DIE BEHOUDENDE WAARDE VAN 'N SIN VIR HUMOR

Dit is onvermydelik dat 'n mens daagliks blootgestel word aan baie voorvalle en gebeurtenisse van 'n onaangename en onplesierige aard. Sommige van hierdie dinge wat so met 'n mens gebeur — as gevolg van omstandighede buite jou beheer, maar soms wel ook deur jou eie toedoen — is egter nie net onplesierig van aard nie; dikwels is die gebeure self, of die gevolge daarvan, so ernstig dat dit 'n ongunstige neerslag het op ons geestesgesondheid èn liggaamlike gesondheid.

Tensy 'n mens dus die nodige geesteskrag het om die onberekenbaarheid van die lewe die hoof te bied, kan klein en minder belangrike gebeurtenisse sulke abnormale afmetinge begin aanneem dat ons ontreddende en ongelukkige mense word. Die belangrike vraag in hierdie verband is dus: waaruit bestaan daardie krag en vermoë wat 'n mens in staat stel om altyd op 'n behoudende en geslaagde manier te reageer op die wisselvallighede van die lewe? En verder: is dit 'n krag of vermoë wat aangekweek en doelbewus beoefen kan word?

Die antwoord op hierdie vrae is gelukkig nie te ongunstig nie. Ons kan sonder twyfel verklaar dat 'n sin vir humor eintlik op 'n gesonde graad van emosionele volwassenheid berus — en dit kan wel nagestreef en aangekweek word, selfs al is dit nie altyd 'n maklike taak nie.

In die werklikheid is emosionele volwassenheid 'n eienskap wat nie te algemeen voorkom nie. Daar kan geen twyfel bestaan aan die feit dat die mens oneindig veel vooruitgang gemaak het wat sy *verstandelike* vooruitgang betref nie. Daarvan getuig al die verbasende tegniese uitvindings van die moderne tyd. Maar die maniere waarop die mens toepassing gevind het vir hierdie uitvindings en ontdekkings — die gevoelloosheid en wreedheid van mens teenoor mens, die voortdurende bedreiging van oorlog en die nimmereindigende gewedywer om bewapening, die misbruik van atoomenergie vir doeleindes van vernietiging in plaas van vir die planmatige bestendiging van die lewe op 'n meer blywende en beskaafde vlak — die toepassing wat die mens langs die bogenoemde weë gevind het vir die produkte van sy verstandsarbeid, toon vir ons aan in hoe 'n onrusbarende mate daar nog behoefte bestaan aan emosionele volwassenheid.

Die eienskap van emosionele volwassenheid veronderstel eintlik daardie nodige mate van insig en helderheid van oordeel wat noodsaaklik is by suksesvolle aanpassing. En dit is ook hierdie eienskappe — insig en oordeel — wat aan die grond van 'n gesonde sin vir humor lê.

Maar wat word daar alles ingesluit onder die begrip: 'n sin vir humor? In die eerste plaas veronderstel 'n sin vir humor die vermoë om te kan lag, en veral die vermoë om te kan lag vir 'n mens self. Hierdie vermoë om vir jouself te kan lag, is nie iets wat in die ware sin van die woord by 'n kind voorkom nie. Om hierdie rede kan 'n sin vir humor in verband gebring word met emosionele volwassenheid. So baie mense groei op na die liggaam en na die gees, maar hulle word nooit volwasse wat hul emosionele reaksies betref nie. As daar dan iets met hulle gebeur wat onaangenaam is of wat hulle nie aanstaan nie, verloor hulle hul selfbeheer. Hulle word kwaad en voer dan enigeen van daardie onbesonnenhede uit waaraan mense hulle skuldig maak in oomblikke van woede. Dit skort by hulle aan 'n volwasse reaksiepatroon omdat dit by hulle skort aan 'n sin vir humor.

Iemand met 'n sin vir humor reageer dus nie soos 'n kind nie. Hy sien homself teen die agtergrond van die groter lewe en nie as die middelpunt van die lewe nie. Hy is dus nie oor-belangrik en opgeblase nie. Hy weet wel deeglik wat sy vermoëns is, maar hy is ook bewus van sy tekortkominge. Hy is dus nie die slagoffer van blinde emosies wat opwel uit gevoelens van mislukking en dwarsboming nie. Hy staan aan die roer van sy eie skip. Hy kan die spanning van enige drukte-toestand breek omdat hy daaroor kan lag. Want die vermoë om te lag veronderstel nie net die moontlikheid van vermaak nie. Dit veronderstel die insigvolle belewing van 'n volwasse gees.

Dit bring ons dan by die tweede grondslag van 'n sin vir humor — die besit van 'n ewewigtige gees. Een van die groot gevare waaraan elke mens elke dag blootgestel is, is die neiging om dogmaties te word — die neiging om 'n mens se denke en oordele volgens 'n vasgelegde patroon te laat verloop, ooreenkomstig oordele wat eintlik vooroordele is.

Om 'n beweeglike gees te hê, wat die waarborg kan wees teen verstarring van 'n mens se lewe en ook die waarborg teen die vervelige, die onplesierige, en die swaarwigtige in die lewe, is dit nodig om 'n sin vir die betreklike van die lewe te hê. En 'n sin vir die betreklike van die lewe beteken dat ons in die eerste en laaste instansie ons eie plek as mens in die breër samelewing kan bepaal; dat ons nie oorloop van ons eie waardigheid nie en dat ons ook nie mank gaan aan gebrek aan eiewaarde nie — dat ons met 'n glimlag die grense van ons eie vermoëns ken en erken: dat ons 'n behoudende sin vir humor het.

THE FIRST YEAR OF LIFE OF THE JOHANNESBURG BANTU

II. TRIBAL GROUPS AND NUTRITION

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I recently found retarded physical development in a sample of Bantu infants in Johannesburg.[1] This sample included all 4 main groups of the South African Bantu. From the same population Kahn and Freedman[2] selected a group of privileged Bantu children and found that their physical development was comparable with White samples of American children of good economic background.

Recent studies of growth have emphasized the importance of the environment on the development of infants. Greulich[3] has shown that Japanese children born in California are heavier and taller than those in Japan and comparable with White American children.

It was therefore thought to be of interest to compare the tribes in the sample of Johannesburg Bantu infants, in order to discover if any tribe showed physical superiority while living with other tribes in a similar urban environment.

MATERIAL

During 1957 and 1958, 1,216 Bantu infants of 1 year or under were medically examined and measured. Seventy-one infants were newly born and were delivered in Baragwanath Hospital, situated between Orlando Township and the City of Johannesburg; 475 infants were living in the municipally-controlled Bantu township of Orlando, and 670 babies were living in Alexandra Township, a residential area for Bantu situated about 8 miles from the centre of Johannesburg, but not controlled by the Johannesburg Municipality.

METHODS

1. *Selection of Sample*

Only babies whose exact birth-dates were known were used in the sample, and in no case was the mother's memory relied upon. Twins were excluded.

(*a*) *Newborns*. All the babies were born in Baragwanath Hospital, and were examined within 3 hours of birth. If the baby was considered distressed or sick it was not examined, otherwise consecutive births were examined while the examiner was attending daily at the maternity section of the hospital.

(*b*) *Orlando Township*. The register of births attended by the district midwifery services was used for obtaining accurate birth dates, and for addresses from which to fetch the babies. Appointments were made at the patients' homes and, with a very occasional exception, all the mothers who were approached were willing to attend for examination. The babies were fetched by car from their homes, and returned by car after the examination was complete.

(*c*) *Alexandra Township*. Approximately half these babies were interviewed and examined while voluntarily attending the infant-welfare clinic run by the Alexandra Health Centre and the University Clinic. Birth dates were checked in the register of the clinic's district midwifery service, and from this register the addresses were obtained for the rest of the sample, who were babies fetched from their homes and were not necessarily regular infant-welfare clinic attenders.

2. *The Examination*

All babies were examined, measured and weighed by me personally, with the exception of 64 infants who were seen by another medical officer using the same method and equipment. Items of information from the mothers were obtained by an African graduate assistant using the mothers' own language. These assistants consciously tried to avoid, by tone of voice, suggesting to the mothers that certain information was, or was not, 'approved'.

An attempt was made on purely clinical grounds, without knowledge of tribe or diet, to assess the nutritional status of the baby. Kahn's[4] criteria were chiefly followed:

(*a*) *Excellent nutrition*. Where the clinical state was such that it was considered unlikely that the nutrition of the child could be improved by additions to the diet.

(*b*) *Good nutrition*. Where it was considered that the clinical state might improve with additions to the diet, the nutrition was judged suboptimal.

(*c*) *Fair nutrition*. Where mild signs of malnutrition (atrophic scalp hair, receding hairline at temples, depigmented patches on cheeks, mild cheilosis) and/or rickets were present.

(*d*) *Poor nutrition*. Where (*i*) there were signs of advanced malnutrition (nutritional oedema, nutritional dermatosis, severe muscular wasting); or (*ii*) where the body weight was less than 60% of the expected average weight for length, even though there were no clinical signs of malnutrition (the table of expected average weight for height which was used was given by Evans and MacKeith,[5] adapted from Grandprey's data given in Brenneman's book[6]).

3. *Age and Race*

Age was calculated to the nearest week, midweek cases being assigned alternately to the lesser or greater age. The racial group to which the infant belonged was assessed by allotting the cases according to the language spoken at home; this was not known by the examiner at the time of the examination.

RESULTS

Table I shows the tribal distribution of the babies in the sample, including newborns.

Table II shows the clinical assessment of nutritional status of the sample, excluding newborns. Signs of malnutrition were shown by 13·55%, in that they were classified as 'fair' or 'poor', while 31·22% were classified as 'excellent'.

Table III shows the nutritional assessment of those tribes who were represented in the sample in fairly large numbers. Of these, 13·79% showed signs of malnutrition, and 30·32% were classified as 'excellent'.

Table IV shows the influence of the type of feeding on the nutritional assessment.

Retarded physical development, described more fully elsewhere,[1] was found. The mean stature of the babies was consistently shorter than that in series of American or British White babies. The mean weight of the babies was lighter at birth than that of those in the White series, actually heavier from 4 - 7 weeks, similar thereafter until 3 months of age, and for the rest of the first year lighter.

DISCUSSION

The numbers of babies in each tribe were not sufficient to construct measurement curves for comparison, so the

TABLE I. TRIBAL DISTRIBUTION OF 1,197 BANTU BABIES

Nguni		*Sotho*		*Venda*		*Tsongo*		*Nyasa*		*Kalanga*	
Xhosa	111	Sotho	189	Venda	83	Shangaan	103	Nyasa	3	Kalanga	4
Zulu	369	Chuana	121								
Swazi	17	Pedi	144								
Ndebele	7	Kgatla	46								
Total	504		500		83		103		3		4
% of total	42·11		41·77		6·93		8·60		0·25		0·33

TABLE II. CLINICAL ASSESSMENT OF NUTRITIONAL STATUS OF BABIES UNDER 1 YEAR (SEXES COMBINED)

Excellent		*Good*		*Fair*		*Poor*		*Total*
No.	%	*No.*	%	*No.*	%	*No.*	%	
355	31·22	628	55·23	146	12·84	8	0·71	1,137

TABLE III. NUTRITIONAL ASSESSMENT OF VARIOUS TRIBES

Tribe	*No.*	*Excellent* %	*Good* %	*Fair* %	*Poor* %
Zulu ..	341	30·20	56·60	12·61	0·59
Chuana ..	114	29·82	53·51	15·79	0·88
Pedi ..	139	31·65	51·08	16·55	0·72
Sotho ..	182	31·87	53·30	14·83	0
Shangaan	99	33·33	61·62	4·04	1·01
Venda ..	80	22·50	67·50	8·75	1·25
Xhosa ..	97	29·90	52·58	16·49	1·03
Total ..	1,052	30·32	55·89	13·12	0·67

TABLE IV. RELATIONSHIP OF NUTRITIONAL ASSESSMENT TO TYPE OF FEEDING

	Breast-fed		*Partly breast-fed*		*Artificially fed*		*Total*
	No.	%	*No.*	%	*No.*	%	
Not assessed ..	0	0	3	75·00	1	25·00	4
Excellent ..	113	47·88	104	44·07	19	8·05	236
Good	156	30·77	264	52·07	87	17·16	507
Fair	11	8·87	72	58·06	41	33·06	124
Poor	1	20·00	2	40·00	2	40·00	5
Total	281	32·08	445	50·80	150	17·12	876

clinical assessment of the nutritional state was used. As shown in Table III, there was a marked similarity among the tribes. The X^2 test was applied with the columns 'fair' and 'poor' combined, and $X^2 = 15{\cdot}2288$, showing no statistically significant difference between the nutritional status of the tribal samples in Table III.

In the sample as a whole, nutritional status deteriorated with age, the older babies showing a lesser incidence of excellent nutrition and a greater incidence of objective signs of early malnutrition. The age composition of the various tribes was similar to the sample as a whole.

Type of feeding also affected the nutritional status in the sample as a whole, deprivation of breast milk affecting it adversely (Table IV). In assessing the statistical significance of the relation between type of feeding and nutritional assessment, categories 'good' and 'excellent', and categories 'fair' and 'poor' were combined, and the percentages of each category for each type of feeding were calculated. The 95% confidence limits were applied, and in no case did the limits overlap, showing that the percentages differed significantly. Unfortunately, the incidence of breast feeding in the various tribes could not be compared with the general sample, since there were insufficient data. The finding among the Johannesburg Bantu that breast-fed babies do much better than artificially fed ones is different from recent experience in England. In English samples there is little difference between the weights of breast- and bottle-fed babies in the early months, but later the bottle-fed babies are heavier.[7] Also, Hammond[8] observed no consistent differences up to the age of 1 year between the weight gains of children of the various social classes.

It will be noticed that nutritional-status assessment was made on objective signs in the categories 'fair' and 'poor', but were largely subjective in the categories 'good' and 'excellent'. Many babies whose nutritional status was assessed as 'good' because there were no objective signs of early malnutrition, were felt by the examiner not to warrant this adjective. Such babies may have had the 'first grade malnutrition' of Gómez and his colleagues.[9] Those categorized as 'fair' were babies with borderline undernutrition and would certainly fit into the category of 'first-degree' and many probably into 'second-degree' malnutrition, or would variously be termed as having 'mild protein malnutrition', or 'pre-kwashiorkor'. Such cases have been much less studied than frank kwashiorkor, which is the final stage.

It was not possible during this stage of the research project to carry out serum-protein estimations or other tests to confirm the clinical evidence of early malnutrition. The team working in the Bantu area was anxious to promote goodwill, and getting samples of venous blood was thought likely to antagonize parents. Judging by the acquiescence with which mothers accepted invitations to come for examination, the research clinic had a good name. Early in the investigation, while we were working in Alexandra Township, several women had the macabre thought that when the children were measured on the measuring board it looked as though they were being fitted for coffins. They wondered if it was 'lucky' to come for examination. However, these rumours then seemed to abate, and the mothers, both in Alexandra and Orlando, on the whole seemed to enjoy watching their babies being examined.

The similarity in the nutritional assessment of the various tribes suggests that the factors operating in the retardation of growth in this sample of Johannesburg Bantu infants are not likely to be tribal or racial in origin. Socio-economic factors, with the emphasis on lack of education and the ability to cope with artificial feeding, are probably of great importance.

SUMMARY

The tribal groups in a sample of Bantu infants are compared by assessment of nutritional status, and do not differ significantly from each other. If the nutritional status of the babies on different types of feeding is compared, however, there is a significant difference.

The sample showed retardation of growth and it is concluded that this is unlikely to be the result of racial or tribal factors.

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