	5	9	0	-
	Non-Izinyanga	49	47	0	
3) Breakdown of traditional curbs encourages indulgence.	Izinyanga	1	13	0	-
	Non-Izinyanga	16	80	0	
C. Strains of urban life encourage indulgence: Views of Non-Izinyanga (N=96)					
Rural:		22	15	0	-
Urban:		27	32	0	
Male:		18	29	0	$X^2= 5.03$ $p< 0.05$
Female:		31	18	0	
13-35 years:		24	22	0	-
36 and above:		25	25	0	
No education to Std. VI:		29	28	0	-
Std. VII and above:		20	19	0	

Results:-

The izinyanga were never unanimous but were nearly-unanimous as follows: in their support of the view that there is more indulgence in town, and in their failure to support the opinion that indulgence is for pleasure, that dagga "clears the mind" and that the breakdown of traditional curbs encourages indulgence (Table 15 A and B). The laity were never unanimous but were nearly-unanimous as follows: in supporting the belief that indulgence is for pleasure or entertainment, that indulgence is an aid to escape frustration, that there is more indulgence in town, and in their failure to support the view that the breakdown of traditional curbs encourages indulgence (Table 15 A and B). The izinyanga differed significantly from the laity as follows: a higher proportion of laity than izinyanga supported the belief that indulgence was for entertainment, and that indulgence helps one to escape frustrations (Table 15 A and B). Among themselves the laity differed significantly only once: a higher proportion of females than males held that the stresses of urban life encouraged indulgence (Table 15 C).

Discussion:-

The tendency of both izinyanga and laity was to analyze the causes of indulgence with a minimum of moral criticism, in terms of pragmatic, psychosocial causes that are easily manifest to the layman; no informant praised indulgence for its own sake, but there was much understanding implied in the attribution of indulgence to urban stress and frustration, and very little condemnation of the individuals who indulged intemperately in the towns. Only one inyanga and sixteen rural and elderly non-izinyanga lamented the breakdown of traditional curbs on drinking and smoking dagga: formerly, it was said, only the older men would indulge, but now young men and even girls were said to smoke and drink without anyone being able effectively to disapprove.

An inyanga with both town and country experience, gave a lengthy account of the reasons for indulgence, including most of the three classes of reason:-

> "Dagga addicts say that they think better after they have smoked dagga, and in olden days the warriors before leading the army to the battlefields would gather to smoke first. All types of people drink, educated or not, but those that drink (heavily) are those who have suffered frustration, shame and disgrace. This has been taken as something for pleasure, to forget sorrows, but when one sobers up he gets the worry again. This leads to drinking frequently, hence one becomes a drunkard ..... They are not bad or wicked .....".

The five informants who argued that smoking dagga was customary in former days and that it never led to anti-social or objectionable conduct, and the one who claimed additionally that it cured asthma, were almost eloquent on the advantages of **dagga** smoking. One young man, a town dweller, gave an almost lyrical defence of **dagga** smoking:-

> "..... It comforts you, it reminds you of things that you have forgotten, it is the food of the brain, it gives one courage while others are cowards ..... More people smoke **dagga** now because they have discovered the work it does to the brain - even "Europeans" smoke **dagga** for the same reason".

Somewhat surprisingly only eight non-izinyanga said that they believed "kaffir beer" to be a valuable food and that therefore nobody should be discouraged from drinking or making it.

Conclusions:-

In general the izinyanga and the laity tended to disagree little, and informants tended to employ psychosocial and environmental explanations; it is interesting that the izinyanga and the laity differed in the attribution of indulgence to the stress of urban life, as this again confirms the tendency of the izinyanga to reflect less than the laity the pressures of a changing social system, and the impact of urbanization.

Section Three: Suicide:-

Introduction:-

The author was concerned with the informants' views on the incidence and causes of suicide, and included suicide as a topic expecting that informants would reveal the extent to which their beliefs were affected by a traditional and Christian abhorrence or by modern and more tolerant attitudes. In addition to the sub-question analyzed, the author asked a few incidental questions about the incidence of suicide among non-Africans, but the results were not sufficiently clear to make analysis worthwhile.

This section is divisible into two parts: the informants' views on (1) the incidence of suicide by age, and (2) the causes of suicide. The material was divided into seven sub-questions: the first three relate to the incidence of suicide by age (Table 16 A); the other four questions relate to the causes of suicide: (4) unfaithfulness of spouse; (5) disturbed mind, shame, disgrace; (6) overwhelming environmental pressure; (7) bewitching (Table 16 B) (Appendix A).

The opinions of izinyanga and non-izinyanga were compared (Table 16 A and B), and those of the laity were compared internally (by age, sex, etc.) on environmental pressure and bewitching as causes of suicide (Table 16 C). The views of the laity on unfaithfulness of spouse as a cause of suicide were also compared but no significant or near-significant differences were found; no analysis was carried out of the agreement of the laity that a disturbed mind be the cause of suicide, because the laity were almost unanimous.

TABLE 16

SUICIDE

			Agree	Dis-agree	Other Responses	Significance
A. Incidence of Suicide by Age: **Izinyanga (N=14) vs Non-Izinyanga (N=96)**						
1)	Mainly under 40's.	Izinyanga	9	5	0	-
		Non-Izinyanga	74	22	0	
2)	Mainly over 40's.	Izinyanga	1	13	0	-
		Non-Izinyanga	6	90	0	
3)	No relationship with age.	Izinyanga	5	9	0	-
		Non-Izinyanga	16	80	0	
B. Causes of Suicide: Izinyanga (N=14) vs. Non-Izinyanga (N=96)						
4)	Unfaithfulness of spouse.	Izinyanga	9	5	0	-
		Non-Izinyanga	50	46	0	
5)	Disturbed mind, shame.	Izinyanga	9	5	0	X^2=12.26 $p < 0.001$
		Non-Izinyanga	92	4	0	
6)	Overwhelming environmental pressures.	Izinyanga	4	10	0	-
		Non-Izinyanga	50	46	0	
7)	Bewitching.	Izinyanga	3	11	0	X^2= 3.08 $p < 0.10$
		Non-Izinyanga	41	55	0	
C. Causes of Suicide: Views of Non-Izinyanga (N=96)						
1)	Environmental pressure.	Rural:	22	15	0	-
		Urban:	28	31	0	
		Male:	23	24	0	-
		Female:	27	22	0	
		13-35 years:	36	10	0	X^2= 5.46 $p < 0.02$
		36 and above:	27	23	0	
		No education to Std. VI:	29	28	0	-
		Std. VII and above:	22	17	0	
2)	Bewitching.	Rural:	23	14	0	X^2= 8.06 $p < 0.01$
		Urban:	18	41	0	
		Male:	17	30	0	-
		Female:	24	25	0	
		13-35 years:	14	32	0	X^2= 3.74 $p < 0.10$
		36 and above:	26	24	0	
		No education to Std. VI:	33	24	0	X^2=10.04 $p < 0.01$
		Std. VII and above:	9	30	0	

Results:-

The izinyanga were never unanimous but were nearly-unanimous in their rejection of the views that suicide is mainly among the over-40's, that the causes of suicide are overwhelming environmental pressure and bewitching; the laity were never unanimous but were nearly-unanimous in their support of the propositions that suicide is mainly by the under-40's, that the causes are a disturbed mind or shame, and were nearly-unanimous in rejecting the opinion that suicide was mainly of the over-40's and bore no relationship to age. The izinyanga and the laity differed nearly-significantly as follows: a higher proportion of the laity supported the belief that the causes of suicide were a disturbed mind and shame; a nearly-significantly higher proportion of the laity held that bewitching was a cause of suicide. Among themselves the laity differed significantly as follows: a higher proportion of the younger agreed that a cause of suicide is environmental pressure, and of the less educated and older (nearly-significantly) that bewitching is a cause, and a higher proportion of rural than urban that bewitching is a cause of suicide.

Discussion:-

In general there was a tendency for the laity to support explanations in environmental terms more often than the izinyanga, a tendency that already has been noted in other sections of this thesis, but an unexpected difference was the significantly higher proportion of the laity who supported the view that witchcraft was a cause of suicide, although only about 42% of the laity and about 20% of the izinyanga supported the belief. It is difficult to explain this difference, but among the laity the older rural and less educated held this belief more often. A person was not described as being directly bewitched into taking his life, but the informants described a situation that read like a psychoanalytic mechanism: the suicide is said to be so upset that he deliberately puts himself into a dangerous situation

despite all warnings and against his better judgment. It may be that the izinyanga have had more experience of the mentally disturbed than their less educated coevals among the laity who accept this belief, and have an empirically founded set of beliefs about the causes of suicide: this view has some support from the tendency of the izinyanga to describe suicide at greater length and with more detail than the laity. One inyanga said:-

> "Suicide happens for several reasons: (1) when a man has a troubled heart; (2) when a man has suffered from many disappointments and disgraces, having committed adultery, for example; (3) when he has deserted his family and he feels that he has done something bad, he often says that his relatives have bewitched him, but of course we know that in most cases he is suffering from guilty conscience; (4) when an old man is not being supported by his children and they are paying him no attention. ..... It does happen too that a person is so angry that he does something so that it will kill him. Thus you hear of people saying "I tried everything to stop so-and-so from killing himself but he went straight into the danger". This usually happens to a person who is deeply troubled by something so that all his attention is drawn to it and he moves about like a person walking in his sleep".

The general tendency of informants was to offer explanations in psychosocial terms: shame, overwhelming environmental pressure, a broken marriage, and except in the anomalous case of bewitching the laity tended to be more frequently environmentalistic. The attribution of suicide to shame or disgrace, was specified rarely: but was said to be a cause if the suicide had been severely disgraced or if someone close to him had been disgraced. Thus for example a father might suffer so deeply if the daughter he loved most was having an illegitimate child that he might commit suicide.

Conclusions:-

There were divisions among the laity along the familiar lines of age, urbanization and education, and between the izinyanga and the laity, particularly in the description of the causes of suicide. It was unexpected to find the laity more ready to accept bewitching as a cause of suicide than the izinyanga, and this possibility reflected the greater experience of the izinyanga in the treatment and handling of severely disturbed people.

Section Four: Sexually anomalous Behaviour:-

Introduction:-

In this section the author discusses the views of the informants on the causes and treatment of male and female homosexuality; the section therefore falls into two parts: relating to (1) males and (2) females. For simplicity the author described homosexuality as a man being in love with another male and a woman being in love with another female; the informants appeared adequately to distinguish homosexuality in this narrow sense from mere strong friendships, and from the states of a man behaving in a feminine fashion and a female in a masculine. The material was analyzable into five sub-questions: the causes of homosexuality are (1) biological: that is, the individual is "bi-sexual", he or she is "naturally" of this type; (2) environmental and (3) "wilfulness", having an evil and sinful nature (Table 17 A); the treatment of homosexuality is (1) medical (Table 17 B), (2) homosexuality is not amenable to treatment (Table 17 B). The diagnosis of homosexuality as "wilful" was made in response to a question by the interviewers, who were asked to find if the informant thought that this behaviour was deliberate. The question was asked because the author was interested in the extent to which homosexuality was regarded as morally reprehensible: a comment that it was "wilful" often implied that it was morally blameworthy.

The views of izinyanga and laity were compared (Table 17 A and B) and those of the laity were compared internally (according to age, sex, etc. (Table 17 C).

TABLE 17

SEXUALLY ANOMALOUS BEHAVIOUR

			Agree	Dis-agree	Other Responses	Significance
A. Causes of Male Homosexuality: Izinyanga (N=14) vs. Non-Izinyanga (N=96)						
1)	Bi-sexuality, "nature".	Izinyanga	7	7	0	-
		Non-Izinyanga	45	51	0	
2)	Environmental.	Izinyanga	3	11	0	-
		Non-Izinyanga	34	62	0	
3)	"Wilfulness", "evil nature".	Izinyanga	3	11	0	-
		Non-Izinyanga	20	76	0	
B. Causes of Female Homosexuality: Izinyanga (N=14) vs. Non-Izinyanga (N=96)						
1)	Bi-sexuality, "nature".	Izinyanga	8	6	0	-
		Non-Izinyanga	31	65	0	
2)	Environmental.	Izinyanga	2	12	0	-
		Non-Izinyanga	32	64	0	
3)	"Wilfulness", "evil nature".	Izinyanga	4	10	0	-
		Non-Izinyanga	16	80	0	
C. Treatment of Male Homosexuality: Izinyanga (N=14) vs. Non-Izinyanga (N=96)						
1)	Incurable, untreatable.	Izinyanga	12	2	0	$X^2=14.53$ $p < 0.001$
		Non-Izinyanga	28	67	1	
2)	Medical.	Izinyanga	0	14	0	-
		Non-Izinyanga	20	76	0	
D. Treatment of Female Homosexuality: Izinyanga (N=14) vs. Non-Izinyanga (N=96)						
1)	Incurable, untreatable.	Izinyanga	9	5	0	$X^2= 8.39$ $p < 0.01$
		Non-Izinyanga	22	74	0	
2)	Medical.	Izinyanga	0	14	0	-
		Non-Izinyanga	19	77	0	

Table 17 continued on next page.

Table 17 continued

		Agree	Dis-agree	Other Responses	Significance
D. Causes of Male Homosexuality: Views of Non-Izinyanga (N=96)					
1) Bi-sexuality.	Rural:	23	14	0	X^2= 3.69 p < 0.10
	Urban:	22	37	0	
	Male:	20	27	0	-
	Female:	25	24	0	
	13-35 years:	21	25	0	-
	36 and above:	24	26	0	
	No education to Std. VI:	22	35	0	-
	Std. VII and above:	23	16	0	
2) Environmental.	Rural:	12	25	0	-
	Urban:	22	37	0	
	Male:	21	26	0	-
	Female:	13	36	0	
	13-35 years:	21	25	0	X^2= 3.21 p < 0.10
	36 and above:	13	37	0	
	No education to Std. VI:	14	43	0	X^2= 6.11 p < 0.02
	Std. VII and above:	20	19	0	
E. Causes of Female Homosexuality: Views of Non-Izinyanga (N=96)					
1) Bi-sexuality.	Rural:	13	24	0	-
	Urban:	18	41	0	
	Male:	13	34	0	-
	Female:	18	31	0	
	13-35 years:	15	31	0	-
	36 and above:	16	34	0	
	No education to Std. VI:	13	44	0	X^2= 4.75 p < 0.05
	Std. VII and above:	18	21	0	
2) Environmental.	Rural:	10	27	0	-
	Urban:	22	37	0	
	Male:	19	28	0	-
	Female:	13	36	0	
	13-35 years:	19	27	0	-
	36 and above:	13	37	0	
	No education to Std. VI:	14	43	0	X^2= 3.93 p < 0.10
	Std. VII and above:	18	21	0	
F. Treatment of Male Homosexuality: Views of Non-Izinyanga (N=96)					
1) Incurable, untreatable.	Rural:	15	22	0	-
	Urban:	13	46	0	
	Male:	11	26	0	-
	Female:	16	41	2	
	13-35 years:	1	45	0	X^2=29.57 p < 0.001
	36 and above:	27	23	0	
	No education to Std. VI:	25	32	0	X^2=14.01 p < 0.001
	Std. VII and above:	3	36	0	
2) Medical.	Rural:	5	32	0	-
	Urban:	15	44	0	
	Male:	12	35	0	-
	Female:	8	41	0	
	13-35 years:	17	29	0	X^2=12.11 p < 0.001
	36 and above:	3	47	0	
	No education to Std. VI:	3	54	0	X^2=18.36 p < 0.001
	Std. VII and above:	17	22	0	

Table 17 continued next page.

Table 17 continued

G. Treatment of Female Homosexuality: Views of Non-Izinyanga (N=96)					
		Agree	Dis-agree	Other Responses	Significance
1) Incurable, untreatable.	Rural:	15	22	0	X^2= 9.02 $p < 0.01$
	Urban:	7	52	0	
	Male:	8	39	0	-
	Female:	14	35	0	
	13-35 years:	4	42	0	X^2= 8.56 $p < 0.01$
	36 and above:	18	32	0	
	No education to Std. VI:	17	40	0	X^2= 2.89 $p < 0.10$
	Std. VII and above:	5	34	0	
2) Medical.	Rural:	4	33	0	-
	Urban:	12	47		
	Male:	9	38	0	-
	Female:	7	42	0	
	13-35 years:	9	37	0	-
	36 and above:	7	43	0	
	No education to Std. VI:	3	54	0	X^2=11.19 $p < 0.001$
	Std. VII and above:	13	26	0	

Results:-

The izinyanga were nearly-unanimous as follows: they disagreed that the causes of male homosexuality were environmental or "wilful", and held similarly about the causes of female homosexuality; they unanimously rejected the opinion that male homosexuality is medically curable, and nearly-unanimous that it is incurable, and they unanimously rejected the view that female homosexuality is medically curable (Table 17 A and B). The non-izinyanga were never unanimous, but were nearly-unanimous in disagreeing with the beliefs that male homosexuality is due to "wilfulness" and that it is medically curable; they held similar views about female homosexuality, and were nearly-unanimous in rejecting the opinions that male and female homosexuality is incurable (Table 17 A and B). There was the following significant difference between izinyanga and laity: a significantly higher proportion of the izinyanga agreed that male and female

homosexuality was incurable (Table 17 C). Among themselves the non-*izinyanga* differed significantly as follows: a higher proportion of higher educated informants held that environmental factors are the cause of male homosexuality and of the younger and better educated that the treatment of male homosexuality is medical, a higher proportion of older and less educated hold male homosexuality as incurable; further: a higher proportion of better educated held that female homosexuality is caused by "bi-sexuality" and of the better educated that the causes are environmental (Table 17 C). There were the following near-significant results: a higher proportion of rural informants believed that male homosexuality is caused by bi-sexuality, and younger informants that it is caused by environmental factors, and a higher proportion of better educated that female homosexuality is environmentally caused (Table 17 C). There were no significant differences between the laity in their belief that mental deficiency bars asocial stigma. A significantly higher proportion of rural and female informants held that female homosexuality was incurably, and a nearly-significant higher proportion of less educated informants agreed.

Discussion:-

There was substantial agreement among informants about the causes of homosexuality, which were divisible into: (1) bi-sexuality: that is, the homosexual is biologically endowed with considerable and dominating drives appropriate to the opposite sex; (2) environmental pressures, such as a boy who was brought up in a family of females and who has learned only female ways, or it may be the response to having no other sexual outlet, as in prison or in school; (3) some homosexuals were said to behave this way deliberately and mischievously, choosing this form of sexual satisfaction to evade the responsibilities of marriage and heterosexual love. The "bi-sexuality" theory attracted a great deal of support, possibly because of the obvious oddities of behaviour of a masculine woman or an effeminate man, and a clear distinction between the "bi-sexual" homosexual who cannot be blamed and the "wilful" homosexual was often made. It is interesting that very few condemnations were made of homosexuality in purely moral terms,

but the tone of condemnation was that such behaviour is disruptive, psychologically sterile and that it leads to unhappiness. One informant said:-

> "Some men and women are known as uncukubili or impisintshange: those with both sexes, but those who behave like this because they are naughty are known as ongqingili. The ongqingili are immoral because they are the same as any other human beings, but those with two sexes are pressed by circumstances. They cannot help themselves; they just do not fit into normal societies".

A traditional belief mentioned was that there is a magical snake known as umamsosi which is used to satisfy a person's sexual needs so that he or she only requires a partner of the same sex and only loves them.

Conclusions:-

In general the izinyanga and the laity were tolerant, pessimistic about the cure of homosexuality and without manifestly strong moral views; the laity tended to split along the now familiar lines, the better educated, younger and urban informants tended to be more optimistic about cure and more prone to accept environmental determinants.

Section Five: Mental Defect:-

Introduction:-

The aim of this and the last section was to explore the general attitude of informants towards mental defect and mental illness, and to gauge the extent to which these disorders are regarded as illnesses caused similarly to physical illnesses. This section and the last probably indicate most clearly the extent to which there has been an irradiation of modern, medical attitudes to the layman. The author had expected to obtain information to enable him to analyze the informants' estimate of the changing incidence of mental defect and mental illness, but the information proved to be too fragmentary for a very detailed analysis.

This section consists of material analyzed into five sub-questions: the causes of mental defect are (1) biological, including "inbreeding"; (2) biological other than inbreeding; (3) bewitching or offending the ancestors (Table 18 A). The treatment of mental defect is (1) medical, (2) purification by an inyanga, (3) there is no treatment possible (Table 18 B). A further question asked if there is a social stigma attached to mental defect (Table 18 C) (Appendix A).

The responses of izinyanga and laity were compared (Table 18 A, B and C),and those of the laity compared internally (by age, sex, etc.) in answer to the question "Is mental defect biological, but not caused through inbreeding"? (Table 18 D). No other analysis of the responses of the laity was carried out because the laity was in other issues nearly-unanimous.

Results:-

The izinyanga unanimously rejected the view that mental defect can be treated medically, and nearly-unanimously rejected the opinions that it is caused biologically (but not by inbreeding), that it is the result of bewitching, that it is curable by purification by an inyanga and that it attracts a social stigma (Table 18 A, B and C). The izinyanga were nearly-unanimous in claiming that no treatment is applicable (Table 18 B). The laity were never unanimous,but were nearly-unanimous in supporting the belief that mental defect is caused biologically (including inbreeding), that there is no treatment and were nearly-unanimous in rejecting the views that it is caused by bewitching, that it is cured medically and that it is cured by purification by an inyanga (Table 18 A and B). The izinyanga and the laity differed significantly as follows: a significantly higher proportion of laity than izinyanga believed that mental defect is caused by biological determinants (including inbreeding) and by hereditary factors other than inbreeding (Table 18 A and B). Among themselves a significantly higher pro-

portion of rural than urban informants said that mental defect is hereditary but not caused by inbreeding (Table 18 D).

TABLE 18

MENTAL DEFECT

		Agree	Disagree	Other Responses	Significance
A. Causes of Mental Defect: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) Biological including inbreeding.	Izinyanga	9	5	0	$X^2=14.71$ $p < 0.001$
	Non-Izinyanga	93	3	0	
2) Heredity, but not inbreeding.	Izinyanga	4	10	0	$X^2= 6.86$ $p < 0.01$
	Non-Izinyanga	66	30	0	
3) Bewitching, offending the ancestors.	Izinyanga	3	11	0	-
	Non-Izinyanga	19	77	0	
B. Treatment of Mental Defect: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) Medical.	Izinyanga	0	14	0	-
	Non-Izinyanga	1	95	0	
2) Purification by an inyanga.	Izinyanga	2	12	0	-
	Non-Izinyanga	10	86	0	
3) No treatment applicable.	Izinyanga	10	4	0	-
	Non-Izinyanga	86	10	0	
C. A social stigma attached to mental defect: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
	Izinyanga	3	11	0	-
	Non-Izinyanga	25	71	0	
D. Causes of Mental Defect hereditary, but not inbreeding: Views of Non-Izinyanga (N=96)					
Rural:		36	1	0	$X^2=20.73$ $p < 0.001$
Urban:		30	29	0	
Male:		30	17	0	-
Female:		36	13	0	
13-35 years:		31	15	0	-
36 and above:		35	15	0	
No education to Std. VI:		39	18	0	-
Std. VII and above:		27	12	0	

Discussion:-

There was in general little disagreement between izinyanga and laity, both groups tending to reject magical or traditional beliefs and to support quasi biological views. Of the biological causes mentioned, the most frequent was maldevelopment of the brain. The protagonists of explanations in terms of inbreeding were not clear about the precise relationship that brings about the disorder, but severe defect is said to result from inbreeding; according to a few informants if a marriage takes place between closely related persons purification ceremonies should be performed, but according to others the damage has been done and no ceremony can help matters. Two informants among the laity objected to the view that inbreeding led to mental defect, arguing that among the Sotho intermarriage often takes place and there is no marked mental deficiency among Sotho children. A typical view of those who hold that mental defect is inherited but not connected with inbreeding is that if the parents are of low intelligence the children are likely also to be of low intelligence. It is possible that the tendency of the izinyanga and the rural informants to support biological causes as operative but not to accept inbreeding as the result of informal observations of animals in the country and some knowledge of the results of animal inbreeding.

Informants offered two terms that corresponded to "mental defective": isilima is used for a person who is severely defective and isiphoxo for a person who is mildly defective. The descriptions of the mentally defective suggest that the informants are clear that the author was interested in their opinions about the relatively severe psychopathological condition, and not about the person who is no more than "not very bright". The symptomatic descriptions given by izinyanga and laity are substantially similar, and the same emphasis was given by both groups. The complex of emotional instability, inability to learn or to reason clearly, inability

to follow a social or moral code, sexual impotence, forgetfulness, failure to follow simple instructions, agree broadly with conventional medical indicia. The defective needs special care and protection, because he acts foolishly and/or unpredictably and may endanger himself or others.

The failure to mention physical appearance as an indication of mental defect, may be related to the medical finding that "mongolism" is rare among Africans. Carothers (1953), perhaps not a highly reliable source, but one of the few comprehensive ones, states that neither he nor Tooth (1950) have seen a case of "mongolism" among Africans, and asserts moreover that no reported case has been diagnosed among American Negroes. It should be noted, however, that it is highly probable that the frail and easily infected Mongoloid baby, who is recognisable as mongoloid with difficulty when he is very young, will die even more readily than the majority of African babies, and therefore rarely lives long enough to be diagnosed as a "mongol".

In general the informants do not confirm the views of Laubscher (1951) who claimed (somewhat sweepingly) that although Africans connect inbreeding with abnormal physical growth they make no connection with mental faculties; he further asserted that mental defect (quaintly included in a category named by Laubscher "degeneracy") is regarded by Africans as an underdevelopment that will correct itself if the parents are patient and allow the child to mature in his own time.

Bewitching or offending the ancestors not only included the direct offence of inbreeding, but included traditional customs not being followed at the birth of the child, or if one teases a defective or laughs at him the ancestors may punish the mocker by making him become defective.

Few informants, laity or izinyanga, thought that there was a social stigma attached to the defective or to his family, but some of the

informants qualified their remarks by pointing out that it might depend upon the circumstances, the nature of the observer and the general respect and sympathy that the afflicted family has in the community. It was argued that people do not worry about defectives, but are content to protect and care for them; some indulgence is said to be shown to them because of their inability to understand the laws and customs, so that if a defective has stolen or broken something belonging to another person, nothing is done to reprimand or to punish him or his parents. Informants said that there is little purpose in punishing a person who cannot understand why he is being punished and (according to a few informants) some people fear the wrath of the ancestors if they punish a defective. Of those who held that there was a social stigma, a small proportion claimed that the defective became defective because he was bewitched as a punishment for being naughty, for hating his family, stealing (and the like): that is, he has been blameworthy in some way, but the majority stated plainly that the child and his family are only laughed at by thoughtless people, who have no sympathy for the parents who continue to love the child and to care for him as though he were a normal child, despite their disappointment, unhappiness and (some say) shame.

Although informants tended to be pessimistic about the possibility of curing mental deficiency, they tended to be clear about the attitudes one should show towards mental defectives: one should be patient and understanding, and take pains to teach the defective simple skills so that he might look after himself and not be helpless.

Conclusions:-

In general izinyanga and laity differed rarely, but agreed in attributing mental deficiency principally to biological causes and in their pessimism towards the possibility of cure. In view of the generally more optimistic attitude towards modern medicine of the laity in other sections

of this thesis, this pessimism may possibly be the result of a misinterpretation of the inability of the hospitals to accept mentally defective patients *per se*, this rejection being misinterpreted as tacit admission by the hospitals that they cannot cure mental deficiency.

Section Six: Mental Illness:-

Introduction:-

The material in this section is divisible into four parts: the causes and treatment of mental illness, if such illnesses have increased with urbanization and if such illnesses are peculiar to Africans. There are eight sub-questions: Are the causes of mental illness (1) physiological or biological; (2) psychosocial; (3) magical, the result of bewitching (Table 19 A). Is the appropriate treatment of mental illness by (1) an *inyanga* exclusively, (2) a doctor exclusively, (3) either an *inyanga* or a doctor according to the nature of the illness (Table 19 B). Have mental illnesses increased (Table 19 C). Do people other than Africans have mental illnesses (Table 19 D) (Appendix A).

The responses of *izinyanga* and laity were compared, and an internal comparison of the responses of the laity (by age, sex, etc.) was made of their opinions that the causes of mental illness are magical, they are treated by a doctor or *inyanga* and mental illnesses have increased (Table 19 A, B, C and D). No other comparisons of laity were made, because they were too nearly-unanimous.

Results:-

The *izinyanga* were unanimous as follows: in supporting the beliefs that the causes of mental illness were psychosocial or bewitching, in their rejection of cure being exclusively by an *inyanga* or by a doctor, in their

TABLE 19

MENTAL ILLNESS

		Agree	Dis-agree	Other Responses	Significance
A. Causes of Mental Illness: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) Physiological, biological.	Izinyanga	9	5	0	$X^2 = 4.86$ $p < 0.05$
	Non-Izinyanga	29	67	0	
2) Psychosocial.	Izinyanga	14	0	0	-
	Non-Izinyanga	78	18	0	
3) Magical, bewitching.	Izinyanga	14	0	0	$X^2 = 5.69$ $p < 0.02$
	Non-Izinyanga	68	28	0	
B. Treatment of mental illness: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
1) By inyanga exclusively.	Izinyanga	0	14	0	-
	Non-Izinyanga	23	73	0	
2) By doctor exclusively.	Izinyanga	0	14	0	$X^2 = 3.58$ $p < 0.10$
	Non-Izinyanga	26	70	0	
3) By doctor or inyanga.	Izinyanga	14	0	0	$X^2 = 5.52$ $p < 0.02$
	Non-Izinyanga	37	59	0	
C. Mental illnesses have increased: Izinyanga (N=14) vs Non-Izinyanga (N=96)					
	Izinyanga	2	12	0	$X^2 = 13.13$ $p < 0.001$
	Non-Izinyanga	66	30	0	
D. People other than Africans have Mental Illnesses: Izinyanga (N=14) vs. Non-Izinyanga (N=96)					
	Izinyanga	6	8	0	$X^2 = 16.23$ $p < 0.001$
	Non-Izinyanga	86	10	0	
E. Causes physiological: Views of Non-Izinyanga (N=96)					
Rural:		11	26	0	-
Urban:		18	41	0	
Male:		15	32	0	-
Female:		14	35	0	
13-35 years:		19	27	0	$X^2 = 4.19$ $p < 0.05$
36 and above:		10	40	0	
No education to Std. VI:		11	46	0	$X^2 = 7.87$ $p < 0.01$
Std. VII and above:		18	21	0	

Table 19 continued on next page.

Table 19 continued

	Agree	Dis-agree	Other Responses	Significance
F. Causes are magical: Views of Non-Izinyanga (N=96)				
Rural:	37	0	0	X^2=22.55 p < 0.001
Urban:	31	28	0	
Male:	34	13	0	-
Female:	34	15	0	
13-35 years:	31	15	0	-
36 and above:	37	13	0	
No education to Std. VI:	45	12	0	X^2= 3.56 p < 0.10
Std. VII and above:	23	16	0	
G. Treatment by a doctor or inyanga: Views of Non-Izinyanga (N=96)				
Rural:	15	22	0	-
Urban:	22	37	0	
Male:	13	34	0	X^2= 3.75 p < 0.10
Female:	24	25	0	
13-35 years:	17	29	0	-
36 and above:	20	30	0	
No education to Std. VI:	20	37	0	-
Std. VII and above:	17	22	0	
H. Mental Illnesses have increased: Views of Non-Izinyanga (N=96)				
Rural:	20	17	0	X^2= 4.99 p < 0.05
Urban:	46	13	0	
Male:	29	18	0	-
Female:	37	12	0	
13-35 years:	29	17	0	-
36 and above:	37	13	0	
No education to Std. VI:	35	22	0	X^2= 2.73 p < 0.10
Std. VII and above:	31	8	0	

support of cure being by either doctor or inyanga, and they were nearly-unanimous in rejecting the view that mental illness has increased (Table 19 A, B and C). The laity were not unanimous but were nearly-unanimous as follows: they supported the belief that the causes are psychosocial, rejected treatment exclusively by inyanga or by a doctor exclusively, supported the view that people other than Africans also suffer from mental illnesses (Table 19 A, B and D). There were the following significant differences between the izinyanga and the laity: a higher proportion of the izinyanga held that the causes were physiological or magical, supported cure by

either doctor or inyanga and disagreed that mental illnesses have increased. They differed nearly-significantly as follows: a higher proportion of izinyanga rejected the view that treatment should be exclusively by a doctor (Table 19 A, B and D). Among themselves the laity differed significantly as follows: a higher proportion of rural held the causes to be magical and the younger and better educated to be physiological; and (nearly-significantly) a higher proportion of less educated agreed; a higher proportion of females held that treatment should be by a doctor or inyanga, and of urban informants hold that mental illnesses have increased, and this view was held (nearly-significantly) by a higher proportion of better educated informants.

Discussion:-

Throughout this section the izinyanga and the laity tended to differ; the former were not unexpectedly in support of explanations of mental illness in terms of bewitching, but unexpectedly favoured psychosocial and physiological, i.e., rational explanations. The izinyanga also unexpectedly rejected magical or traditional cures as the exclusive cure, and favoured cure by either doctor or inyanga according to the nature of the illness. It is possible that this comparatively rational approach of the izinyanga reflects their empirical concern with the mentally disturbed, whom the traditional diagnoses and therapies do not effectively help: possibly more often than the laity, the izinyanga have been faced with the problem of treating a mentally disturbed patient and have not been able to do other than refer the patient to the hospital, which is likely to weaken their belief in their power to help that type of disorder. On the other hand it is curious that the izinyanga are less in favour of the proposition that mental illnesses have increased than the laity; it might have been expected that the izinyanga in the cities would be more likely to meet professionally mentally disturbed people, and through their professional

experience to be readier to diagnose these conditions: on the other hand, an inyanga pointed out that fewer mentally disturbed patients come to an inyanga for help, and that therefore the izinyanga as a group could not judge if there were more or fewer mentally disturbed people. Further, the izinyanga have tended in other sections to minimize psychosocial factors, and though in this section they support explanations on psychosocial terms, they might not relate general psychosocial conditions to illness, because of their general lack of sympathy with these explanations.

Most accounts by the non-izinyanga gave a plurality of causes, some magical and some rational, a typical account of a young, less educated man stating:-

> ".... The causes are worry, bewitching and poverty. It is worse now than it used to be, because there is a lot of frustration and poverty amongst our people; the cost of living is high and yet our people are not earning enough to meet their needs .....".

An inyanga also wove together a plurality of causes:-

> "There are many and varied causes. For example there are some illness caused by worry and by guilt. I had a patient who said he wouldn't go home because his brothers were bewitching him, but really he had deserted his home. I found this out by bone-throwing, but saw that the man was mentally ill and the causes was his guilt ..... Amafufunyane is also a cause ..... and head injury".

The informants who specified bewitching as a cause often described the type of magical means that causes amafufunyane, one of the more interesting symptoms of which being "speaking with tongues"; this was described as

> "caused by certain types of medicines, which if properly mixed make one do the impossible. So an illiterate person will speak English when you know very well that he has never been to school, or speak an Indian language, and when he is over the fit he cannot repeat the language any more. This is caused by mixing medicines with rubbish from where there has been a gathering of Europeans or Indians speaking".

Some informants said that earth from the appopriate grave was used.

The informants who supported the intervention of the izinyanga did not necessarily exclude the treatment by a doctor: there was implicit the view that certain types of mental illness were specifically African disorders, and that these although alleviated by conventional medicine would not be completely cured without the intervention of the inyanga who would get to the deeply underlying causes. One inyanga said that he could diagnose if the patient were mentally ill, and having made his diagnosis he would send the patient to the doctor or hospital, and he stated that the majority of people who consult him about mentally ill patients only bring him aggressive and troublesome patients, or those suffering from amafufunyane who were not cured in hospital.

Many informants (about 50%) gave descriptions of people appearing to be mentally disturbed, who are well-known to wander eccentrically about Durban, and the substantial proportion of informants who agreed that people other than Africans suffer from mental disturbances often stated that all peoples have troubles and frustrations and that it was reasonable to find mental disturbances among all peoples. A few informants pointed out that Indians might be particularly prone to mental illness because they were in the habit of scattering charmed money and of administering medicines, which would mainly affect their own people; there was little support for the view that there are specifically African mental disorders.

Conclusions:-

In general the informants were practical and non-magical in their thinking about mental illness, and were more sympathetic to rational than to magical explanations. On the whole the influence of "western" medicine is marked in the views of informants about the treatment of mental illness, relatively few informants excluding doctors from treatment; the author doubts whether the attribution of mental illness to non-rational

causes is substantially more often than among any group of psychologically lay informants, but was impressed by the sympathy and understanding of many of the izinyanga who might be expected to have defended vigorously explanations in terms of magic because their livelihood is threatened by the encroachment of modern medicine.

Overall Conclusions:-

In the chapter taken as a whole there was a tendency for the izinyanga, the older, less educated and rural informants to hold views of a less rational nature than the younger, better educated and urban informants; there was no marked tendency for males to be distinguishable from females. The laity tended to support explanations in psychosocial terms, and appeared to be more directly influenced by urban pressures and education (with its mildly rationalistic bias), and more sensitive to the changes implicit in the decline of traditional values and their replacement by modern concepts.

CHAPTER SEVEN

DISCUSSION OF RESULTS; CONCLUSIONS

Introduction:-

In the second chapter of this thesis the author described the methodological difficulties that he anticipated, and those that arose during the course of the field work and analysis. He suggested that the difficulties were not unique to the project, but were common to social-psychological studies employing field work, such as Dollard's "Southerntown" study. He argued further, that despite the methodological difficulties, the conclusions of the study were established satisfactorily.

In this chapter, the author discusses further the methodological problems of the research, analyses his results and draws conclusions from them. Specifically the author discusses (1) the methodological problems of the research, how they were met and the degree to which (if at all) he judges his results to be weakened by them; (2) the aims and objects of the research, and the extent to which they have been satisfied; (3) the findings; (4) the broad significance of the project, and (5) its implications for further research.

Section One: Methodology:-

The main causes of the difficulties arising during the research were from the unavoidable problems of rapport, some of which are universal for the field worker, and others of which were exacerbated by the social system and laws of this country. The universal problems were (1) language, and (2) socio-educational barriers. The author was compelled to interview

with the aid of two bilingual (English-Zulu) interpreters, and he was therefore subject to their accuracy, skill, intelligence and integrity. He was faced with the problem that his two interviewers might disagree in the interpretation of some terms, that one or both might infect the protocols with his (or her) standpoint. Unfortunately the author was unable to carry out his intention of having independent checks made of the material, but he was able to compare several versions of concepts obtained by his interviewers with accounts given him by Dr. D.McK. Malcolm, and he found that they corresponded very closely. For example, Dr. Malcolm described at length the Zulu terms "Ithwazi", "Isazelo", "Unembeza" and "Ugovane", which correspond to various aspects of the term "conscience". Although the accounts of his informants varied in their length, clarity, sophistication and definition, there was agreement sufficiently close between Dr. Malcolm's scholarly account and the less-scholarly accounts of the informants to support the supposition that reporting had been accurate and full. It would of course, be more likely that errors would creep into the reporting of accounts of complicated and subtle concepts (such as "conscience") than in reporting simpler notions. The interviewers' accuracy was informally checked by a complete reading of the text by a bilingual (Zulu-English) attorney with both a rural and urban background, who was asked specifically to consider the possibility of a linguistic error or anomaly in the reporting. He suggested for example, that the terms Amafufunyane and Ufufunyane, interpreted as "hysteria", had subtle undertones of meaning: he stated that the former is the more correct form, and that the latter is more often used in the towns by those who wish to refer to the ailment slightingly. The author has unfortunately few formal checks upon the accuracy of the reported material, but he believes that the informal checks above described, and his frequent checking of his interviewers minimized the possibility of substantial error.

It might be argued that the author could have eliminated all but the barest possibility of error, by using a more elaborate and highly structured interview schedule, in which the responses were codified or classified by the interviewer, thus avoiding the clumsiness of translation and the misunderstandings that can arise during conversation. The author considers that his research needed the richest content of response, which could only be obtained by an open-ended schedule; further, where the interviewing is not carried out by the investigator, the more flexible method (to some extent) precludes the loss of significant material that might not have been revealed by a closely systematized schedule, and that a more rigid interview might inhibit the informants from expressing their spontaneous opinions.

The social barriers to rapport cannot be formally evaluated. It is impossible to estimate how deeply the investigator has penetrated the defences of his informants to obtain their full, frank, co-operation and interest. The author intuitively judges that his very wide circle of friendships (and superficial contacts) adequately enabled him to breach the social barriers; he feels that although the research was organized by "a white", a foreigner, of higher social and educational status than most of the informants, the suspicions of the informants were overcome sufficiently to ensure that the information was reasonably accurate. The author was present at five interviews with izinyanga and at some ten with the laity, but even when he was present it was clear to the informant from the introduction to the interview schedule that he was concerned, and the need to allay suspicion and to reduce the danger of obtaining answers that might be conventional (or otherwise) unrevealing to a white investigator still arose. Further, the author has earlier suggested that an advantage of working with interviewer-interpreters drawn from the community among whom the fieldwork is being carried out, is that they appreciate the cultural

assumptions of the informants. The interviewers may be more sensitive than the alien author to nuances of meaning, to the informant's accuracy, intelligence, eagerness to please an investigator, inarticulateness, eccentricity, and similar inhibitions to the accurate expression of opinions.

Objectively to appraise the impact of these difficulties is not easy, but there are two indications that the material is accurate: (1) the consistency of group trends and (2) the extent to which the responses are unstereotyped and do not follow a pattern of, for example, exaggeratedly praising traditional notions, or contrariwise, claiming that traditional notions are moribund.

A striking characteristic of the analyzed results is their consistency and their overall conformity to group trends; the author considers that this suggests that the information was neither capricious nor unreal, but meaningful in the context of the needs of the various groups into which the informants were classified. Analysis of the material revealed that the izinyanga were frequently unanimous, the older, younger, better and less educated, urban and rural, frequently agreed among themselves significantly often, but there were unexpectedly few issues on which the male informants different significantly from the female. It is hardly concievable that the material was so gathered that the statistical analysis produce a given pattern of results; it is no more probable that there was such a careful dissemination of information in answer to the interview schedule that groups could simulate conformity to group trends, particularly as the groups were rarely completely unanimous, and there was a variety of illustration and explanation by informants. Another possibility is that the group trends were consistent because the interviewers had a consistent bias. The author has no means to estimate the extent to which interviewer bias might account for the trends, but considers that this possibility is more remote than that the trends indicate the material was accurate and adequate. The

author believes that the only reasonable way to interpret the group uniformities, is that each of the groups experiences particular social-economic conditions that operate to bring about a more or less marked uniformity of opinion and attitudes.

The izinyanga for example were unanimous in twenty major issues, either supporting or rejecting a proposition, and notwithstanding individual differences of opinion among them or modification of the group norms, they appear as a group to be threatened by certain socio-economic conditions and to be supported by others, and their attitudes and opinions may be determined accordingly. It is a task of the investigator to consider what might be the social pressures and inducements that predispose the izinyanga to hold certain opinions, to reject others, to be doubtful and divided about others, and to differ (or agree) with the laity.

The author was impressed that the informants did not appear to be offering stereotyped, conventional responses, nor did they give answers that might be expected to please the authorities or the author, or that seemed to express some political or religious distortion. One might have been suspicious had all the younger informants unequivocally volunteered the opinion that there was no longer any belief in witchcraft, or if the izinyanga had rejected in toto any but traditional ideas. Groups offered information that they might reasonably have expected to show their society to a disadvantage vis à vis modern notions: some informants confessed to believing some traditional ideas, and (in general) the author did not feel that there was any attempt to present him with a picture that exaggerated the modernity and sophistication of the informants' society, nor that they attempted to minimize the residual legacy of tradition.

Therefore, although the author cannot assert unequivocally that his material is completely accurate, he is confident that the material is

substantially reliable; on the contrary, he senses that it might be unsatisfactory to employ each individual protocol as the basis for a detailed analysis of some attitudes of some Africans, despite the adequacy of the cumulative effect of the uniformity of the interviews to reveal broad, reliable trends.

The author selected the informants to provide (as far as feasible within the limits of his time and assistance) an adequate cross-section of the urban dwelling Africans, and he therefore drew his sample from age, sex, education groups, and from those with varying degrees of rural and urban upbringing and background. He considers that there is no undue preponderence of any group, and that the informants are a wide cross-section of urban Africans.

The sample included both izinyanga and laity, and the author hypothesized that the izinyanga would be a cohesive group, as a class maintaining their support of traditional opinions, attitudes and values more consistently than the laity. The izinyanga were included as a group to contrast with the more modern laity, and unlike the laity tended to be drawn from among narrowly demarcated groups: the older, less educated, rural and male. Table 1 (op cit) shows that the fourteen izinyanga included only one female, two members of 35 years or younger, no member (of the eleven from whom information was obtained) with an education above T.4.; of the eleven for whom rural-urban background was clear, six were urban - a not significant difference from the laity. Although it was hypothesized that a salient characteristic of the izinyanga is their clinging to traditional ways of thought, even they were only partly traditional: in some issues they tended to hold traditional views with small dilution by modern concepts, in other issues they tended to reject traditional views and substitute modern ideas. For example, the izinyanga unanimously rejected the opinion that Illusions should be treated exclusively by a doctor, and un-

animously supported the view that the causes of mental illness are magical. On the contrary, they unanimously supported the theory that brain damage causes physical and/or mental disability, and unanimously supported the proposition that mental illness should be treated by either an inyanga or by a doctor, according to the nature of the illness. In their consideration of brain damage they held modern opinions, but on the last issue their views are ambivalent, including modern and traditional elements. In summing up, the issues about which the izinyanga were unanimous, sketch a core of traditional opinions, and where there was division or they were only nearly-unanimous their traditional concepts were modified by modern ideas.

Possibly there are now almost no completely traditional izinyanga except in the most remote rural areas, and the author has even met at meetings of the (now banned) African National Congress, izangoma (prophetesses) dressed traditionally, and hailing from a remote corner of rural Natal. Although the izinyanga in the author's sample have been influenced to varying degrees by urban life, and are therefore not completely typical of the rural izinyanga, they may be regarded as a group consisting of accepted izinyanga, of partly rural, partly urban background.

The author described earlier the background of the izinyanga, and showed how they had all passed through a conventional period of apprenticeship (save for the woman), and stressed that he was at some pains to exclude from the sample mere herbalists as distinct from those who could diagnose illnesses. The author only included izinyanga who were commonly held to be "genuine" and eliminated those who appeared to be carrying out a business rather than following a vocation. The sample may therefore be regarded as representative, with the possibility that they are, as a group, more urbanized than the average rural izinyanga, who himself is now becoming increasingly influenced by urbanization - as the politically conscious izangoma.

It was thought worth enquiring into the divisions of opinion among the izinyanga, to see if differences by age, sex, etc. might account for divisions of opinion, or to see if there was a non-conformist element among the izinyanga. Unfortunately there proved to be insufficient information to make this enquiry other than impressionistic. It appeared however, that the minority opinion was not always held by the same individuals: the two youngest izinyanga often took a non-traditional position, but sometimes the woman supported tradition and the man supported modernity, and one elderly, rural and barely literate man tended to modify traditional views on many issues and was strongly sympathetic to modern medicine. A rebellious clique was not identifiable.

An unusual feature in the analysis of the data was the comparative scarcity of unclassifiable responses; in some sub-questions there were no unclassifiable or otherwise anomalous responses. In a footnote to Table 2, Chapter 4, the author described his manner of classifying and tabulating the responses: they were divided into "Agree", "Disagree" and "Other Responses".

In the first class were included responses that unequivocally agreed with the proposition expressed in the sub-question; agreement was complete, unqualified and manifest, e.g., the statement that "the brain is made of ubuchopo, ukukhayi and isiphundu. That's what we call them". In the second class were placed responses that did not agree unequivocally with the proposition, either because they flatly rejected it, or because they agreed with it with such qualifications as to suggest that despite the prima facie verbal agreement, the informant was disagreeing rather than agreeing. This occurred in about twenty sub-questions - a very small proportion of the entire number - of which an example is: "I think that you always know what you are doing, and you are always responsible for what you do; but sometimes people are suffering from amafufunyane and are "pushed"

to have fears and behave without control". In this statement there is a *prima facie* rejection of the proposition that Unconscious motivation exists, which is modified by the reference to *amafufunyane*. "Other Responses" were those that the author was unable to classify or understand, and were very few; their rarity was probably because of (1) the form of the interview, and (2) the intensity of involvement of the informants with the interview and the research.

The interview was informal, and within the limits of the interview schedule and the author's instructions and continuing direction, the interviewers were free to obtain the material as they felt was most appropriate. It was sometimes appropriate to end the interview part-way through, and continue later; or to leave a topic to return to it when the informant had remembered what he had wanted to say, or when he had marshalled his throughts; it was sometimes necessary to permit, even encourage a digression that keenly interested the informant, and later to utilize this enthusiasm in the strict application of the interview schedule. By patiently and skillfully interviewing informally the material was drawn insensibly from most informants, a high level of interest was maintained and very few blanks were drawn.

The author does not think that his material is less reliable than information obtained in a loosely structured interview. He was impressed with the interest shown by many informants about the nature of the research project, and by their anxiety to give him as much and as accurate information as they could. Often the sentiment was expressed: "It is so unusual for a "white" to be interested in what we think. I want to do my very best to give you my help", and informants responded to invitations to give examples from their own experience, and patiently repeated unclear information or amplified it, because of their eagerness to assist, and this too reduced the number of unclassifiable responses. The author considers that the

marked group trends, and the richness of individual variation within the trends, supports the assumption that the information was substantially accurate; the author's constant checks upon the interviewing minimize the risks of deception by the interviewers.

But the author appreciates that his partially subjective method of analyzing the material is open to objections, and that other investigators might prefer methods that were more rigorous, even if the material was analyzed to provide less rich but more certainly objective results. The author would be reluctant to trade his subjective, detailed (if not unquestionably reliable) material for more certainly reliable and more subtly quantified material. He feels that a satisfactory balance has been achieved in his methodology between the claims of objective and subjective methods of the collection and handling of data. The author considers that the consistency of group trends and the variability of individual material makes plausible his judgment that the information was accurately recorded, and that no anomalous material has been concealed.

Section Two: Aims and Objects:-

In Chapter 1 the author states that "this thesis is a study of how some Africans living in urban areas conceive certain psychological matters", and he offers the hypothesis that the informants' concepts of psychological topics will vary in levels of sophistication and closeness to modern notions according to the informants' age, sex, education and urbanization.

The author traced his growth of interest in the research problem, and stated that a major root of his interest was his dissatisfaction with psychologists' neglect of the layman's "phenomenal field", and in particularly their neglect of the views of the layman about general psychological

topics. It was felt that no understanding of the layman's "personal frame of reference" is adequate, unless it includes some account of his views about psychological questions, and that an enquiry into the "personal frame of reference" might be expected to reveal socio-economic influences, which (though this was not investigated in this thesis) might relate conceptual changes to changing socio-economic conditions. It is for example reasonable to assume, that the concepts of Africans have moved towards modern and away from traditional ideas as more Africans have come closely into contact with modern conditions of living, in the same way as such a drift of ideology has followed socio-economic change in other societies undergoing industrialization (Mannheim, 1934 and 1957). There is great urgency in this rapidly changing continent to have the most accurate, topical picture of the extent to which modern ideas are irradiating among the lay population, which groups are more (or less) permeable by modern ideas, and what might be the causes for these group differences in permeability. Of course, the author does not consider that Africans are more or less receptive to changing notions than any other section of the population; he confined his investigation to Africans partially because of the exigencies of time and assistance, partially because the Africans are possibly the section of the population who are most eager for change, who display among themselves the widest range of levels of modernity and its lack, and who face the strongest pressures from changing conditions.

The author was content to have few hypotheses, and these were of a low order of generality, because the investigation was exploratory and primarily fact finding: it was an attempt to describe the personal-social frame of reference of a group of psychologically naive informants, to relate this framework to the individual's social group, and thereby to add to our knowledge of some of the specific factors that create this framework. This project was among the first that have methodically attempted to describe

the attitudes of urban Africans, and because of this novelty the author did not wish to complicate the problems of fact finding with the testing of elaborate hypotheses. Nevertheless, he has indicated that certain relationships hold between beliefs and membership of a group, and these relationships no doubt imply some hypothetical sociological framework.

In general the author's aim to explore certain empirical relationships was fulfilled, and there are no major omissions in his overall plan of investigation; he considers further, that despite the qualifications that he has admitted about the methodology, the aims and objects of the project have been satisfied.

Section Three: Discussion of Results:-

In this section the author further discusses the results, and offers possible explanations of some of the group differences. The order of treatment will be: (1) Izinyanga unanimity; (2) Lay unanimity; (3) Issues in which the izinyanga and the laity differ significantly, and (4) Issues in which the laity differ internally.

Overall Summary:-

There were thirty issues in which the izinyanga were unanimous, compared with only five for the laity, and if one were to include the issues in which the izinyanga and laity were nearly-unanimous the disparity would be even more marked. The izinyanga tended therefore more often than the laity to respond as a discrete group. An examination of the unanimous issues suggests that the izinyanga tend to hold traditional and to reject modern ideas, and that the reverse holds for the laity. The izinyanga differ significantly from the laity in fourty-five issues: the laity tending to reject traditional, hereditarian, magical explanations, and the izinyanga tending to support these opinions and to reject the laity's more frequent

reliance upon psychosocial explanations. Among the laity there were ten significant differences between rural and urban informants, four between males and females, fourteen between older and younger, and twenty-four between less and more educated. The disparities between all but males and females would be sharpened if the tabulation were to include near-significant differences. In general: rural, older, less educated informants tended to hold traditional ideas and to reject modern notions, and the reverse held of the urban, younger and better educated.

TABLE 20

ISSUES ON WHICH IZINYANGA ARE COMPLETELY UNANIMOUS IN FAVOUR:
1. Brain is master organ of the body.
2. Brain is divisible and traditionally named.
3. Damage to brain causes physical and/or mental disability.
4. Unconscious motivation exists.
5. Strong personality is a function of status and personal qualities combined.
6. Compulsive thought exists.
7. Compulsive behaviour exists.
8. Illusions may be harmful or beneficial.
9. Illusions exist.
10. There is more indulgence in dagga and alcohol in towns than in the country.
11. The causes of mental illnesses are magical.
12. Mental illness may be treated by an inyanga or a doctor.
ISSUES ON WHICH IZINYANGA ARE COMPLETELY UNANIMOUS AGAINST:
1. The treatment of sleepwalking is medical.
2. Illusions should be treated by a doctor exclusively.
3. Stealing is caused by mental disturbance.
4. The treatment of male homosexuality should be medical.
5. The treatment of female homosexuality should be medical.
6. The treatment of mental deficiency should be medical.
7. Mental illnesses should be treated exclusively by an inyanga.
8. Mental illnesses should be treated exclusively by a doctor.

1) Izinyanga Unanimity:-

Throughout the research the izinyanga tended to support traditional explanations, sometimes invoking bewitching or other magical forces, and tended to be suspicious of explanations in medical and psychological terms. They, for example, unanimously named the brain traditionally (Table 2), attributed mental illnesses to magical causes (Table 19), rejected medical treatment of Illusions (Table 11), of homosexuality (Table 17), and of mental deficiency (Table 18).

There are several factors that combine to encourage the izinyanga to shun modern and cling to traditional opinions, and that contribute to their tendency to think as a group: (1) they are drawn largely from the older men from rural areas, and are not being replaced by younger; they are therefore becoming isolated, increasingly thrown upon each other for sharing professional ideas, and perhaps even for general companionship; (2) they are increasingly faced with the competition of modern medicine, and the success of modern ideas inevitably erodes their confidence in themselves and the power they have to propagate the traditional ideas, and thereby diminishes their influence as the ideological leaders of their society and the champions of tradition, (3) as education (however rudimentary) influences more Africans yearly, so must the izinyanga look old fashioned survivals of a generation the ideas of whom modern, educated men and women wish to discard, because the older ideas have no meaning in the modern world.

The marginal role of the izinyanga (particularly in the town) is strikingly similar to the role of the chiropractor, and like the chiropractor, some part of the tendency of the izinyanga to withdraw into their own group, arises from their "strain in a marginal social role" (Wardwell, 1955). Wardwell compares the role of chiropractor with that of an orthodox

physician, and finds that it is marginal because (1) the chiropractor has a lower degree of technical skill; (2) he is narrower in the scope of his practice; (3) his legal status is inferior to that of a physician; (4) his income is usually lower than that of a physician, and (5) his prestige is lower than that of a physician. The chiropractors attempt to relieve the strain of operating marginally by developing an ideology of an oppressed minority, and holding their principles of medicine on faith, as though they formed a religion or set of principles, held dogmatically and invulnerable to reality. The izinyanga shares all the chiropractor's inferior characteristics compared with the orthodox physician, and the author believes that (to some extent) their beliefs are sufficiently encapsulated to suggest that they hold them dogmatically rather than rationally.

In his study of the urban area of Baumannville, near Durban, Kumalo (1955) analyzes the views of his African informants about the modern role and influence of the izinyanga, and concludes that the inyanga "is on his last legs in Baumannville. Even those who still look up to him for help, watch his performance, not with the traditional faith but with profound scepticism. By others he is categorically rejected". Kumalo explains that this is an inevitable result of urbanization and industrialization: the beliefs that the izinyanga traditionally accepted and that were adequate to explain or interpret the world, or to give practical guidance in the vicissitudes of everyday life in health and disease, are manifestly inadequate in the city. The younger, urban, educated man or women knows that no use of herbs, magical charms or medicines will help him to find or keep employment, to cross safely the road, to avoid arrest for some petty infringement of "The Pass Laws", to prevent the authorities from evicting him from his family plot of land. The izinyanga, tending to draw their clientèle from the older and less educated, probably tend to draw their company from the like-minded older and less educated, nostalgically re-

living the past, and as far as they can, insulating themselves psychologically from the harsh winds of the present. Some extent of the rejection of the izinyanga is given by Kumalo (1955) who made a survey of "The extent of consultation of the doctor, inyanga and ancestors" by 118 respondents: he found that western medicine was exclusively consulted by 22.9% of his informants, an inyanga or the ancestors by 5.1%, and either a doctor or an inyanga or the ancestors by 8.4%.

Kumalo analyzes skillfully the threat to the izinyanga of technological competition and changing ideas of medicine, and ingeniously suggests that many patients will consult the inyanga if they think themselves suffering from diseases caused "psychophysically" or those that are explicable in terms of bewitching or magic. He has devised an illuminating table of "the problem areas of the inyanga and those of either doctor or inyanga", from which it is clear that the inyanga was consulted by his informants mainly to cure traditional complaints: for example, nearly one-third of the complaints were "ufufunyane", a further one-seventh were uthando (a form of love magic), a further one-eighth were umbulelo umeqo (a disease magically caused by placing poisonous medicines along the paths where someone might pass), and in sum about two-thirds of the complaints centered about magical or quasi-magical beliefs. The province of the doctor and/or inyanga was much smaller, and consisted exclusively of physical ailments, which conceivably might be often curable by the administration of appropriate simples. But as the efficacy of medicine to cure psychophysical disorders increases, and as its success becomes more widely known, we can expect the competence of the izinyanga to be adversely compared with that of the doctor, with a consequent diminution of the izinyanga's influence. Already the Child Guidance Centre in Durban is attracting African patients suffering from emotional and behavioural disorders, whose parents would once have consulted the izinyanga. A further erosion of the izinyanga's

traditional position of influence is the appearance of practitioners who have not followed the strict traditional training and apprenticeship, who have no vocation but are izinyanga as a business. The izinyanga have to cling to the purity of their traditional beliefs to minimize their corruption by the imposter-inyanga.

2) Lay Unanimity:-

Compared with the izinyanga the laity were strikingly divided; they were only unanimous about five issues, only one of which was other than trivial: they unanimously rejected the proposition that unconscious motivation is caused exclusively by witchcraft. Even if one were to include the issues on which the laity were nearly-unanimous, they would still be markedly divided compared with the izinyanga.

TABLE 21

ISSUES ON WHICH THE LAITY ARE COMPLETELY UNANIMOUS IN FAVOUR:
1. Brain is master organ of the body. 2. Damage to the brain causes physical and/or mental disability. 3. Inadequate brain development causes mental deficiency.
ISSUES ON WHICH THE LAITY ARE COMPLETELY UNANIMOUS AGAINST:
1. Unconscious motivation is caused exclusively by witchcraft. 2. A father resembles his child.

The laity do not tend as a group to hold opinions in unison, and this is probably due to their far wider range of social background, education, etc., than the izinyanga (and to their fewer numbers). As Table 1 demonstrates, the laity range from the illiterates to university graduates, include both sexes, townspeople and countrymen, and represent all age groups from 90 to 15 years. The laity therefore have been exposed to conditions of

life that differ far more widely than those of the izinyanga, and the younger laity have been particularly sharply faced with the rapidity of socio-economic change. In the space of barely one generation there has been a migration to the towns that in the United Kingdom took more than a century to accomplish; within this period the Africans have speedily become less a rural people and have become increasingly an urban, landless proletariat (Woddis, 1960). Young men and women now go to school, whose parents had no or small opportunity for schooling, and are exposed to a plethora of elementary information of a quasi-rational, quasi-medical kind. Such magazines as "Drum" are rapidly spreading the elements of general knowledge, social, political and medical, and even the highly selective medium of the film and the radio are effective agents of dissemination of information. The increase of urbanization and the volume of information, the passionate interest in education and self-betterment, probably most influences the younger men and women, hence their tendency to rational and psycho-social explanations of behaviour; this tendency for the younger to think among more modern lines and for their elders to be more conservative and guarded accounts for the rarity of unanimity among the laity. It is further possible that the break down of traditional restrictions of thought, coupled with the spread of literacy, has destroyed a tendency towards uniformity of opinion that is more typical of a tradition-directed society than a modern.

3) Izinyanga versus Laity:-

It was earlier suggested that the general tenor of the izinyanga's responses are traditional, magical or quasi-magical, and the laity (on the contrary) tend to be more rational, less magical, and rely more frequently upon psychosocial or naturalistic explanations of behaviour. In forty-five issues the izinyanga and the laity differed significantly, and this large proportion of the results would be markedly augmented by the inclusion of the near-significant differences. The issues are scattered throughout the

TABLE 22

ISSUES ON WHICH IZINYANGA DIFFER SIGNIFICANTLY FROM LAITY

A.	Issues supported by proportionally more izinyanga than laity	
1)	Unconscious motivation caused exclusively by witchcraft.	$p < 0.001$
2)	Strong personality a function of status and personal qualities.	$p < 0.001$
3)	Sleepwalking should be treated by an inyanga.	$p < 0.001$
4)	Causes of compulsive behaviour are magical.	$p < 0.001$
5)	Causes of compulsive thought are magical.	$p < 0.001$
6)	Illusions may be harmful or beneficial.	$p < 0.05$
7)	Illusions should be treated exclusively by an inyanga.	$p < 0.02$
8)	Fears are caused supernaturally.	$p < 0.001$
9)	Treatment of aggression should be educational.	$p < 0.001$
10)	Treatment of aggression should be by an inyanga.	$p < 0.05$
11)	Male homosexuality is incurable.	$p < 0.001$
12)	Female homosexuality is incurable.	$p < 0.01$
13)	Causes of mental illness are physiological.	$p < 0.05$
14)	Causes of mental illness are magical.	$p < 0.02$
15)	Mental illness should be treated by an inyanga or a doctor.	$p < 0.02$
B.	Issues supported by proportionally more laity than izinyanga	
1)	Inadequate brain development causes mental deficiency.	$p < 0.001$
2)	Loss of memory due to psychosocial factors.	$p < 0.001$
3)	Distortion of memory due to mental illness.	$p < 0.001$
4)	"Good" environment is definable and influential.	$p < 0.001$
5)	Physical and personality types are related.	$p < 0.01$
6)	Either parent may resemble the child.	$p < 0.001$
7)	Dreams are natural events.	$p < 0.001$
8)	The "soul" stays in the body during dreaming.	$p < 0.001$
9)	Daydreams are caused by the day's events.	$p < 0.001$
10)	Treatment of sleepwalking should be medical.	$p < 0.001$
11)	Causation of projection is conscious and deliberate.	$p < 0.001$
12)	Causes of compulsive behaviour are psychological.	$p < 0.001$
13)	Causes of compulsive thought are psychological.	$p < 0.05$
14)	Illusions are "natural".	$p < 0.05$
15)	Illusions should be treated exclusively by a doctor.	$p < 0.05$
16)	Fears are caused by psychosocial factors.	$p < 0.01$
17)	Fears are caused by natural or psychosocial factors.	$p < 0.001$
18)	Aggression is due to psychosocial causes.	$p < 0.001$
19)	There is no treatment for aggression.	$p < 0.001$
20)	Stealing is caused by poverty.	$p < 0.02$
21)	Stealing is caused by bad company and temptation.	$p < 0.001$
22)	Stealing is caused by mental disturbance.	$p < 0.05$
23)	Stealing is commoner in town than in the country.	$p < 0.001$
24)	Indulgence in dagga and alcohol is for pleasure.	$p < 0.001$
25)	Indulgence in dagga and alcohol is to escape frustrations.	$p < 0.001$
26)	Suicide is caused by shame or a disturbed mind.	$p < 0.001$
27)	Causes of mental defect are biological, including inbreeding.	$p < 0.001$
28)	Causes of mental defect are hereditary, but not inbreeding.	$p < 0.01$
29)	Mental illnesses have increased.	$p < 0.001$
30)	Peoples other than Africans have mental illnesses.	$p < 0.001$

project, and no particular set of problems tended to attract substantially more significant differences; the cleavage between the izinyanga and the laity appears not to be confined to matters that, for example, are closely connected with magic.

Perhaps the most striking examples of divergencies between izinyanga and laity are in their views of the causation and treatment of anomalous behaviour. For example, the laity significantly more often than the izinyanga support the propositions that, 1) loss of memory is due to psychosocial factors, 2) dreams are natural events, 3) the causes of compulsive thought and compulsive behaviour are psychological, 4) illusions are natural, 5) fears are caused by psychosocial or natural factors, 6) aggression is caused by psychosocial causes, 7) causes of mental defect are biological, 8) suicide is caused by shame or a disturbed mind, 9) the treatment of sleepwalking should be medical, 10) illusions should be treated exclusively by a doctor. On the other hand, the izinyanga significantly more often than the laity supported the propositions that, 1) unconscious motivation is caused exclusively by bewitching, 2) sleepwalking should be treated exclusively by an inyanga, 3) causes of compulsive thought and compulsive behaviour are magical, 4) fears are caused supernaturally, 5) illusions should be treated exclusively by an inyanga, 6) the causes of mental illness are magical. It is interesting that the laity significantly more often than the izinyanga affirmed that mental illnesses have increased, and that peoples other than Africans have mental illnesses.

Broadly the izinyanga hold essentially pessimistic and irrational opinions, rejecting the manifest comparative success of modern medicine, scorning the immediate and major pressures of urban life upon the individual; and in their denying that mental illnesses have increased and that non-Africans suffer from them, the izinyanga are possibly betraying a covert belief that mental disorders are traditionally African in their

nature, causation and treatment. The izinyanga, in their frequent rejection of rational, medical treatment, are pessimistic: despite the laity's rejection of the izinyanga's methods, partially (no doubt) brought about by their failures, the izinyanga cleave to their old fashioned ways.

The author considers that the rift between the izinyanga and the laity is largely attributable to the higher educational level of the laity, and their comparative youth and urbanization. The importance of education and urbanization is that they imply contact with modern ways of thought and behaviour, not only much elementary information and techniques, but pervasive attitudes, and a general style of interpreting the world. The mass-media are "educational" in their power to influence changes of attitudes, and even the pictorial magazines (such as "Drum") may be major agents to form more modern and to discourage traditional attitudes. For example, in "Drum", March 1959, there is a long article headed: "Muti and Sport - it's time to kick out the jujumen!", which described how some African soccer teams employed a "witchdoctor" to treat the team and its equipment magically and bring about victory. The article gives much detail about the unscrupulousness of those managers and "witchdoctors" who encouraged this practice, and ends with the sober comment of the President of a football club that the only "muti" that can produce results is practice. Other issues have carried lengthy exposés of reports about a ghost of a clergyman in Cape Town, and of a female inyanga who claims to heal the mentally disturbed. "Drum" also carries copiously illustrated and persuasively worded quasi scientific recommendations for medicines, advertisements for radios, gramophones, correspondence colleges, banks, etc., and discusses in a matter-of-fact way the many problems that affect the townsman. There is, therefore, in "Drum" alone, for the literate, or even the semi-literate, a wealth of influential material that on the whole is rational rather than magical or mystical, that deals with the problems of today and

has little room for the problems of a rapidly vanishing traditional culture, and moreover brings the reader into contact with the world outside South Africa, often with the other continents.

It is probably the greater contact of the younger and better educated townsmen with the modern world that is responsible for their sharply divergent attitudes from those of the more conservative, more isolated izinyanga. A similar view is held by Mead (1961) in her study of cultural transformations among the Manus of the Admiralty Islands, near New Guinea, who argues that rapid change (in ideas and attitudes as well as in techniques), is both possible and desirable, and that the very fact of entering a world in which there is novelty of material things and of ideas encourages change. The younger, better educated, townsmen are thrust daily into contact with a new and changing environment, and have more incentive to change their traditional attitudes for modern attitudes than the culturally more isolated izinyanga and older, less educated rural people. Mead makes a much neglected point that in the same way that the persistence of traditional patterns of behaviour are a drag on the development of modern patterns, so does the establishment of modern patterns support the development of a broader modernity. Thus the urban dweller (be he African or non-African) has learned the modern pattern of treating pains by employing a patent medicine or consulting a doctor, and no longer often employs traditional recourse to a herbalist or other traditional healer; but each time that the city dweller employs a modern technique and rejects a traditional, he has edged further away from a general acceptance of the traditional ways. Each element of distrust of the traditional ways, makes the hold of the modern ways stronger and that of the traditional weaker, because the pragmatic rationale for the traditional ways is being whittled away.

4) Internal Differences among the Laity:-

(a) Urban versus Rural:-

In ten issues there were significant differences between rural and urban informants, the trends of which were that the urban informants were less sympathetic to magical explanations than the rural, and that the urban informants were more sympathetic to medical treatment.

TABLE 23

ISSUES ON WHICH THE LAITY DIFFER INTERNALLY

A. Issues supported by proportionally more urban than rural laity	
1) Use of anatomical terms to describe the brain.	$p < 0.001$
2) Illusions should be treated exclusively by a doctor.	$p < 0.02$
3) Fears should be treated exclusively by a doctor.	$p < 0.02$
B. Issues supported by proportionally more rural than urban laity	
1) Witchcraft causes unconscious motivation.	$p < 0.001$
2) Dreams are natural events.	$p < 0.01$
3) Causes of sleepwalking are magical.	$p < 0.01$
4) Causation of projection is conscious and deliberate.	$p < 0.01$
5) Causes of mental defect are hereditary.	$p < 0.001$
6) Causes of mental illness are magical.	$p < 0.001$
7) Mental illnesses have increased.	$p < 0.05$

Despite the relatively few cases of significant difference between rural and urban informants, there is clear tendency for the urban informants to hold more modern (and less traditional) views; this tendency is slightly re-enforced by an examination of the nearly-significant results in Tables 4, 5, 8, 10, 11 and 17. Some part of this lack of contrast is because of the frequency with which both rural and urban informants have responded in similar directions, usually a large proportion rejecting the traditional and supporting the modern view; for example, in Table 14, about five-sixths of both rural and urban informants held that stealing is caused by poverty, and in Table 5 about one-third of the rural and one-sixth of

the urban informants believed that bewitching causes bad dreams - a small proportion of both groups, with a nearly-significant difference between them. It is therefore arguable that compared with the izinyanga the laity holds more rational views, and that there is a closer affinity between the rural laity and the izinyanga than between the latter and urban informants.

The author suggests the now familiar explanation that the crucial variable is education, and it is possible that the elements of education have pervaded the laity to such an extent that they are now - rural or urban - sharing many basic, rational, modern, untraditional ideas. It is noteworthy that the izinyanga are more powerful and influential in the country, than in the town.

(b) Male versus Female:-

Unexpectedly in only four issues were there significant differences between male and female informants, and these were not distributed so as to indicate unequivocally if males or females are more traditional or more modern in their opinions.

TABLE 24

ISSUES ON WHICH MALE AND FEMALE LAITY DIFFER

A.	Issues supported by proportionally more male than female laity	
1)	Causes of sleepwalking are natural.	$p < 0.05$
2)	Causes of compulsive thought are psychological.	$p < 0.02$
B.	Issues supported by proportionally more female than male laity	
1)	Bewitching causes unconscious motivation.	$p < 0.001$
2)	Strains of urban life cause indulgence in alcohol and dagga.	$p < 0.05$

This is an unusual finding: females are usually found to be more conservative than males in their attitudes. The issues in which dif-

ferences were demonstrated suggest (but do no more than suggest) that males are slightly more likely to have modern opinions (Table 24).

A possible explanation of this lack of difference is that the informants have a similar cultural background, regardless of their sex, that both sexes are influenced by the rural or by the urban environment, and that both are equally exposed to the influences of elementary education and mass media. Another influence might be the recent and increasing emancipation of African women, who are being thrust into the urban-industrial system as are the men, and who no more than the men find the traditional beliefs inadequate in modern conditions of living.

The findings of Doob (1960) in an investigation of some beliefs of Zulu women (rural and urban) and a comparison of their beliefs with those of men, modify the findings of this thesis. There was a near-significant tendency for rural women more than urban women to say that "Native doctors can treat any disease", and a significant tendency for more of the males to favour this belief than the females in both urban and rural environments. A possible explanation for this reversal of the more-typical conservatism of females is that women (more than men) have experience of taking children and relatives for treatment (which sometimes fails), whereas men might be more inclined to leave matters to the traditional expert.

(c) Younger versus Older:-

In fourteen major issues there were significant differences between the younger and the older informants, and if the near-significant differences were to be included, the disparity would be more marked.

TABLE 25

ISSUES ON WHICH YOUNGER AND OLDER LAITY DIFFER

A.	Issues supported by proportionally more younger (13-35 years) than older (36 and above) laity	
1)	Use of anatomical terms to describe the brain.	$p < 0.001$
2)	Environment influences personality.	$p < 0.01$
3)	Daydreams are caused by the day's events.	$p < 0.01$
4)	Causes of compulsive behaviour are psychological.	$p < 0.01$
5)	Causes of compulsive thought are psychological.	$p < 0.02$
6)	Causes of aggression are biological.	$p < 0.02$
7)	Aggression may be a symptom of mental illness.	$p < 0.05$
8)	Causes of suicide are environmental pressure.	$p < 0.02$
9)	Treatment of male homosexuality is medical.	$p < 0.001$
10)	Causes of mental illness are physiological.	$p < 0.05$
B.	Issues supported by proportionally more older (36 and above) than younger (13-35 years) laity	
1)	Bewitching causes unconscious motivation.	$p < 0.001$
2)	Witchcraft causes bad dreams.	$p < 0.01$
3)	Causes of sleepwalking are magical.	$p < 0.01$
4)	Male homosexuality is incurable.	$p < 0.001$

In general, the older more often expressed opinions indicating a traditionally directed belief in bewitching and a minimizing of psychosocial influences. The younger tended to reject bewitching and other traditional explanations, and to favour psychosocial (Table 25). It is possible that here two variables overlap: the younger informants are more exposed to urban influences and to education, and it may not be feasible to distinguish these two influences. Only during the past twenty years have education and urbanization begun to spread rapidly and widely. Therefore the older informants have had less opportunity than the younger to get a primary education, or to join the growing mass of urban workers. There are still many young people whose education has progressed to the higher primary or secondary level whose parents may be barely literate; and there are many completely urbanized young people whose parents retain some rural ways of thinking and behaving. But education and urbanization, though possibly overlapping, are not equivalent: a comparison of Tables 25 and 26

shows that education more often differentiates groups than does age, and a comparison of both with Table 23, shows that the urban-rural background is less influential than either.

It is generally accepted that the older people are temperamentally more prone to be conservative and unchanging in their wyas than the younger, and this temperamental difference probably strengthens the tendency towards conservatism of the more often rural older men and women.

(d) Less versus More Education:-

In twenty-four issues there were significant differences between informants of differing levels of education, and if one were to include nearly-significant differences, the divergencies would be even more marked.

TABLE 26

ISSUES ON WHICH LESS EDUCATED AND MORE HIGHLY EDUCATED LAITY DIFFER

A.	Issues supported by proportionally less educated (no education to Std. VI) than more highly educated (Std. VII and above) laity	
1)	Bewitching causes unconscious motivation.	$p < 0.001$
2)	Witchcraft causes bad dreams.	$p < 0.001$
3)	Causes of sleepwalking are magical.	$p < 0.05$
4)	Illusions should be treated exclusively by an inyanga.	$p < 0.001$
5)	Fears should be treated exclusively by an inyanga.	$p < 0.001$
6)	There is no appropriate treatment for aggression.	$p < 0.01$
7)	Causes of suicide are bewitching.	$p < 0.01$
B.	Issues supported by proportionally more highly educated (Std. VII and above) than less educated (no education to Std. VI) laity	
1)	Use of anatomical terms to describe the brain.	$p < 0.001$
2)	Environment influences personality.	$p < 0.02$
3)	Daydreams caused by the day's events.	$p < 0.01$
4)	Causes of daydreams are natural.	$p < 0.001$
5)	Treatment of sleepwalking should be medical.	$p < 0.01$
6)	Causes of compulsive behaviour are psychological.	$p < 0.02$
7)	Illusions are natural.	$p < 0.001$
8)	Illusions should be treated exclusively by a doctor.	$p < 0.05$
9)	Fears are caused by natural phenomena.	$p < 0.001$
10)	Fears should be treated exclusively by a doctor.	$p < 0.05$
11)	Causes of aggression are biological.	$p < 0.02$
12)	Aggression may be a symptom of mental illness.	$p < 0.05$
13)	Causes of male homosexuality are environmental.	$p < 0.02$
14)	Causes of female homosexuality are "bisexuality".	$p < 0.02$
15)	Treatment of male homosexuality should be medical.	$p < 0.001$
16)	Treatment of female homosexuality should be medical.	$p < 0.001$
17)	Causes of mental illness are physiological.	$p < 0.05$

To summarize: the less educated groups more often believed in bewitching as an explanation of behaviour, relied more upon the inyanga than upon the doctor for treatment, and rejected psychosocial and naturalistic explanations of behaviour. The converse held of the more educated informants, who rejected witchcraft, the power of the inyanga to heal, relied upon psychosocial and naturalistic explanations of behaviour, and tended to be more optimistic than the less educated about the possibility of curing behaviour disorders.

The rationalizing influence of education (even the diluted and distorted "Bantu Education") needs little elaboration, and the thirst for education and literacy of Africans is no less well documented. Some of the influences of education have already been discussed in the author's analysis of the reasons for the divergence between the izinyanga and the laity, it is sufficient here to draw the reader to the differing educational backgrounds of the izinyanga and the laity, and to the striking differences in belief between the two groups.

Section Four: Significance of the Research:-

Among the many invalid myths about Africans held by non-Africans, is that which propagates the belief that the capacity of Africans to change their behaviour, thought and culture is in some way limited, and vis à vis non-Africans inferior. A corollary of this myth is that Africans should be maintained in a "traditional" economic social system for the foreseeable future, because the changing of their attitudes, beliefs, techniques to a more modern form, is disruptive and generates severe personal and social maladjustment. This myth, a part of what Simons (1958) describes as the "evolutionary fallacy", minimizes the extent and the fundamental nature of the changing environment of Africans during the past generation, from predominantly tribal to urban or semi-urban, or industrialized.

The author believes that the most important conclusion of his research is the further evidence it offers to disprove the belief in the "fixity" of the Africans' attitudes and beliefs, and to confirm the view that Africans are no different from non-Africans in their capacity to change and to adapt to altering conditions of living. He further believes that it is probable that the changing of attitudes is not lip service but an indication of the day-to-day detail of their lives.

This judgment is supported by the investigations of Biesheuvel whose views have moved far from a pessimistic, conservative appraisal of the ability of Africans to change. Biesheuvel (1956) talked of "the historic apathy of African peoples", their "static cultural life" that made them "highly resistant to change", and concluded that various environmental factors would for many generations to come make modernization of beliefs and attitudes of Africans a difficult task. Biesheuvel, has to a large extent changed his view, and recently wrote that:-

> "Educated Africans have a thorough appreciation of the moral and legal codes of western culture in South Africa. They wholeheartedly identify themselves with both ethical and religious values, except in such matters as man's natural needs and belief in witchcraft, where traditional attitudes tend to persist" (Biesheuvel, 1959).

In his earlier paper Biesheuvel was concerned with African peoples regarded globally, and failed to allow for the wide levels of education and urbanization-industrialization that existed even in 1956; he further omitted to give weight to the very active and considerable struggle of Africans to obtain education and basic economic rights (see Woddis, 1960). Biesheuvel appears to have shifted his ground, and admits freely that the educated African (if none other) has modern attitudes. The implication of Biesheuvel's finding appears to be that education is a highly important variable inducing attitude change, and that it can counteract the retarding influences that Biesheuvel claimed earlier to exist. The author welcomes

even partial support, but considers that his findings qualify and extend those of Biesheuvel. The author considers that the alleged belief in bewitching is as residual as, and means little more than, the non-African's reluctance to walk beneath a ladder, of the non-African's interest in horoscopes, fortune tellers or the magic of differences in skin colour. Further, the author's research suggests that, although the major trends towards modernity were among the more educated and the younger informants, this trend was by no means confined to them.

The author believes that the official policy of pretending that Africans are traditional in their values, attitudes and beliefs, and that they are correspondingly less modern, is not substantiated; there is support for the author's opinion even in the ambivalent propaganda material issued by the Department of Information. A typical issue of Bantu (May, 1962) depicted Africans in tribal dress, carrying out tribal traditions and customs, and carried an article (of a kind commonly found in Bantu) seeking to demonstrate the extent of "The adaptation of the Bantu in Industry".

A further significance of the research is that the attempt to bring about changes in the values and attitudes of African communities, should not be mediated through the traditional leaders such as the elders, chiefs or izinyanga: the traditional leaders are more conservative and more resistant to change than the younger and better educated. In planning for example a new drainage scheme or attempting to increase school attendance, it would be more effective to arouse the interest and sympathy of the younger and better educated, who are more amenable to new ideas and probably have already a larger fund of information and enthusiasm than their less educated elders. Some support for this hypothesis is found in the failure of government attempts to persuade certain rural peoples to accept a form of government that would revive a tribalism that is no longer of functional significance to them. Despite the efforts of the government

to enlist the support of the elders, chiefs and other traditional leaders, resistance is vigorous: the traditional tribal culture and its values are alien to the younger Africans, whose lives, even in the remote Transkei or Tembuland, are influenced by what happens in the towns and who do not wish to retreat to tribalism. The traditional media of social direction have vanished, as the traditions have ceased to be meaningful. Other traditions and other media are now influential, demanding modern modes of persuasion. The traditional leaders of opinion have lost their traditional roles, and have been replaced by others of a different status in the different context of urban life.

Throughout the research the author has stressed the major influences of education and urbanization in forming opinion; therefore, if it be sincere public policy to assist and encourage Africans to become a more fully modern-thinking people, then education and industrialization should be energetically fostered. This, of course implies that the education operates from fundamentally modern values. It is interesting that despite the inferior quality of "Bantu Education" with its tendency towards praising traditional, tribal values, the general trend towards modernity seems not to have ceased or even markedly slowed, and the younger informants who have spent some or all of their schooling under "Bantu Education", show no return to traditional beliefs. In a policy statement, the "Minister for Native Affairs" in 1954 stated with brutal clarity that "Bantu Education" was designed (1) to inculcate in African children an acceptance of apartheid, and their exclusion from all but semi-skilled or unskilled labour in the towns, and (2) provide an education that was firmly rooted in traditional "Bantu" society (Verwoerd, 1959). It seems clear that "Bantu Education" is split in its orientation, and that despite the overall flavour of antiquated tribalism and traditionalism, there is being taught some modern techniques of thought and behaviour; although the children are

taught to revere the Chief (or some urban fascimile of him), they are also taught basic skills and, for example, elementary hygiene. The general effect of "Bantu Education" is not exclusively to foster traditionalism, but cannot avoid the spreading of modern ideas and the erosion of traditional.

The author has been impressed that despite the social and physical isolation of Africans, which exacerbate their lack of cultural privileges, contact is maintained with the modern world, and the activity of "locations" is modern rather than traditional. Although of course, beer may be brewed in the traditional manner, dances, concerts, sports, film shows, voluntary and charitable organizations flourish in the townships, despite the almost crippling financial and material disadvantages with which organizers have to contend. It seems that the values and ideas generated in, say, Lamontville, are modern rather than traditional, and that were the physical isolation and the general lack of privileges and rights to be relieved, a complete assimilation of modern ideas would occur. Other unacknowledged quasi-educational agencies are the mass media such as newspapers, and the author again concludes that literacy, of even the barest minimum, is a mild prophylactic against basic ignorance.

Section Five: Indications for Further Research:-

The author confined his research to (1) a few fundamental psychological concepts, and (2) informants drawn mainly from one urban area. Further research should include a wider range, and perhaps a more specialized series of concepts, and be extended to other populations.

(1) The author suggests that other concepts to be investigated might include the causation and treatment of illness; moral and ethical attitudes and beliefs, their description and how they are inculcated into the growing child; the lay diagnoses of emotional maladjustment and indications for its treatment. It would also be useful to investigate the infor-

mants' concepts of, and attitudes towards, socio-economic change: whether they think that change is faster now than in their parents' time, what are changing fastest, has city life increased the rate of change. How does the rate of change affect the way that informants think about basic psychological concepts, for example, the role of environment in determining personality? A drawback of questionnaire research is that the attitudes expressed might not be reflected in the daily life of the informants: research could be carried out to investigate who consults the izinyanga, whom the clinic or doctor, and about what ailments (vide Kumalo, 1955).

(2) The author considers that his research (or extensions of it), should be administered to other social groups, cross-culturally (matching comparable educational groups) and among Africans. It would be valuable, for example, to compare the modernity of recently rural Afrikaaners with comparable Africans. It would be further useful to know whether the rate of modernity is substantially different in the larger cities from the smaller, and compared with the changes in the rural areas; and the extent to which, and the issues about which, such differences occur. A little explored field is the longitudinal study of an individual who has moved from the country to the city: the patterns of strains and conflicts (and their resolution) at intervals during his town life.

A P P E N D I X A

PSYCHOLOGICAL CONCEPTS : INTERVIEW

I. General introductory comments:-

I am working with a scholar who has many African patients who have troubled minds. Sometimes they are sent to him by the inyanga, and sometimes by their family, and they tell him about the bad thoughts they have in their minds, and he talks about the thoughts with them and helps them to become well again. My friend wants to help his patients as well as he can, and would like your help in telling him what we in Africa believe about people with troubled minds, so that he can understand their problems.

(My friend does not want to take your secrets or your medicines from you, for he respects them; he would be very grateful for your advice).

Like you, my friend knows that African life is changing, and the young people often do not understand the traditional ways and beliefs. He wants to have your help, so that he can write and preserve these beliefs so that people and scholars in the world can read about these beliefs in years to come.

N.B. Bracketed portion for inyangas only.
N.B. Emphasis in last paragraph probably has to be altered for sophisticated subject.

II. General background information:-

a = for inyangas
b = for laymen

a) INYANGAS:-

Sex ..... 'Ethnic' grouping ..... Age .....

Family members and occupation (rural/urban; educational; occupation - mother, father, brothers, sisters); church membership (active or not?)

Inyanga's own family and occupation (rural/urban; eudcational, occupation and aspirations - wife, children); church membership (active or not?)

Inyanga's history: where spent most of life (childhood, adolescence, adult); rural/urban; educational; other occupation?

How long been an inyanga?
Where/what training as an inyanga?

Why became an inyanga?
Were family willing/unwilling?

Ever had patients with complaints of being troubled in mind? e.gs. What did you do about this?

Ever advised a patient with a troubled mind to see a 'European' doctor?
Why did you not treat patient yourself?
What results from treatment?

Which European methods do you think are satisfactory? For what ailments?

Are there African illnesses of the mind that 'western' medicine cannot treat?
Could you give examples, from your own experience or from what you know?

b) LAYMEN:-

Sex ..... 'Ethnic'grouping..... Age .....

Family members and occupation (rural/urban; education; occupation - mother, father, brothers, sisters); church membership (active or not?)

Subject's own family and occupation (rural/urban; education; occupation and aspirations -- wife, children); church membership (active or not?)

Subject's history: where spent most of life (childhood, adolescence, adult); rural/urban; educational, occupation and aspirations?

Background information:-

1. Ever had in family a member sick in mind? What did you think the cause? What did he/she do?

2. What did you do about it?

3. What was the result? O.K. now?

4. Ever heard of such a thing happening in your community, to neighbours?

5. Do you think this happens among 'Europeans', 'Indians', 'Coloureds'? Could you give examples?

6. What usually causes illnesses of the mind? Worse than when you were young? Different now from when you were young? Why is this? Examples?

7. Can a 'European' doctor help sick minds? (ref. Question 1). If not, what should you do?

8. Have you ever gone to a wise woman, inyanga, priest, to seek advice for someone sick in mind? What did he/she do? What result?

9. Do you know any stories in your community about people sick in mind? Examples?

10. Can bad dreams, bad thoughts, make a person sick in mind? What should one do?

III. Epistomological:-

1. Conscious-Unconscious:- Do people always know why they do things, and think things? Children cf. adults? Males cf. females?

   Yes - What makes you think that they do know? How do you know?
   No - What makes you think they don't? e.g. age, sex, sickness of mind, bewitching.

2. Despair-Suicide:- What circumstances cause people to kill themselves? Is despair ever a cause? e.g. sex and frustration, faithfulness of spouse, shame or disgrace.

   Men more/less than women? Age? Bewitched to do this? Amafufunyana?

3. Drug taking:- Why do people take dagga/alcohol? What type of people? e.g. bad/wicked people? Sick in mind? More or fewer than in olden times? Strain of urban life?

4. Fears:- What sort of things cause fear in people? Age? Sex? Education?

5. Heredity and Environment:- What of things (personality characteristics) are passed from generation to generation? What effect has environment on people? On children? Is there such a thing as a good/bad environment? What is this?

6. Illusions:- Is it possible that some people can see things that others do not see? e.g. fairies, visions. What causes this? What 'cures' this? Can 'western' medicine cure this; in what circumstances? Are illusions good/bad, e.g.'s?

   Does the seeing of illusions depend upon age, sex, education, town/country - why, what manner?

7. Memory:- i) Loss of
   ii) Distortion

   i) Do people ever lose their memories? What causes this? Can it be cured? How? What sort of things do people remember? What sort of things do people forget?

      Repressed bad memories. Restored memory. Improved memory. Sign of mental sickness?

   ii) Do people ever remember things wrongly, when others can remember them well? What causes this? What cures this?

8. Mental Defect:- Are there people who seem to be of very low intelligence? How do you know they are? What do they do? What are the causes? How do you cope with them? Is there a social stigma attached to mental defect? - to the individual? to the parents? to the family?

   Is this connected with inbreeding? How? Can purification against the inbreeding be used? (Isilima is ? Isiphoxo is ?)

9. Brain and Cortex:- What does the brain do? What do different parts of the brain do? (N.B. Sketch to make quite clear). What are the effects of damage to different parts of the brain? (N.B. Sketch to make quite clear). Distinguish mental illness arising from i) damaga, ii) inadequate development.

10. Obsessions, Compulsions:-

i) Does it sometimes happen that people do things that they themselves are not aware of consciously wanting to do? Can you give examples of this? Has it ever happened to you or someone in your family or a friend? What is it caused by? Is it ever a sign of mental illness? EG's. What is then its cause?

ii) Does it sometimes happen that people think about things that they themselves do not consciously want to think about? Can you give examples? Has it ever happened to you or to someone in your family or to a friend? What is it caused by? Is it a sign of mental illness? What is then its cause?

E.g. compulsive handwashing, compulsive fears, compulsive thoughts about sex.

11. Personality:- Are there ways of describing a person so that others may know what sort of a person you are talking about? What do you call this sort of description? (Use isitunzi, etc.)

1. Relationship of physical type to personality type;
2. Differences/similarities between a) parents and child; b) child and child (any special peculiarities about twins?)
3. Eccentricity-oddness-strangeness (but not madness): what are forms this might take, what causes this?
4. 'Strong', powerful personality: is this due to status or to personal quality? What personal qualities? (Unogazi or isigqi).

What do subjects understand by Isigqi, Unogazi, Isitwazi?

12. Projection:- Have you heard of people who think others are going to harm them, but really they themselves want to harm others? They claim that others are talking about them, but really they are making mischief. What causes this to happen? Are such people normal? If not, why not?

13. Sexual behaviour, perversions:-

i) Have you ever heard of women who behave like men? What causes this? What should be done about it (if anything)? What is, in fact, done about it? Do you think this sort of behaviour is wrong and immoral? Why?

ii) Have you ever heard of men who behave like women? What causes this? What should be done about it (if anything)? What in fact is done about it? Do you think this sort of behaviour is wrong and immoral? Why?

iii) Have you heard of women who seem only to love women? What causes this? What should be done about it (if anything)? What <u>is</u>, in fact, done about it? Do you think this sort of behaviour is wrong and immoral? Why?

iv) Have you heard of men who seem only to love other men? What causes this? What should be done about it (if anything)? What, in fact, <u>is</u> done about it? Do you think this sort of behaviour is wrong and immoral? Why?

14. <u>Sleepwalking:-</u> Have you ever heard of people walking in their sleep? What causes this? What should be done about it? Is this a sign ever of mental illness? Children cf. adults.

15. <u>Dreams:-</u> People often have dreams at night? What is the cause of dreams? Do you remember any of your dreams? What do you think is the explanation of them? What happens to the 'soul' when you dream? What do you think is the cause of bad dreams, nightmares?

N.B. I am interested in getting at, if possible, any notion that dreams are wish-fulfilments, and nightmares connected with anxiety.

16. <u>Day dreams:-</u> What is the cause? Do you remember any of your daydreams? What do you think is the explanation of them?

17. <u>Stealing:-</u> Do people always steal because they are in need? What might be some causes of stealing, e.g., naughtiness, compulsion (bewitching, unhappy thoughts), madness? How should stealing be treated? Sex differences? Age differences? Rural/urban differences?

18. <u>Tempers:-</u> Some people have exceptionally bad tempers? What are the causes? What situations might this arise (e.g. frustration situations, bad day with the job so take it out wife at night, sexual frustration)? Is this ever a sign of mental illness or abnormality? Age differences (in case of children does difference kind of early experiences lead to this)? Sex differences? How should this be treated?

IV. <u>From Doke and Vilakazi, from Henderson & Gillespie</u>

This part of the interview is in the nature of trying to construct a dictionary of terms, i.e., the interviewer will try to get from the subject what he understands by a certain word, if he can give other similar words with that meaning, if there is an equivalent for the English term.

1. <u>Aggression:-</u> <u>Aggressive:-</u> Qcweleza; Chwensa; Sangana (or, Sangane); Phambama (or, Phambene).

2. <u>Agitated, excited:-</u> Ukuthukela.

3. <u>Blame, guilt:-</u> Ukusola; Ukuzisola.

4. <u>Hysterical blindness:-</u> (Applies also to other disorders, e.g., 'hand doesn't work') Caused by Umdlinzo.

5. <u>Claustrophobia:-</u> Irrational fear of enclosed spaces.

6. Agaraphobia:- Irrational fear of open spaces.

7. Compulsion:- Compulsion to do evil; causes (bewitching, tokoloshe)

8. Conscience:- Isazelo; Unambeza; Ugovane.

9. Conscious-Unconscious:- Phaphamele; Bona; Qaphala.

10. Delusions:- Only referred to ufufunyana?

11. 'Dense' (i.e., stupid, 'dumb', 'thick':- Words for different degrees. Isithutha; Isiphukuphuku; Isilima; Isiphoxo; Sidunyelwa.

12. Depressed:- Dangele; Danile.

13. Despair:- Dangele.

14. Dissociated:- i.e., emotionally cut off from fellows because of personal preoccupation with some thoughts, problems ..... that are a part of his mental illness. The dissociation is equally from reality; a retreat from real life and its problems. Hlukanisa.

15. Mind, brain:- Divisions, functions of divisions, effect of injuries, effect of maldevelopment. Ingqondo; Ubuchopo; Ukhakhayi.

REFERENCES

ACKERKNECHT, E.H., Problems of primitive medicine. Bull. Hist. Med., 1942, 11, 516-518.

_____ Psychopathology, primitive medicine and primitive culture. Bull. Hist. Med., 1943, 14, 30-67.

BARKER, A., Giving and receiving. London: Faith Press, 1961.

BASCOM, W.R. and HERSKOVITS, M.J., Continuity and change in African cultures. Chicago: University of Chicago Press, 1959.

BERELSON, B., Content analysis. In: LINDZEY, G. (ed.), Handbook of Social Psychology. Cambridge, Mass.: Addison-Wesley, 1956.

BIESHEUVEL, S., The measurement of African attitudes towards European ethical concepts, customs, laws and administration of justice. J. Nat. Inst. Personnel Res., 1955, 6, 5-17.

_____ Further studies on the measurement of attitudes towards western ethical concepts. J. Nat. Inst. Personnel Res., 1959, 7, 141-155.

_____ Aspects of Africa. Series of two lectures given on the Third Programme of the B.B.C. on April 12th and 19th, 1956. Johannesburg, 1956, N.I.P.R.

BRYANT, A.T., The Zulu people. Pietermaritzburg: Shuter and Shooter, 1949.

CALLAWAY, H., Religious systems of the AmaZulu. London: Trübner, 1884.

CAROTHERS, J.E., The African mind in health and disease. Geneva: W.H.O., 1953.

COHN, A.E., Changes in public attitudes to medicine: Historical aspects. Bull. Hist. Med., 1942, 11, 12-36.

COMBS, A.W. and SNYGG, D., Individual behaviour. New York: Harper, 1959.

DOKE, C.M., MALCOLM, D.McK. and SIKAKANA, J.M.A., English and Zulu dictionary. Johannesburg: Witwatersrand University Press, 1958.

DOLLARD, J., Caste and class in a southern town. New York: Doubleday Anchor, 1957.

DOOB, L.W., Becoming more civilized. New Haven: Yale University Press, 1960.

ENGLISH, H.B. and A.C., A comprehensive dictionary of psychological and psychoanalytical terms. New York: Longmans, Green, 1958.

EVANS-PRITCHARD, E.E., Witchcraft, oracles and magic among the Azande. Oxford: Oxford University Press, 1937.

FIELD, M.J., Mental disorder in rural Ghana. J. Mntl. Sci., 1958, 104, 1043-1051.

FIELD, M.J., Search for security: An ethnopsychiatric study of rural Ghana. London: Faber and Faber, 1960.

GOFFMAN, E., The presentation of self in everyday life. New York: Doubleday Anchor, 1959.

HOGGART, R., The uses of literacy. Harmondsworth: Penguin Books, 1958.

HUNTER, M., Reaction to conquest. London: Oxford University Press, 1961.

HUXLEY, E., What future for Africa? Encounter, 1961, 16, No. 6, 8-21.

JACKSON, C.G., The medicine man in Natal. S.A. Jnl. Sci., 1918, 15, 191-204.

JOAD, C.E.M., Guide to modern thought. London: Pan Books, 1948.

KOHLER, M., The Izangoma diviners. Union of South Africa Ethnographic Publications, 1941.

KRECH, D. and CRUTCHFIELD, R.S., Elements of Psychology. New York: Knopf, 1958.

KRIGE, E.J., The social system of the Zulus. Pietermaritzburg: Shuter and Shooter, 1957.

KRIGE, J.D., The social function of witchcraft. Theoria, 1947, 1, 8-21.

KUMALO, C., Religion, medicine and magic. In: HALLENBECK, W.C. (Ed.) The Baumannville community. Durban: University of Natal, 1955 (Mineographed edition).

LAUBSCHER, B.J.F., Sex, custom and psychopathology. London: Routledge and Kegan Paul, 1951.

LEE, S.G., Some Zulu concepts of psychogenic disorder. Jnl. Soc. Res., 1950, 1, 9-19.

_____ Social influences in Zulu dreaming. Jnl. Soc. Psychol., 1958, 47, 265-283.

MAIN, T.F., Perception and ego-function. Brit. Jnl. Med. Psychol., 1958, 31, part 1, 1-8.

MARWICK, M.G., African witchcraft and anxiety load. Theoria, 1948, 2, 115-129.

_____ Another modern anti-witchcraft movement in East Central Africa. Africa, 1950, 20, 100-112.

_____ The continuance of witchcraft beliefs. In: SMITH, P. (ed.). Africa in transition. London: Reinhardt, 1958.

McCORD, J.B., The Zulu witchdoctor and medicine-man. S.A. Jnl. Sci., 1918, 15, 306-318.

MEAD, M., New lives for old. New York: New American Library, 1961.

RADIN, P., Primitive man as a philosopher. New York: Dover Publications, 1957.

RADIN, P., Primitive religion. New York: Dover Publications, 1957.

RIVERS, W.H.R., Medicine, magic and religion. London: Kegan Paul, 1924.

SIEGEL, S., Nonparametric statistics for the behavioral sciences. New York: McGraw Hill, 1956.

SIGERIST, H.E., A history of medicine: Volume 1 - Primitive and archaic medicine. New York: Oxford University Press, 1951.

SIMONS, H.J., Mental disease in Africans: Racial determinism. J. Mntl. Sci., 1958, 104, No. 435, 377-389.

SUMNER, W.G., Folkways. New York: Dover Publications, 1959.

TOOTH, G., Studies in mental illness in the Gold Coast. London: H.M. Stationery Office, 1950.

VERWOERD, H.F., Bantu Education-policy for the immediate future. Pretoria: The Government Printer, 1959.

WARDWELL, W.I., The reducation of strain in a marginal social role. Amer. Jnl. Sociol., 1955, 61, No. 1, 16-25.

WODDIS, J., Africa: the roots of revolt. London: Lawrence and Wishart, 1960.

ABSTRACT OF THESIS

"SOME PSYCHOLOGICAL CONCEPTS OF URBAN AFRICANS, AND THEIR RELATIONSHIP TO AGE, SEX, URBANIZATION AND EDUCATION"

This thesis is an empirical and exploratory study of the views concerning some twenty basic psychological concepts, of 110 Africans mostly living in Lamontville, near Durban. The sample included 14 izinyanga (practitioners of traditional African medicine), and covered a wide range of age, education and urbanization and both sexes. The study attempted to relate the modernity or traditionalism of the informants' views to their age, sex, urbanization and level of education; a specific comparison was made between the izinyanga (as guardians of tradition) and the laity; conflict was noted between traditional and modern ideas, and the full rejection/acceptance of modern/traditional ideas.

The research was carried out by interpreter-interviewers, employing an interview schedule.

The author concluded that the younger, urbanized, better educated informants accepted modern and rejected traditional beliefs significantly more often than the older, rural and less educated; there were more differences between the izinyanga and the laity, between the better and the less educated informants. The izinyanga emerged as the guardians of a much eroded system of traditional beliefs. The laity were markedly less ready to invoke witchcraft or magical explanations of behaviour than were the izinyanga.

The author suggested implications for further research, including longitudinal studies of people coming to the city from the country, the extension of the investigation to a wider range of concepts and to a larger sample of informants.