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ENVIRONMENT AND MENTAL ILLNESS: A STUDY OF THE EFFECTS OF SOCIAL-ECONOMIC FACTORS IN THE RELAPSE OF THE MENTALLY ILL AT CHAINAMA HILLS HOSPITAL - LUSAKA

BY

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DEDICATION

This thesis is dedicated to my late father, Joachim Moses Mtonga who gave me a lot of encouragement initially. He died on 6th May, 1991, at the time when I was collecting my data.

DECLARATION

I, Rose M. Mtonga, do solemnly declare that this dissertation represents my own work which has not previously been submitted for a degree at this or another university.

Signed ---------Mtonga---------------------

Date ---------18/8/94---------------------

APPROVED

This dissertation of **Ms. Rose M. Mtonga** is approved as fulfilling part of the requirements for the award of the degree of Master of Social Work by the University of Zambia.

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ABSTRACT

There are many factors that have been said to play a part in the cause of mental disorders. However mental illness in Zambia is largely influenced by socio-cultural factors (Msoni, 1990).

Mental Health Services in Zambia were established twenty six years ago but to date, only 20% of the estimated population suffering from mental disorders has been covered. This is due to various reasons such as problems of understanding the disease, identification, treatment and rehabilitation of those affected by mental disorders and many more.

The available records indicate that more people seek psychiatric treatment nowadays than before. In 1962 when the hospital opened only 281 cases were recorded. Over the years more people sought psychiatric treatment and the numbers increased as follows; 1984 fourteen thousand, 1987 eighteen thousand, 1989 eighty two thousand and in 1990 one hundred and eighteen thousand people were treated for various disorders (Annual Mental Health Report).

Frequently, patients who had been previously discharged end up being re-admitted presenting different symptoms from the previous admission or having similar manifestations but in a deteriorated state.

For instance in 1990 total annual admissions were 118,457 of which only 29,485 were new cases but the rest were re-

admissions. The figures show that the number of people seeking treatment for the first time is less than that of those who had been previously treated.

On the basis of the above, it is fair to assume that proper rehabilitation is lacking within the community where patients live after discharge.

The study is an attempt to establish whether socio-economic factors have an effect on the relapse of the mentally ill. This study is also intended to enlighten those who may not understand the problems of mental disorders.

The study is confined to Chainama Hills Hospital and the compounds of Lusaka urban district due to limited resources. It is an exploratory survey with a sampling frame comprising 40 male and female patients in the ratios of 25 to 15 respectively who have been admitted to Chainama Hills Hospital more than six times within the past four years. 40 relatives of patients and 20 professionals added up to make 100 respondents. A simple random sampling technique was used so that every respondent had an equal opportunity of being chosen.

The data was collected by personal interviews using a question guide and also by use of a structured questionnaire to the professionals. Data analysis included the use of percentages, frequency tables and cross-tabulations.

The findings of the study reveal close association between socio-economic factors and frequent relapses of the mentally ill.

In terms of incidence, the findings reveal that 87.5% of the total sample were between 15-35 years while those between 36 to 40 and above years accounted for only 12.5%. This indicates that generally it is the youth that experience more problems of mental disorders.

Secondly, this is due to the fact that 80% of the Zambian population is dominated by the youth. To a large extent the findings have shown that socio-demographic variables contribute to the relapse of the mentally ill.

With regard to public attitudes, it has been confirmed from the findings that social stigma hinders effective rehabilitation. The situation is aggravated by cultural and traditional beliefs about the causes of mental illness. To this effect 47.5% of the relatives sampled indicated that mental illness is caused by witchcraft and magic. On the other hand the majority of the professionals were of the opinion that negligence by relatives caused patients to relapse. 32.5% of the patients sampled also indicated that they relapsed often due to social problems.

As far as rehabilitation is concerned, the professionals cited lack of resources, inadequate staff, lack of clear policies and negative public attitudes as being responsible for hindering effective rehabilitation programmes for the mentally ill.

As a result of the above findings it is recommended that first and foremost effective clear policies regarding the prevention, treatment and rehabilitation of the mentally ill will go a long way in making the public aware of mental health problems. Only then will the public be willing to change attitudes. Secondly, these policies should be backed by large sums of money and material resources to make the programmes a reality.

CHAPTER ONE

INTRODUCTION

Mental illness is widely regarded to be caused by various factors which can be organic, genetic,psychological or environmental. Studies in mental disorders began in the nineteenth century in England. The early studies were concerned mainly with the inmates of the lunatic asylums (Clerckly, 1964). The First International Congress in Mental Hygiene which was held in Washington in 1930 brought an impetus to further epidemiological research in mental disorders. Thereafter many more surveys were conducted on the prevalence of mental illness all over the world and by 1959, England and Wales reported that 140,000 hospital beds were occupied by patients with mental disorders.

Despite numerous studies, mental illness remains one of the major health problems.

It is not the intention of the study to discuss the different conditions of mental Illness but for the benefit of the reader, reference will be made to the four major categories. The first category is what is known as organic disorders which may present with cardinal symptoms and these include epilepsy and dementia.

The first category is schizophrenia whose symptoms are essentially based upon disorders of the experience of thought within the individual. Another category is affective disorders which include conditions of mania, depression, anxiety states, phobias etc. Behavioural disorders is the fourth category which include alcoholism, drug abuse and other related conditions.

Although much of the literature is based on surveys and findings found in Western countries, other surveys done in Nigeria, Uganda, Kenya and minor studies done in Zambia have provided a basis for carrying out this study.

In Zambia, mental illness is one of the major public health problems because it is a personal and family tragedy of immense magnitude. Until now there has not been a systematic epidemiological study on major psychotic illnesses in the country but mental health problems have often been overlooked due to lack of understanding for the disease (Msoni, 1989).

The impact of rapid social and economic changes have caused the emergence of a number of psycho-social stresses on the Zambian population. If we were to rely on the available figures it is fair to say that more people seek psychiatric treatment nowadays than before. Despite the extended family system which has to some extent cushioned the sufferings of some mentally ill persons, some have been rejected by their families and have ended up as destitutes (Msoni, 1989).

The lack of developed mental health services has been exercebated by the government's inability to have a clear cut policy on the handling of mental health problems.

The only national policy on mental health care in Zambia is contained in Cap.539 of the Act of the Laws of Zambia which covers the disorders ordinance.
The Act allows for the detention of a suspected mentally disturbed person for a period of two weeks. Within this period, two designated medical officers should examine the patient who may be discharged from the order or be detained for a further period. This Act requires review because people generally victimise those suspected to be mentally ill by signing a detention order on flimsy grounds.

The Alma Ata declaration (1979) stipulates that mental health is a component of Primary Health Care (PHC). There is a deliberate policy currently being strengthened of integrating mental health services in PHC in Zambia.

Hopefully, the community mental health delivery system currently being introduced will help alleviate the unnecessary suffering and improve the quality of life among the mentally ill.

Mental health problems are universal but social cultural factors greatly influence the type of psychiatric symptoms that are manifested and subsequent treatment. For example 'Mashabe' (Spirit possession) is an illness with strong

cultural element.

To a Western trained doctor the symptoms may appear to be hysteria or neurosis.

The socio-cultural background of the `patient' determines the illness behaviour. This state of affairs has necessitated the joint efforts of traditional healers and Western trained doctors in the management of mental illness in Zambia (Msoni, 1990).

Having realised the need to incorporate traditional healers in the treatment of mental disorders, the Zambian government has formalised the Traditional Healers Association of Zambia by registering it with the Ministry of Health.

There are deliberate programmes such as workshops and Seminars for traditional healers and other doctors where conflicts pertaining to procedures and treatment of mental illness are discussed. This is done to strengthen the cooperation between the two cadres whose main aim is to alleviate the suffering of mentally ill persons.

It was not until 1962 that Zambia opened its own national mental hospital called Chainama Hills Hospital. It is the only referral psychiatric hospital with a capacity of 600 beds of which 150 are for forensic patients.

Apart from being a hospital, it is a teaching college for Clinical Officers Psychiatry and Zambia Enrolled Psychiatric Nurses *. Since 1992 the college has been offering Post Basic training in Psychiatry for Clinical Officers and Nurses.

* Note: Clinical Officer is a diploma holder who is able to diagnose, examine, prescribe and treat patients just like a medical doctor.

1.1 STATEMENT OF THE PROBLEM AND RATIONALE

More often patients who had been previously discharged end up being re-admitted presenting different symptoms from the previous admission. This is expected because mental illness is like any physical illness which can recur in ones lifetime.

However, the rate at which patients deteriorate is so rapid after discharge that it becomes a source of concern. For instance, in 1990 the total annual admissions were 118,457 of which only 25% were new cases but the rest were re-admissions. Msoni (1990) attributes the high rate of re-admissions to the impact of rapid social and economic changes that have caused the emergence of numerous psycho-social stresses on the population. On the basis of the above, it seems logical to argue that the environment under which patients live after discharge is not conducive.

The study is intended to assess the extent to which environmental conditions lead to relapse.

There are several reasons why this study is important. First and foremost, it is hoped that the findings will contribute towards the formulation of policies relating to mental health issues in areas of prevention, cure and rehabilitation tailored to the Zambian context. Secondly, the study was designed to enlighten those who may not understand or know the social problems of the mentally ill.

1.2 OBJECTIVES OF THE STUDY AND HYPOTHESES

The major objective of the study was to identify socio-economic factors in the environment and assess the extent to which they lead to the relapse of the mentally ill. Secondly, the study aimed at exploring cultural beliefs as they relate to mental illness and how these contribute to an unconducive environment.

With the above objectives in mind, the following assumptions were made:

i. Socio-economic factors lead to society's negative attitudes towards the mentally ill;

ii. Socio-economic factors, contribute to lack of rehabilitation; and

iii. Lack of rehabilitation contributes to the relapse of the mentally ill.

1.3 THEORETICAL FRAMEWORK

The theoretical foundation for this study was the social systems theory. Whittaker (1974) defines a system as an assemblage of things connected to form a complex whole.

He contends that any system has a boundary and therefore an open system is ideal essentially for the system's continuity and change. The focus is placed on interaction hence it becomes necessary for a system to receive inputs and send out output for survival. In this connection an individual is viewed as a participant in the various

interacting groups.

This includes sick individuals as well as others within their systems. This approach draws our attention to the communication and interaction which take place between individuals and their system within and outside the boundary. The emphasis is on maintaining the whole system through striking a balance and harmonizing the relationship.

As regards the above, mental patients live as participants in a number of interacting and interdependent dynamic social systems. For example, a bit of interaction goes on between the patient and his family, employers, neighbours and the larger community. As a result of such interactions patients get affected by the change in behaviour of the other systems. The assumption is that most of the transactions experienced by the patient are degrading, isolative and/or stigmatizing.

Hence patients develop poor self-image and sense of hopelessness leading to a relapse. The cause of the relapse leading to admission can be said to have been determined by the environment.

Coleman (1967) proposes that the concept of social systems enables us explore not only the mental patient as an individual but also what takes place at the interfaces between him and the various social systems if we have to plan for

effective aftercare. Therefore the study dealt with various social systems and their effect on the relapse of the mentally ill.

1.4 OPERATIONAL DEFINITIONS

Mentally ill, in this study, refers to those patients receiving treatment at the out patient psychiatric unit in the category of acute and mild cases which are maintained on regular medication and also have the potential for rehabilitation.

Socio-economic factors include income of patients, area of residence, level of education, employment status, interpersonal relationships indicated by loneliness and isolation, love, acceptance, emotional support indicated by concern for the patients physical and moral requirements.

Relapse refers to a state of returning to the same state or condition as during previous admission or in a worse condition of deterioration.

Rehabilitation refers to awareness by patient and ability to personal hygiene, use of public facilities (such as transport, post office, toilet etc) on their own, family integration, community adaptation and potential for resocialisation, training and employment.

Social Stigma according to Goffman (1963) refers to the negative perceptions and behaviours of the so called normal people to all individuals who are different from them.

However in this study the concept refers to fear, resentment, rejection, discrimination, lack of understanding and tolerance toward the mentally ill.

Employment in this study refers to productive economic activity in the formal and informal sector. Unemployment refers to absence of productive economic activity for income. Youth in this study refers to those between the age of 15 to 35 years.

1.5 RESEARCH DESIGN

Methodology

This study used an exploratory survey method because the study intended to assess general understanding of the population on mental health issues and their attitudes. Secondly, there is no evidence that a study of this nature has been conducted before in Zambia.

Sample Size and Sampling Techniques

The sampling frame comprised male and female patients from Chainama Hills Hospital seen between 1985-1989. These patients were chosen among those who had been admitted more than six times within four years. (Note that this period does not have any special significance).

Their mental state is in the category of mild i.e. those who are maintained on regular medication and have potential for rehabilitation as defined by case workers. Apart from patients, relatives and professionals were also interviewed.

Relatives of patients were either heads of households, spouses or significant others who had direct responsibility over the patient. Professionals comprised those that dealt with diagnosis, treatment, nursing and rehabilitation of patients at the hospital.

A simple random sampling technique was used so that every respondent would have an equal chance of being selected. The number of patients appears small but it was intended to have an indepth knowledge of psycho-social situation of the mentally ill. 40 patients in the ratio of 25 males to 15 females from the admission register were chosen, 40 relatives and 20 professionals made up the sample of 100. The criterion used for selecting an equal number of patients and relatives was to compare the views of the patients with those of their relatives.

The breakdown of professionals is as follows:

Profession	Number	Comments
Doctors	2	50% of the total establishment that time
Clinical Officers	7	35% of the total staff establishment
Social Workers and Occupational Therapists	4	50% of the total staff establishment
Nurses	7	20% of the total establishment

Nature and source of Data

Primary data was obtained from interviews with the sample and secondary data was obtained from official hospital records, books, articles, journals and magazines.

Note:The breakdown of professionals and the percentage have no other significance except of including all groups in the sample.

Manner of Data Collection

The data that were vital to this study were collected by personal interviews using a question guide because the study was aimed at assessing attitudes which the researcher considered to be quite sensitive more especially that a patient had to talk about a person who looks after him. The researcher was aware that patients could hide some information and the relatives could also be defensive in their responses. A structured questionnaire was administered to professionals. The veracity of patient and relatives responses was dealt with by use of qualitative as well as quantitative method of gathering information and counter checking.

Data Analysis

The data analysis included the use of percentages, frequency tables and cross-tabulations.

Limitations of the Study

The setting of the study was limited to Lusaka urban mainly due to limited financial resources that were at the researcher's disposal. The small sample may have profoundly affected the generalisability of the findings to the mentally ill in Zambia.

CHAPTER TWO

LITERATURE REVIEW

According to Richter (1984) mental illness (synonymous to mental handicap, mental retardation, mental deficiency, mental subnormality) implies a permanent impairment of the intellect sufficiently severe to prejudice normal existence in the community. Mental illness is thus a social as well as a medical and psychological concept which reflects both the lack of intelligence of an affected individual and the complexity of the society in which he/she lives.

One of the problems that researchers on the subject of mental disorders face is that of definition and conceptualisation. The problem of definition arises because all behaviours occur within specific group context. Disorders become visible only when one exhibits symptoms that are disturbing and pose a danger to himself/herself as well as others.

David Mechanic (1967) has argued that the social definition predominates in the channelling of patients into psychiatric hospitals because it is the laymen in the community who observe the peculiar behaviour of the sick leading to subsequent admission.

Mechanic contends that the consequences are that often the very sick persons may not receive treatment while the

moderately sick are admitted because selection is based upon social criteria other than psychiatric evaluation. Mechanic, in his study of two hospitals in England for a period of three months, discovered that there was not a case where the psychiatrist advised the patient that he did not need treatment despite the ability to function adequately during psychiatric evaluation.

Conceptualisation of mental disorders has been based upon sociological, psychological and medical models. The medical view seems to obscure important psychological and social processes when it is applied to mental disorders.
This has led to the formulation of other explanations. Sullivan (1953) views mental disorders as a disturbance of interpersonal relations. Another popular psychiatrist Thomas Szasz (1961) argues that mental illness is a myth which has outlived its usefulness in the European community. He contends that psychiatric symptoms reflect man's inability to cope with his environment.

It has been claimed that Carl Berger (1931) was the first to carry out a community based systematic study of the volume of cases in a particular community in England.

In the same year Emerson Harvey carried out a survey which revealed that mental disorders constituted a major public health problem which overshadowed that of physical infectious diseases prevalent at that time (Brown, 1978). Thereafter

many more surveys were conducted on the prevalence of mental disorders all over the world.

However, in 1959, England and Wales reported that 140,000 hospital beds were occupied by patients with mental disorders. By 1979 the total admission of mentally ill persons to hospitals in England and Wales had risen to 180,613 (Davies, 1983). According to Davies studies in England have shown that only a tiny proportion of mental illness is hereditary but the illness is quite common and incidences keep increasing. Davies reported that each year 62,000 persons (125 per 100,000 population in England) who had not been previously treated were being admitted to a mental hospital. This means that many families had some individual who had suffered from mental disorders. This does not however alter the fact that there is still serious stigma attached to this condition.

In India, several epidemiological studies have been carried out and the results reveal that quite a significant proportion of the population is affected by mental disorders (Sethi, 1988).

Although there has not been a systematic epidemiological study on major psychotic illnesses in Zambia, other minor studies indicate that incidences of mental disorders are increasing. Rough estimates show that of the affected population, only 20% has been covered due to inadequate mental health services. Mambwe (1987) found that the youth (those

between 16-35 years in Zambia) account for 80% of the total mental health problems in the country. This seems normal considering the relative small proportion of the elderly in the overall population. Only about 12% elderly people have mental disorders and those below 15 years account for 8%. According to Msoni (1990), mental and neuropsychiatric health problems have often been underestimated. He argues that incidence and prevalence of these mental disorders should not be any different from those found in other countries in Africa.

Social factors are of vital importance in the causation, aggravation and amelioration of mental disorders. De Alarcon (1972) has shown that the social factors are significant predictors of the outcome of major and minor mental disorders. Several investigations have reported on the co-existence of chronic social and psychiatric problems such as social-economic pressures and depressive illness (Steinback, 1965).

This demonstration of the role of social factors in causation of mental disorders suggest that treatment of mental patients is therefore not simply concerned with the relief of symptoms but also with an attempt to control the social factors which may impede social recovery.

In Spain, Seva et.al (1989) found that mental disorders are to a significant degree associated with largely unfavourable social-environmental conditions as well as with

poor levels of social integration in both urban and rural areas. In the United States of America, Birchwell (1969) established that problems of social stress coupled with poor sanitation and congestion are likely to lead to mental illness. In a study carried out by Kulhara and Chandiramani (1988) in India, the results revealed that poor drug intake after discharge poor social support, poor family interaction were attributed to frequent relapses is schizophrenic patients.

In a study by Andrew et.al (1978) in Australia to establish the relationship between clinical and social factors, the findings revealed that life event stress, adverse childhood experiences and poor social support were associated with both physical and psychiatric illnesses.

Crome (1972) contends that all mental disorders have an environmental component. He further argued that recent research has validated the importance of maintaining a health environment for the prevention of mental disorders. Rutter and his associates (1975) carried out a study in England where the results showed that prevalence of mental disorders was high for children who came from homes where there was overcrowding, family disruption and lack of intimacy. Similar conclusions were made by Serpell (1982) in a study of retarded children in Zambia.

Throughout history attitudes towards the mentally disturbed have remained unfavourable. Osei-Hwedie (1989) contends that one major obstacle in trying to help people with mental disability lies in society's negative attitudes. For a long time, the mentally ill have continued to suffer from alienation and discrimination to the extent of being denied meaningful interaction with other societal members.

A study published a few years ago in U.S.A. revealed that out of 21 groups of disabled persons, the mentally disturbed were least preferred (Worrely & Taylor, 1989). Studies have shown that people generally feel that once someone received psychiatric treatment he/she is incapable of functioning normally again (Freeman, 1984: Muya, 1983: Osei-Hwedie, 1989).

They contend that one major obstacle in trying to help people with mental disability lies in society's negative attitudes. For a long time the mentally ill have continued to suffer from alienation and discrimination to the extent of being denied meaningful interaction with other societal members.

Freeman says that, in fact it is a misconception to regard anyone who receives psychiatric help as a mental patient. On the other hand, it is a fact that many of the mentally ill who receive proper and adequate treatment get well and live satisfactory and productive lives (Case Records and caseworkers' Reports).

In a study by Serpell (1982) on retarded children in Zambia, the results showed that not only did the general public avoid social interaction with these children but their parents also showed lack of interest.

Social-cultural factors greatly influence the type of psychiatric symptoms that are manifested and subsequently treated (Msoni, 1989). It is for this reason that traditional healers have been encouraged by the Zambian government to manage types of mental disorders that are culturally related. For example `Mashabe' is an illness behaviour with strong cultural element and an ideal person to manage such cases is a traditional healer.

Mashabe is an illness which is believed to be caused by evil spirits in the Zambian culture; therefore, it is only rituals performed by a traditional healer that can drive away these spirits.

Traditional healers are sometimes very successful in curing mental illness, however, at times they also advise patients to stop taking the medication that they brought home with them from the hospital. As a result some patients relapse due to drug default (Haworth, 1983).

To this effect cooperation between the western trained doctors and traditional healers is being strengthened through Seminars and workshops at which conflicting issues are discussed and resolved.

Studies have shown that it is common practice in African communities that a large majority of people seek traditional treatment for mental disorders before consulting a western trained doctor (Asumi, 1983: Kalumba, 1984: Malepe, 1983: Muya, 1983).

According to Malepe (1983) traditional treatment refer to use of traditional herbs and through rituals and cleansing ceremonies. Once divination occurs to the traditional healer he/she is able to suggest methods of manipulating the environment so that cure is achieved soon.

The African society according to Lambo (1961) does not perceive any recovery from any type of mental illness through conventional psychiatric treatment because the causes are believed to be attributed to supernatural forces and magic.

Mental illness often affects the social adjustment of the individual, his personal friendships and family relations. Therefore effective rehabilitation requires that the mentally disturbed be socially accepted, economically accommodated, properly housed and legally helped whenever necessary (Davies: 420-421, 1983).

In addition the family with a mentally disturbed person has to be supported because of the special strains of having to look after a sick person.

Steinback (1965) came to a conclusion that the loss of employment or the lack of it had a lot to do with the mental

state of a person. In his study unemployment was noted to be the most dominating factor among patients diagnosed with depression in America.

Fear, resentment and rejection are feelings which are all too often experienced by people coming in contact with the mentally ill. Heron (1983) established that because of community and family rejection many patients who need simple support to be able to keep functioning are forced to return to hospital after being discharged or are unable to move on after completing a programme. McMichael (1971) concluded that retarded children in London who attend school for retarded children felt accepted when among other disabled children.

CHAPTER THREE

SOCIO-ECONOMIC FACTORS AND MENTAL ILLNESS

It is generally argued that socio-demographic variables to a significant degree are associated with causation, aggravation and amelioration of mental disorders. The intent of this chapter is to discuss socio-economic factors in relation to mental illness.

Findings

AGE

With respect to age, the study reveals that there are more cases of mental illness between the ages 15 years to 35 years than there is between 36 years to 45 years. These cases are from the sample and not from the overall population. Those below 15 years were deliberately left out in the sample because in terms of occupational rehabilitation and in the normal labour force they are considered to be under age for employment. The table below shows that 72.5% represent those between 15-35 years.

Those above 36 years account for 27.5% of the total sample. These findings have replicated Mambwe's (1987) observations that the youth in Zambia account for 80% of the total mental health problems.

It should be noted that there are several definitions of youth, however, in this study a youth is one who is between 15 to 35 years old

Table 1 AGE OF PATIENT SAMPLE

AGE	NUMBER	PERCENTAGE
15 - 20	6	15%
21 - 25	9	22.5%
26 - 30	8	20%
31 - 35	6	15%
36 - 40	6	15%
41 - 45	2	5%
46 - 50	2	5%
51 - 55	1	2.5%
TOTAL	40	100%

RESIDENTIAL AREA

An overwhelming majority (40%) of the subjects are from self upgraded (high density) areas where houses are very close together with shared social services such as piped water. To those who can afford, electricity has been connected for them and waterborne toilet systems have also been installed although the majority use pit latrines.

Another 30% represent those who live in squatter areas characterised by congestion, lack of proper streets and temporary houses, or huts made of rusty iron sheets, mud or hardboards.
Electricity in such areas is not a common feature although the local authorities have provided piped water. Those living in medium cost areas accounted for 20% of the total sample. This residential area is characterised by well designed and spacious houses built by the local municipal council with electricity and waterborne systems. Streets within those areas are tarred, named and electrified.

The lowest percentage of 10% represented those from low-density areas whose features can be described as luxurious homes with big yards and beautiful security wall fences.

Table 2: RESIDENTIAL AREA

RESIDENTIAL AREA	NUMBER	PERCENTAGE
LOW DENSITY	4	10%
MEDIUM COST	8	20%
SELF UPGRADED	16	40%
SQUATTER	12	30%
TOTAL	40	100%

Level of Education

The table below shows that the semi-literate were represented by 50% which is the highest among the sample. The literate group comprised those who did senior secondary, college and up to university level. These made up 40% while 10% represented those who did not attend school at all.

Since the sample included respondents who had gone as far as post-graduate level as well as those who never went to school at all the definition of literate, semi-literate and illiterate does not match the official social development.

In this paper those who have done nine years in school have been categorised as semi-literate while those from senior secondary school upwards have been categorised as literate

According to the National Policy, literacy refers to the ability to read and write. This was the basis for introducing adult literacy classes but in fact these adults can only read and write in local languages.

Table 3: EDUCATION

LEVEL OF EDUCATION	NUMBER	PERCENTAGE
LITERATE	16	40%
SEMI-LITERATE	20	50%
ILLITERATE	4	10%
TOTAL	40	100%

EMPLOYMENT BY SEX

It is apparent from the table below that 47.5% were employed while 37.5% were unemployed and 15% were retired on medical grounds. Of the employed 35% were male and 12.5% are female. The disparity is due to gender bias which is a normal trend in Zambia.

On the national level statistics show that out of the total labour force 55.1% are male while only 44.1% are female (Labour Force Survey, 1986).

Although the figures show that those in employment are in the majority, in actual fact most of them have been shifted from their careers of specialisation to perform less demanding jobs, (Responses and Case Records 1986 - 91).

Table 4 EMPLOYMENT BY SEX

EMPLOYMENT

MALE	14 35%	5 12.5%	6 15%	25 62.5%
FEMALE	5 12.5%	10 25%	0	15 37.5%
TOTAL	19 47.5%	15 37.5%	6 15%	40 100%

Income

What a mentally disabled person contributes to his survival appears to be important in terms of the respect and acceptability by significant others. The table below shows that 67.5% of the sample have some source of income from formal and informal sector activities.

Females without any source of income account for 25% of the total sample. It is apparent from the table that more males than females have a source of income. This could again be attributed to gender bias.

TABLE 5 SEX BY INCOME

SEX	INCOME		
	DO NOT HAVE INCOME	HAVE INCOME	TOTAL
MALE	3 7.5%	22 55%	25 62.5%
FEMALE	10 25%	15 12.5%	15 17.5%
TOTAL	13 32.5%	17 67.5%	40 100%

DISCUSSION

The general picture in terms of age reveal that most people affected by mental disorders are between 15-40 years old with sharp decreases towards the late 40s and above. The possible reason for such a tendency is due to the fact that over 60% of the Zambian population comprises youths whose needs have not been matched to the social services provided. The absence of proper recreation facilities, unemployment, dropping out of school and inadequate training opportunities

make the youth prone to other activities that society disapprove of. It is such activities such as drug and alcohol intake and other social pressures that would precipitate a state of mental imbalance. With respect to area of residence, there seems to be significant association with prevalence of mental disorders. The findings reveal that the majority of the sample lived in self-upgraded and squatter areas. This is in line with the Birchwell's (1969) findings who argues that problems of social stress coupled with poor sanitation and congestion are likely to lead to mental illness.

It is also fair to classify this category as school drop outs who have to face many challenges just at the onset of adolescence. In the Zambian context the recommended age for enrollment into grade 1 is 7 yrs although some may enter at 6 yrs especially those who attend pre-school. However some start much later due to the limited school places.

Under these circumstances one is expected to complete junior sec. school at the age of 13-17 yrs old giving an average of 15 yrs. At this stage, the process of adolescence is still taking place therefore those who drop out of school are not old enough to cope with the challenges of society in terms of job seeking and eventually leading independent lives. The onset of puberty may not necessarily mean maturation in an individual because in girls for instance, puberty starts at the age of 10 yrs. On the assumption that education is related

to one's career and income, it is reasonable to say that this is not an advantaged group. They are bound to experience worry and anxiety due to increased competition on the labour market.

Income and employment are related variables in that unless one is employed in formal or informal sector income is hard to come by. The findings show that 47.5% of the sample were employed and 67.4% had a source of income. One would ask why the majority in the sample are mentally ill and yet they seem to be economically active and well placed in terms of meeting their basic needs. The reason for this state of affairs is that since they have a mental disability, they have anxieties and worries about maintaining their jobs in order to avoid possible dismissals and retirement from their employers. Another striking findings is that the retired constituted 15% of the total sample.

This category is on a monthly compensation having been retired on medical grounds. Naturally in terms of income this group is in a better position than the unemployed with no source of income.

What is striking is that most of the retired desire to be employed again except that their pleas have been in vain to their former employers (responses and case records). It is difficult to explain this finding except to speculate that it could be due to prestige.

Of the total 67.5% that have income only 12.5% are

females, this can be attributed to the normal trend in Zambia where more males are employed and therefore have income. This does not suggest that females cannot be self-employed, except that in most cases they lack initial capital for starting up a business.

CHAPTER FOUR

SOCIAL STIGMA AND REHABILITATION

The concept of stigma is a social reality that the mentally ill face. For a long time, the mentally ill were treated like or worse than erupting volcanoes-- something to flee from as fast as one can and never look back. According to Goffman (1963) stigma refers to an attribute that is significantly discrediting and a stigmatised person as one who is thought to be not quite human or normal. Mental illness is not recognised as an illness which is curable. Rather it is dreaded, places of treatment are feared and mental patients are rejected when they return to their homes and communities. This in turn makes complete recovery very difficult. Moreover, it is not understood how to prevent it, either in the primary, secondary or tertiary sense of preventing the early symptoms from developing into a serious illness.

This chapter discusses social stigma and it's consequences in rehabilitating the mentally ill.

FINDINGS

EXPERIENCES OF THE MENTALLY ILL

Social stigma has serious consequences for the employment of those being stigmatiseed. Within the context of employment, social stigma refers to those practices which deny rightful opportunities to people who are labelled mentally ill but

could perform in the employment sector.

The table below shows responses to the effect of mental illness on those who were employed. It should be appreciated that mental illness has a tendency of recurring in one's lifetime and the chances of deterioration are quite high. The findings reveal that the majority, 30% of those employed have been shifted to less demanding jobs while only 12.5% have maintained the same jobs. This is an indication that as one deteriorates in the mental state his performance also decreases. However, there is reason for one to believe that such practices are due to lack of tolerance on the part of employers. (To be discussed later in this section).

Those retired on medical grounds were represented by 15%. The general feeling among the respondents was that their employers considered them as hindrances to the organisation's progress.

This is a common assumption among employers although it is also true that one can be incapacitated due to mental illness hence become unproductive.

Table 6: EFFECTS OF ILLNESS ON JOB

EFFECT OF ILLNESS ON JOB	NUMBER	PERCENTAGE
RETIRED ON MEDICAL GROUNDS	6	15%
GIVEN LESS DEMANDING JOB	12	30%
MAINTAINING SAME JOB	5	12.5%
NOT APPLICABLE	17	42.5%
TOTAL	40	100%

Family Support

Lenny (1974) argues that the recovery of a sick individual largely depends on the physical, moral and emotional support given by significant others.

Table 7 below shows responses on whether relatives were supportive to the patients each time he/she was admitted to hospital. The data indicated that a large number (60%) were visited rarely. Another 25% showed that they were visited very often while 15% were never visited.

Table 7 FAMILY SUPPORT

FAMILY STATUS	VISITS VISITED	RARELY	NEVER	TOTAL
SPOUSE	10	4	0	14
	25%	10%		35%
DEPENDANT	0	20	6	26
		50%	15%	65%
TOTAL	10	24	6	40
	25%	60%	15%	100%

Support in this case is interpreted as caring attitude for the patient, provision of necessities , concern for his recovery by taking him for reviews.

Those who were visited rarely, although in the majority, were of the opinion that after several admissions their relatives are no longer anxious about their condition and the treatment.
But there could be other implications such as the cost of travelling to and from the hospital. The 25% that were visited often comprised those who were either heads of households or spouses indicating very close relationships.

Interviews with professionals confirmed that this category

normally harbour guilt feelings for deciding to have their spouse admitted to hospital; therefore they are anxious to see a quick recovery so that the patient is discharged as soon as possible.

Another 15% indicated that they were never visited. It was evident from the findings that more than 50% of discharged patients were being neglected by their relatives through lack of interest and care. Before a patient is finally taken back to his family a lot of negotiations have to be done. One reason for not visiting their sick is that the relatives do not want to be identified with the patient for fear of taking responsibility for him/her.

Reception at home as perceived by Patients

A favourable reception would be indicated by excitement upon seeing the patient from hospital, hugging, greetings and other positive gestures by relatives. On the other hand if relatives showed fear, resentment, suspicions, lack of interest, etc. this would be regarded an unfavourable reception.

In the table below, the data revealed that 55% felt that they were unfavourably received after being discharged. Such findings indicated that the relatives do not realise that it is equally their responsibility to care for the patient when hospitalisation is no longer needed. These findings are in

line with Msoni's (1990) contention that some relatives reject the sick to a point of turning them into destitutes.

Table 8: RECEPTION AT HOME AS PERCEIVED BY PATIENTS

	NUMBER	PERCENTAGE
FAVOURABLE	18	45%
UNFAVOURABLE	22	55%
TOTAL	40	100%

Of the total sample 45% indicated that they were received favourably.

It should be mentioned that according to the responses the majority that formed this group were those from a nuclear/conjugal family set up as opposed to those whose relations were extended. In the extended family system the intensity of obligation tends to fade away as the family circle gets wider. Davies (1983) is of the view that favourable home conditions enhance the patient's quick adaptation and family integration. The findings in his study seems to confirm this view.

Does the Patient Feel Teased in the Community

The table below shows that 57.5% of the total sample felt that they were being teased by the neighbourhood. Of this percentage 35% were male and only 22.5% were female. The disparity could be due to the cultural fact that males interact with a wider circle of people than women who are more or less confined to household chores.

Table 9: DOES THE PATIENT FEEL TEASED BY NEIGHBOURS

FEELING TEASED BY SEX

SEX	YES	NO	NOT SURE	TOTAL
	14	9	2	25
MALE	35%	22.5%	5%	62.5%
	9	5	1	15
FEMALE	22.5%	12.5%	2.5%	37.5%
TOTAL	23	14	3	40
	57.5%	35%	7.5%	100%

The findings on patients' experiences with regard to teasing is supported by McMicheal's (1971) conclusions of retarded children in London when he revealed that children who attend school for retarded children felt accepted when among other disabled children.

Reasons for frequent Relapses by sex

Below is a table showing responses of what patients thought were the reasons for their frequent admissions. It is interesting that a large number represented by 32.5% indicated that social problems were responsible factors for their relapses. Males dominated and accounted for 20% of the 32.5%. This is significant in association with levels of tolerance to stress and pressure between sexes.

One informant (a psychiatrist) during interviews confirmed that females tend to have higher tolerance capacity perhaps because they are allowed to relieve stress through emotional outbursts such as crying.

Table 10: REASONS FOR RELAPSE BY SEX

	DRUG DEFAULT	BEWITCHMENT & SPIRITS	SOCIAL PROBLEMS	DON'T KNOW	TOTAL
	5	5	8	7	25
MALE	12.5%	12.5%	20%	17.5%	62.5%
	3	7	5	0	15
FEMALE	7.5%	17.5%	12.5%		37.5%
	8	12	13	7	40
TOTAL	20%	30%	32.5%	17.5%	100%

Those who believed that they were bewitched and had a conviction of not recovering from their condition represented 30%. This category had more females (17.5%) than males (12.5%). This could indicate that more females suffer from illnesses that are culturally related and of a hysterical type.

Although the difference is marginal considering that the sample was small, it can still be argued that more females suffer from culturally related illnesses if one looks at the symptoms that women manifest from the hospital records (Case Records).

There is another 20% of the total sample that indicated that their relapse was due to drug default. The implications of drug default are associated with shortages of drugs in other care units forcing patients to travel to Chainama Hill Hospital which again brings in the issue of transport costs. Another implication could be fear and shame to go to a psychiatric unit because of the social stigma. There were 17.5% of the total sample who did not know why they relapsed.

Discussion on Patient's Experiences

In an effort to protect the mentally ill from unfair practices there is a procedure for retiring those with mental disorders from the labour force. This is by means of

convening a medical board comprising a committee of 3 medical doctors chaired by a consultant in psychiatry. The Committee has to recommended that one's condition has deteriorated to the point that his/her is no longer productive although there is provision for review at a later date. Despite this procedure, some employers do dismiss employees outright.

It can be deduced from the findings that most work places are simply not accessible to those with a disability when employers have their own criteria. The disabled are judged on the basis of their limitations rather than their potential. It is also true that due to mental illness some patients become incapacitated and therefore become unproductive.

Family support is vital towards the recovery of a sick person. An individual's sick behaviour serves as a message of inner distress and a call for help to other significant persons within the interpersonal milieu. Thus a sick individual's to achievement of integration within the group depends upon the individual's ability to relate appropriately. The foregoing suggests that if we are to understand the mental patient we must first of all understand the situation from which he/she comes from and the circumstances that led to the definition that he/she needed psychiatric treatment.

It is desirable to provide a supportive environment in order to facilitate the patient's adjustment to normal life. With regard to this, the study primarily looked at perceptions

of the patient in this regard.

Generally, the results indicate that patients feel they are victims of public attitudes of fear and dislike. Due to such negative attitudes, it is likely that patients feel oversensitive to what people think about them. Hence the overwhelming 57.5% of the total felt teased.

The patient's responses also indicated that they often feel uneasy and awkward in the community after long periods of hospitalisation.

The responses from patients confirmed that they find it difficult to adjust to life at home because of feelings of inadequacy and lack of confidence. In certain instances, patients reported that the public expected them to be as normal as they were prior to the breakdown which led to admission. As a result patients experienced anxieties and felt demoralised.

Another issue that was raised is that of verbal hostility towards patients. They reported that most times people in their communities referred to patients as `Chainama Cases.' This is the name of the hospital and it appears that the name carries a stigma on those who seek treatment there.

From the total discharges a good proportion are subjected to verbal hospitality. This is evident from the short time they spend home before coming for treatment.

The foregoing are some of the factors that hinder

effective rehabilitation as far as the patients are concerned.

4.1 The community and Mental Illness

In the field of mental health, more than in any field of medicine or human endeavour the blessings of the community are invaluable. This means, the will, the resources and the ability all rests with the community. In the treatment of the mentally ill, professionals always involve the patients relatives because they are the people who have a clear picture of the development of symptoms.

In this study relatives were interviewed to represent views of lay persons and also for the purpose of assessing general understanding of mental illness. It is worth mentioning that the relatives comprised those from nuclear families and extended family who were directly responsible for the patients welfare.

Findings

The table below shows that distribution in terms of relationship to patients i.e whether the relative was close to the patient or he/she was an extended relation. the responses show that 77.5% patients were looked after by their close relatives while 22.5% were regarded as dependants to their relatives.

Table 11: RELATIONSHIP TO PATIENT

	NUMBER	PERCENTAGE
CLOSE RELATIVE*	31	77.5%
DEPENDANT	9	22.5%
TOTAL	40	100%

*Close relative refers to spouse, child, sister and brother.

Reasons for looking after Patient

The study aimed at finding out what motivated relatives to continue looking after their sick. Out of the total sample 85% indicated that it was a family obligation to do so and most of such responses came from those whose relationship was close to the patient. This tendency could explain the sense of obligation within communities where responsibility over needy family members is almost a natural thing to do.
In fact in Zambia the culture dictates such practices. Thus no one has an excuse for deviating from the normal. A small percentage 10% represented those who indicated that among all family members the patient preferred them to any other and they, too, did not mind taking such a responsibility. Those who expressed lack of interest but were obliged were

represented by 5%. What is significant about this group is that the relationship to the patient was not close as defined in this study, i.e. the patient was a dependant.

Table 12: REASONS FOR TAKING RESPONSIBILITY OVER PATIENT BY RELATIONSHIP

	FAMILY OBLIGATION	CHOICE OF PATIENT	NOBODY ELSE EXCEPT ME	TOTAL
CLOSE RELATION	28 70%	3 7.5%	0	31 77.5%
DEPENDANT	6 15%	1 2.5%	2 5%	9 22.5%
TOTAL	34 85%	4 10%	2 5%	40 100%

Encouraging Patient to Resocialise

Davies (1983) suggests that a correctly chosen occupation can do much either to prevent a person developing a mental

disorders or to avoid a relapse. The study focused on whether or not relatives encourage patients to resocialise after discharge.

Resocialisation in this context refers to encouraging personal hygiene, household chores, farming, use of public transport, toilet, postal services and employment. As shown in table 13 below only 27.5% indicated that they encourage patients to be occupied and productive. The possible explanation could be that the community adopts an apathetic attitude towards helping the patient. A significant percentage of 62.5% indicated that they do not encourage the patients to do some work because they felt it was unfair to burden them further. This finding supports the views of professionals who concluded that close relatives to a patient tend to be over protective hence making rehabilitation difficult.

Table 13: ENCOURAGEMENT TO RESOCIALISE * BY RELATIONSHIP

	YES	NO	TOTAL
CLOSE RELATIVE	6	25	31
	14%	62.5%	77.5%
DEPENDANT	9	0	9
	22.5%		22.5%
TOTAL	15	25	40
	37.5%	62.5%	100%

*Resocialise refers to encouraging to be productive and adaptation to normal life.

Causes of Mental Disorders as perceived by community

On the issue of what relatives thought the causes of mental illness were, 47.5% indicated that the illness was caused by magic, witchcraft and spirit possession. These results reveal that the local culture conceptualises mental disorders as originating from supernatural forces.

The findings are along the same lines as those of Lambo et. al. (1983) in a study of the Yoruba in Nigeria. Those who believe that one is born with the disorder constituted 20%.

Another 12.5% of the total sample indicated that mental illness is cased by affective disorders i.e. stress, drugs, alcohol.

This is significant in comparison with the patients responses which accounted for 32.5%. It appears patients are more aware of the stress imposed on them than are the relatives who may be the source of the stress. Those who did not know the causes of mental illness were represented by another 20%. In comparison with patients responses (17.5%) there is not much difference. However the general picture is that many people are still ignorant about the causes of mental illness.

Table 14: CAUSES OF MENTAL ILLNESS AS PERCEIVED BY RELATIVES

CAUSES	NUMBER	PERCENTAGE
BEWITCHMENT, SPIRIT POSSESSION AND MAGIC	19	47.5%
HEREDITY	8	20%
AFFECTIVE FACTORS*	5	12.5%
DON'T KNOW	8	20%
TOTAL	40	100%

* Stress, drugs, alcohol drinking

What is an ideal place for keeping patients as seen by Relatives. According to the responses 47.5% indicated that patients should be confined to mental institutions. 52.5% were of the opinion that patients should be confined when they fall sick and after discharge they should go to their homes.

What is significant is that the literate are expected to understand the concept of shared responsibility and yet out of the total literate sample which was 67.5%, the majority were not ready to look after their sick at home.

Table 15: WHICH PLACE IS BEST FOR PATIENTS AS SEEN BY RELATIVES BY LEVEL OF EDUCATION

	MENTAL INSTITUTIONS	BOTH INSTITUTION AND THEIR HOME	TOTAL
LITERATE	17 42.5%	10 25%	27 67.5%
SEMI-LITERATE	2 5%	8 20%	10 25%
ILLITERATE	0	3 7.5%	3 7.5%
TOTAL	19 47.5%	21 52.5%	40 100%

Discussion

Community mental health care implies that prevention, treatment and rehabilitation of the mentally disabled should be undertaken while he/she is at home.

In Zambia there is emphasis on community involvement in the planning of health services, goal setting and also decision making in order to make the service acceptable and

affordable (Msoni, 1991). The main objective is to promote good mental health through prevention, identification and treatment of mental illness within the community.

The findings suggest that the community still harbour feelings of fear resentment and rejection due to ignorance and cultural beliefs about the causes of mental illness. In terms of rehabilitation, the findings reveal that feelings of guilt, unworthiness, attitudes of underrating patients capabilities and over protection on the part of patients' relatives hinder effective rehabilitation.

4.2 Professionals' Views

Findings

The table below shows the distribution of occupation that are concerned with diagnosis, treatment, nursing and rehabilitation of patients at Chainama Hills Hospital. The professionals interviewed had varying work experience in mental health work. The least experienced were those who had worked for less than five years and the most experienced had worked for more than 15 years in the field of mental health services. Experience is important in terms of focusing what could be the ideal future policies and programmes.

Table 16: OCCUPATION BY SEX OF PROFESSIONALS

	DOCTORS	SOCIAL WORKERS & OCC.THERAPY	CLINICAL OFFICER	NURSING STAFF	TOTAL
MALE	1 5%	2 10%	4 20%	3 15%	10 50%
FEMALE	1 5%	2 10%	3 15%	4 20%	10 50%
TOTAL	2 10%	4 20%	7 35%	7 35%	20 100%

Suitable Rehabilitation

Table 17 shows responses of which type of rehabilitation is appropriate for the mentally ill as perceived by workers of different professional backgrounds. Those who were in favour of community based rehabilitation accounted for 75% of the total sample. Only 25% were of the opinion that suitable rehabilitation is that based on institutions. The findings are in favour of community based programmes. The change in emphasis is believed to encourage communities to appreciate and understand the problems of the mentally ill.

Table 17: SUITABLE REHABILITATION

	NUMBER	PERCENTAGE
COMMUNITY BASED	15	75%
INSTITUTIONAL BASED REHAB	5	25
TOTAL	20	100%

Community Attitudes as perceived by professionals

With respect to how professionals thought of community attitudes towards patients, 75% indicated that the relatives and community were hostile to the mentally ill. Only 25% of the total sample thought that relatives were sympathetic. All the doctors in particular were of the opinion that relatives were sympathetic except that their sympathy is not realised due to some frustration i.e lack of support from other societal members and lack of motivation from the caring institutions. The variance in opinions could also be due to the fact that some professionals deal with the community as much as they deal with the patient. On the other hand doctors and nurses are confined to duties within the ward.

Table 18: COMMUNITY ATTITUDES AS PERCEIVED BY PROFESSIONALS

	HOSTILE	SYMPATHETIC	TOTAL
DOCTORS	0	2 10%	2 10%
CLINICAL OFFICERS	7 35%	0	7 35%
SOCIAL WORKERS & OCC. THERAPIST	4 20%	0	4 20%
NURSING STAFF	4 20%	3 15%	7 35%
TOTAL	15 75%	5 25%	20 100%

Why do patients Relapse so often

According to the data (table 19) 55% were of the opinion that negligency and rejection of patients by their relatives cause frequent relapse. Those who indicated drug default as being the cause accounted for 15% while 30% represented those who indicated that a combination of social problems and drug default were responsible factors.

These findings suggest that the environment has a lot to do with the causation of mental illness. The findings appear to confirm what Chave (1964) established in England that the immediate environment can produce mental illness.

Table 19: WHY DO PATIENTS RELAPSE FREQUENTLY

	REJECTION & NEGLIGENCE	DRUG DEFAULT	BOTH	TOTAL
DOCTORS	0	0	2 10%	2 10%
SOCIAL WORKERS & OCC. THERAPIST	4 20%	0	0	4 20%
CLINICAL OFFICERS	2 10%	1 5%	4 20%	7 35%
NURSING STAFF	5 25%	2 10%	0	7 35%
TOTAL	11 55%	3 15%	6 30%	20 100%

4.2.1 Constraints on Rehabilitation

According to Freeman (1984) there are problems in providing effective care of the mentally disabled because society often assumes that the patients are uncooperative. Rehabilitation centres existing for the mentally ill are what one would refer to as settlement centres because they lack proper programmes. There are precisely only two centres in the country. One is at Nsadzu in the Eastern Province and it is for the chronically ill with no potential for training. The other one is at Kawimbe in the Northern Province. In terms of function this centre needs reorganizing. It is hoped that this centre will emphasize on training skills. The Zambia Council for the handicapped only admits eight patients at its rehabilitation farm.

There are many patients who need rehabilitation but given the limited rehabilitation services only a few are privileged to go through such programmes. As a result many patients who need simple support to be able to keep functioning are forced to return to hospital after being discharged because of community rejection. The few that are able to go through a rehabilitation programme are unable to move on after completion.

Sherperd (1980) says that community psychiatry implies that the community should be responsible for the prevention, treatment and rehabilitation of all mental disorders. The responsibility must actually extend beyond the known causes of mental disorders to the unrecognised cases of current or future disorders to the 0unrecognised cases of current or future disorders in any given population.

The advent of community Mental health in the early 1970s saw the establishment of psychiatric units in all peri-urban clinics in Lusaka region as well as all provincial headquarters in the country.

One objective in community psychiatry services was to facilitate the development of a referral system with a view to improving hospital community liaison. However responses from professionals indicated disappointment that the referral system has not developed due to limited resources.

Lack of equipment, shortage of drugs and transport were cited as the most pressing problems that subject members of staff to work under difficult conditions. Diagnostic and therapeutic procedures used are those that have been outdated, a common feature in third world countries.

The typical situation at Chainama Hills Hospital is that it is usually understaffed in terms of qualified doctors. Meanwhile facilities have never kept abreast of continued population growth and the admission wards are usually overcrowded.

The institution has an establishment of 25 doctors yet at the time of this study, there were only 4 of them. With an average of 341 patients per day, it meant that one doctor had to attend to about 85 patients per ward round each morning. This is besides attending to administrative and lecturing duties since Chainama is also a teaching college.

Due to overcrowding in acute wards, the doctors do not have sufficient time to make proper diagnostic assessment on every patient nor are they equiped for an expeditious screening due to lack of necessary analytical tools. Overcowding is a consequence of common practice at Chainama Hills Hospital to absorb all persons who come to hospital for admission through a detention order. A detention order. A detention order is a legal document obtained from the court signed by a magistrate admitting a person suspected to be mentally ill into a mental hospital for an initial period of

2 weeks subject to renewal without the person's consent.This type of admission is a violation of rights to an individual in that it subjects one into confinement. The implications are that relatives sometimes use detention orders on false allegations so that the patient is admitted and they are relieved of the burden. Thus far are the views of professionals as regards issues of attitudes, care and rehabilitation of the mentally disturbed in the community.

CHAPTER FIVE

SUMMARY AND CONCLUSION

Conventional sociology acknowledge the vital role of socio- economic factors in the causation, aggravation and amelioration of mental disorders. This study dealt particularly with socio-econimic factors in relation to frequent re-admissions of the patients to Chainama Hills Hospital.

The patient sample of the study was chosen at random from a list of those patients who were attending the out patient department after several admissions. These patients had the potential for rehabilitation in terms of both occupational and familial factors. The researcher is aware that a small sample does not allow for broad generalisations. However, it is adequate in highlighting the extent and nature of problems faced by the mentally ill in a given population. This being the case the reader should be made aware of these limitations before conclusions are made.

The main objective of the study was to identify social-economic factors in the environment and assess the extent to which they lead to the relapse of mental patients. Secondly, the study explored cultural beliefs as they relate to mental illness and how these contribute to a less than conducive environment.

The findings revealed that the community at large view mental illness in terms of social-cultural perspective. They believe that mental illness is caused by magic, spirit possession and bewitchment. These beliefs about causes of mental illness cast some doubt about the recovery through conventional medicine. This is the reason why a traditional healer is consulted to treat cases of mental disorders because culturally, the traditional healer is seen as the media and the authority who can communicate with the Gods or spirits. An additional role of a healer is that of witch-hunting.

The relationship between cultural beliefs and mental illness is a negative one in that a mentally disturbed person will be viewed with fear and suspicion due to what society thinks of him as an individual cursed by evil spirits. Such beliefs affect proper treatment in the sense that although patients come to hospital, it appears that they are brought because the community fails to control the violent behaviour. Otherwise society seems to have preconceived ideas about relapses in mental health. There is a possibility that with such attitudes patients cannot be encouraged to attend out-patients psychiatric units for review.

From the findings, social stigma has been established as a factor that surrounds the life of a mentally disturbed person. It is also evident from the findings that work places do not readily accept people with clearly defined mental disorders. Their capabilities are doubted, resulting in massive changes in responsibilities and eventual dismissals.

Interpersonal relations outside work have also revealed that because of the fear of the patients' unpredictable behaviour friends are not willing to associate with them. The general picture that has not come out is that the family and community does not understand the illness as a result they lack tolerance for the awkward behaviour displayed by mental patients.

The socio-economic factor that have been identified and dealt with in the study have highlighted the constraints and their effects on rehabilitation of the mentally ill. Lack of information on mental health and poor hospital-community liason have been said to be factors that hinder smooth running of community programmes. It is essential to have adequate staff, equipment, materials and transport facilities to go round the community. Moral and material support to families with patients will alleviate their burdens and also motivate them towards assisting the patients acquire emotional and physical independence.

Professionals have recommended home visits as an important intervention because it is useful for diagnostic, treatment and supervisory purposes. Home visits enable the worker to assess the enviroment, observe family and other relevant social interactions at first hand and develop fuller understanding of his patient for appropriate treatment planning Nielsen (1963).

The finding have established that as much as people may be aware of existing services, it is difficult to get them due to economic hardships imposed on most Zambians these days such as inflation and transport costs.

Keeping a mental patient idle is torturing an already sick mind; therefore emphasis should be placed on occupying the mental patients. A correctly chosen occupation can do much either to prevent a person developing a mental illness or to avoid a relapse. As observed by professionals, the country lacks proper rehabilitations programmes for the mentally ill, such programmes have not developed mainly due to lack of clear policies regarding the mentally ill.

On the basis of the analysis of this study data has generally estasblished the extent to which socio-economic factors affect the relapse of mental patients. According to Brennan (1989) the environment can produce and alleviate mental disorders. This means that a bad environment is responsible for causing mental disorders while a good environment can prevent its onset.

RECOMMENDATIONS

As a result of this study on the effects of social-economic factors in the relapse of the mentally ill at Chainama Hills Hospital, it is recommended that:

1. In the context of enhancing general understanding of mental illness by the community and changing the negative attitudes of the society at large, first and foremost, the government of Zambia must formulate policies directed towards improving mental health services. For example, the provision of adequate resources to motivate those working in this field to reach out to the community.

2. There is need to intensify mental health education with emphasis on preventive measures. For the prevailing cases, mental health education should aim at removing fears from people's minds so that they consider mental disorders like any other physical condition. Mental healty workers, social workers and Primary Health care personnel should be responsible for dissemination of mental health education at different forms.

3. In order to enhance hospital- community liaison, social workers and public nurses should be given transport facilities so that they intensify home visits in the community.

4. The Ministry of Health should establish day care centres and sheltered workshop within the community and integrate them with other health projects so that social stigma is minimised.

5. The already established Mental Health Resource Centre should be given powers and authority of planning, budgeting and coordination of all mental health services in the country.

6. A policy pronouncement that all mental patients will be regarded like other physically ill patients, that their interest be safeguarded is essential to change attitudes and bias.

7. To attract more young people to take up the challenge in psychiatry, incentives should be given to staff working in psychiatry such as, up to date equipment, availability of drugs, transport facilities,salaries matching with speciality and experience and other allowances.

BIBLIOGRAPHY

1. Achola, P.P.E & Bless, C (1987). Fundamentals of Social Research Methods. An African Approach. University of Zambia.

2. A garwal, A.K. (ed) (1989). Indian Journal of Psychiatry Vol. 31(1).

3. Ari Jiev, (1972) Transcultural Psychiatry. Free Press, New York.

4. Asumi, T. (1973); Existing Concepts of Mental Illness in Different Cultures and Traditional forms of Treatment. Paper presented to W.H.O. Seminar in Addis-Ababa.

5. Annual Mental Health Report 1962, 1984, 1090.

6. Barofsky, J. & Connelly, D. (1983). The Chronic Patient in the Community. M.T.P. Press Ltd., London.

7. Birchwell, J. (1969) Parental Social Class Mobility in Psychiatric Patients and General Population Control, Stanfold University Press, California,U.S.A.

8. Brenran, F. (1983) A Jesuit Journal on the Mentally Handicapped, Camps Publishers, Toronto.

9. Brown, G.W. (1978) Social Origins of Depression. A Study of Psychiatric Disorders in Women, Tavistock, London.

10. Chans, A. (1986); The Mentally Ill and Society. Article in shum, P. (ed) Mental Health Association of Hong Kong.

11. Chave, D. & Taylor, L. (1964) Mental Health and Environment. Longman, Green and Co. Ltd. London.

12. Chewe, L. (1983) Outpatient Psychiatric Morbidity at U.T.H. and George Health Centre. A fifth year research project for medical students, University of Zambia.

13. Crome, L. (1972), Pathology of Mental Retardation. Churchill Livingstone, London.

14. Coleman, B. (1961), Group Integration. An article in scheff, T. (ed) Mental Illness and Social Process, Harper and Row Publishers New York, 1967.

15. Davies, J.B. (1983). Community Health, Preventive Medicine and Social Services. Baillire & Tindall, London.

16. Fan, C.T. (1986). Social Treatment. An article in Shun, P. (ed) The Mentally Ill and Society. Mental Health Association of Hong Kong.

17. Freund, P.J. & K. (1985). The UNICEF/GRZ Monitoring and Evaluation Study of Child Health and Nutrition in Western and Northern Provinces, Zambia. Integrated Report, Community Health Research Unit. IAS. 1984.

18. Freeman, H. (1984). Mental Health and Environment Longman Group New York.

19. Goffman, L. (1963) Stigma Prentice Hall, Englewood Cliffs, NJ, Herman Melvin and Freeman Lucy (1974) The Pursuit of Mental Health Macmillan, New York.

20. Harworth, A. (1983) The Role of the Traditional Healer. A paper presented at the Regional Conference of the Mental Health Association of Zambia, Lusaka.

21. Hollingshead, A. & Reddich, F. (1958) Social Class and Mental Health. A Community Study, John Wiley and Sons Ltd. London.

22. Heron B. (1983). Rehabilitation Programmes. A research paper of the Mental Health Association Of Zambia.

23. Kalumba, K. (1984). The UNICEF/GRZ Monitoring and Evaluation Study of Child Health and Nutrition in Western and Northern Provinces, Zambia. Integrated Report, Community Health Research Unity. IAS. 1984.

24. Kulhara, P. and Chandiramani, K. (1988) Outcome of Schizophrenia in India using various diagnostic systems Schizophrenia Research 1, 339-349. Indian Journal of Psychiatry, vol. 31(1).

25. Lambo, al. et al. (1961). Pychiatric Disorders Among the Yoruba in Nigeria. Comell University Press, U.S.A.

26. Leigh, A. (1973). A Study of Prevalence and Incidence of Psychiatric illness in Africa. Psychiatric Journal vol. 7, 847.

27. Lenny, V. (1974). Preventive Psychiatry from the point of view of the General Practitioner. Mental Health in Australia, vol; 1(2).

28. Mambwe, C. (1987) Mental Health Services in Zambia. Silver Jubilee Report. Lusaka, Zambia.

29. Malepe, T. (1983) Mental Health Services in Swaziland. A paper presented at the Regional Conference of the Mental Health Association of Zambia, Lusaka.

30. Mc Micheal (1971). Contemporary European Psychiatry. Library of Congress, U.S.A.

31. Mechanic, D. (1961) Psychiatric Symptoms. An article in Scheff, T. (ed) Mental Health and Social Processes. Harper & Row Publishers, New York 1967.

32. Mwendapole, I. (1983) Mental Health Issues in Zambia. Paper presented to the regional Conference of the Mental Health Association of Zambia, Lusaka.

33. Muya, W. (1983) On Modes of treatment for the Mentally Ill. A paper presented at the regional Conference of the Mental Health Association of Zambia, Lusaka.

34. Msoni, P. (1991) Outline of Mental Health Services. Paper Prepared for the Ministry of Health, Lusaka.

35. Msoni, P. (1990). The Management of Mental Health Services in Zambia. Paper presented at the SADCC Seminar Gaborone.

36. Narang, P. (1981). Rehabilitation. Paper presented at the Mental Health In-Service Centre, Chainama Hills Hospital, Lusaka.

37. Nielsen, J. (1983). Community Intervention Paper presented at the W.H.O. European Conference on Mental Hygiene Practice. England.

38. Osei-Hwedie, K. (1989). Perspective in Resolving Social Stigma in Employment for ex-mental patients Journal of Social Development in Africa. University of Zambia Lusaka.

39. Ruttler, M. (1975) The Prevalence of Psychiatry Disorder, Journal of Psychiatry in Britain. Vol. 126:493.

40. Richter, D. (1984). Research in Mental illness. Biddles Ltd. Great Britain.

41. Seva, A. et.al (1989) Mental Health Project SAMAR The European Journal of Psychiatry Vol. 4(1).

42. Sethi, B.B. (1988) Family in Management of Psychiatric Disorders. Paper presented at Moscow Congress, Moscow.

43. Sherperd, M. (1980) Mental Illness in the Community. Tavistock publication, London.

44. Steinback, A. Object Loss and Depression, Archives of General Psychiatry. No.12.

45. Sullivan, F. (1953). Interpersonal Relationships. Free Press, London.

46. Szasz, T. (1961) The Myth of Mental illness. Article in Scheff, T. Mental Illness and Social Processes. Harper & Row Publishers, New York 1967.

47. Tuckman, B.W. (1972) Conducting Educational Research Harcourt Brace Joranovich, Inc. New York.

48. Whittaker, J.K. (1971). Social Treatment. Aldine Publishing Co. Chicago.

49. Whittington, H.G. (1966). Psychiatry in the American Community. International University Press, U.S.A.

50. The Encyclopedia of Social Work (1977) No. 17 Vol.II NASW. Washington.

APPENDIX A.

QUESTIONAIRE FOR PATIENTS.

1. AGE :......................................

2. SEX : FEMALE................. MALE...........

3. RESIDENTIAL AREA

   (a) Low Density (c) Self Upgraded

   (b) Medium Cost (d) Squatter

4. OCCUPATION :

   (a) Wage employed (c) Unemployed

   (b) Self employed (d) Retired on medical grounds

5. LEVEL OF EDUCATION :

   (a) Primary (c) University

   (b) Secondary (d) Post-graduate

   (e) College (f) None

6. What is your income per month......................

7. How many times have you been admitted in hospital

   ....

8. Apart from Chainama Hospital where else have you sought treatment

   (a) Traditional (c) Faith healer

   (b) Private doctor (d) All of the above

9. Since you became ill, have you ever lost a job on grounds of being mentally ill.

   (a) Yes (b) No

   If the answer is yes how many times..................

10. At work, how does your employer treat you?

(a) Sympathetic
(b) Indifferent
(c) A hinderance to the company's progress

11. How do your workmates treat you?

(a) Hostile
(b) Encouraging and sympathetic
(c) Not willing to mix

12. When you are admitted how often do your relatives visit you?

(a) Rarely
(b) Often
(c) Not at all

13. When you are discharged how is the reception at home?

(a) Favourable
(b) Unfavourable
(c) Total rejection

14. When you are at home, does the neighbourhood tease you and call you names?

(a) Yes
(b) No

15. Upon discharge if you were given a choice where would you go?

(a) Remain in hospital
(b) Go home
(c) Go to a rehabilitation centre

16. In your opinion why do you keep coming to Chainama?

(a) The illness is incurable due to bewitchment
(b) The illness is hereditory
(c) Medicine is not effective
(d) Bad treatment at home
(e) Medication non compliance

APPENDIX B

QUESTIONAIRE TO RELATIVES

1. AGE : ....

2. SEX : MALE .... FEMALE ....

3. RESIDENTIAL AREA :

   (a) Low density (c) Self upgraded

   (b) Medium density (d) Squatter

4. OCCUPATION :

   (a) Wage employed (c) Unemployed

   (b) Self employed

5. What is your income per month ....

6. Relationship to patient ....

7. LEVEL OF EDUCATION

   (a) Primary (d) University

   (b) Secondary (e) Post-graduate

   (c) College (f) None

8. Why are you looking after the patient?

   (a) Nobody else can (c) Part of my responsibility

   (b) Patient likes me (d) Forced by hospital staff

9. Do you visit the patient in hospital?

   (a) Yes (b) No

10. Is it safe to keep an ex-mental patient?

    (a) Yes (b) No

    Give reasons if answer is no

    ....

17. In your opinion which place is best for mental patients?

(a) Hospital

(b) Home

(c) Both

APPENDIX C

QUESTIONAIRE TO PROFESSIONALS

1. AGE : ....

2. SEX : MALE: .... FEMALE: ....

3. OCCUPATION:

   (a) Psychiatrist
   (b) Mental Nurse
   (c) Occupational therapist
   (d) Social Worker
   (e) Psychologist
   (f) Clinical Officer
   (g)..................... Other

4. LEVEL OF EDUCATION

   (a) College
   (b) University
   (c) Post-graduate

5. How long have you been working in a psychiatric hospital?

   ....

6. In what way is mental illness different from other illnesses?

   ....

   ....

7. When you discuss with patient's relatives concerning rehabilitation, how do you find them?

   (a) Helpful
   (b) Not helpful
   (c) No interest
   (d) Defensive

8. What type of rehabilitation would suit the patients in Zambia?

(a) Sheltered workshops

(b) Community based

(c) Institutional rehabilitation centre

(d) Other ....

9. Why do patients relapse so often?

....

....

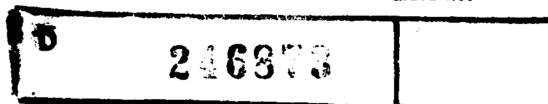
....

10. What would be the appropriate way of dealing with relatives who reject patients?

(a) Take them to court

(b) Motivate them through incentive

(c) Force the patient on them.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