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Zimbabwean Families of the Mentally Ill: Experiences and Support Needs

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ABSTRACT

The paper presents the results of a study undertaken in Zimbabwe which set out to document the experiences, attitudes and needs of families as they face the responsibility of caring for persons with mental illness. The basic aim of the study was to paint a "broad brush" picture of the service needs of both mentally ill persons and their families and to determine under what burdens, if any, families labour as caretakers.

The study involved families of patients whose illnesses were distinguished as or closely resembled schizophrenia or major affective disorders. Altogether no fewer than 34 interviews were conducted in various parts of Zimbabwe. A fundamental conclusion of the study is that families continue to bear a heavy responsibility for providing assistance to persons with mental illness, and hence require a great deal more support, education and additional services from government, NGOs and the wider community to help them successfully assist in caring for their family members.

Introduction

Zimbabwe, like most countries in sub-Saharan Africa, faces many challenges of social and economic development. Issues of stimulating economic growth, controlling inflation, reducing unemployment and providing basic services to its population continue to attract the attention of policy makers and the public. Such issues are serious and affect the social health of every member of the society.

At the same time that these large scale issues attract attention, however, many personal and family crises continue to affect the lives of individuals. One of these issues is the impact on families when one of their members develops a severe and persistent mental illness. These illnesses, particularly schizophrenia and the affective disorders, are found world-wide and are everywhere a source of anxiety, confusion and dismay.

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There is an important and growing literature about the impact that these illnesses have on families. Much of that writing is based on North American and European studies. Various scholars (Creer & Wing, 1974; Hatfield 1979; 1981; Terkelsen, 1987; Wintersteen, 1991) have identified the stressful effects of having a family member with mental illness, as well as a range of useful approaches for professionals working with families (Anderson, Hogarty & Reiss, 1980; Falloon, Boyd & McGill, 1984; Leff & Vaughn, 1985; Hatfield & Lefley, 1987; Wintersteen, 1988). These studies have addressed concerns about relieving family stress, facilitating problem solving and breaking down barriers between families and professionals. Such few references as exist related to other societies and cultures are often anecdotal and do not necessarily represent a systematic attempt to reveal the responses and coping patterns of families in those societies.

Like other developing and developed countries (Ben-Tovim & Cushnie, 1986:578), Zimbabwe has a population of individuals who struggle with mental illness, and families who have to cope with the stresses posed by these illnesses. The purpose of this study was to capture in a systematic fashion the experiences, coping patterns and needs of those parents, siblings and adult children who take on or have imposed on them the burdens of being caregivers.

In Zimbabwe, care for persons with disabilities was traditionally a responsibility of extended families. After the land became a British colony in the late nineteenth century, the then government of Southern Rhodesia developed some psychiatric hospitals. The government of Zimbabwe has largely limited its involvement to the continuation of these hospitals, although some community services have been developed in recent decades (Chikara & Manley, 1991). Nonetheless, the major burden for ongoing care of persons with mental illness continues to fall to families.

In Zimbabwe, like many developing countries, modern psychiatry lives side by side with traditional explanations of mental illness and its treatment. While understandings about these illnesses may vary, it seems clear that availability of modern treatment is more a factor of adequate resources than of inherent resistance to Western medical approaches. In a conversation with a Kenyan social work professor in 1991, it was learned that the majority of mentally ill persons go untreated not because of a disinterest in psychiatric care but because the resources to train and support psychiatric personnel are simply not available. As a consequence, many ill persons are being supported by their families or simply wander untreated.

It may be government policy to continue to encourage families to continue the majority of caregiving, but to do so must take into account the experiences of families in providing this care, their needs and desires, and the "state of the art" in psychosocial rehabilitation, as well as changing circumstances within Zimbabwe.

Nature of the Study

In order to assist service providers and policy makers in developing programmes consistent with the needs of both families and persons with mental illness, a small study was conducted to describe the experiences, attitudes and needs of families as they face the responsibility of caring for persons with mental illness. This was part of a two country research project designed to provide this information, as it applies to family members of persons with mental illness who live in developing countries (the other country was Malaysia). As such, its aim was to paint a "broad brush" picture of the service needs of both mentally ill persons and their families, and to determine under what burdens, if any, families labour when functioning as caretakers.

This report will discuss only the findings for Zimbabwean families. A similar report will elaborate on the Malaysian findings, and a third paper will evaluate all the results against the backdrop of the literature of developed countries.

Objectives

The objectives of this study were to explore fundamental issues of family coping with mental illness, by asking three related questions about families in developing countries:

(1) What coping or management systems are employed by families when a family member becomes mentally ill?

(2) What actual or potential assistance is available through social welfare networks to assist families in coping with mental illness?

(3) How do patterns of adaptation in those nations compare with what the literature tells about Western experiences?

The project was conceived by two American psychiatric social workers (one an academic, the other a practitioner) on leave to visit the host countries, and funded by a research grant from Mankato State University, Mankato, Minnesota, USA. It emerged from an awareness that while the literature on family burden and coping with mental illness is extensive and growing, little or nothing has been published about the impact of mental illness on families outside of the developed world. Inquiring about the circumstances of families in less advanced countries would potentially increase understanding of family responses, as well as assisting policy makers and providers in planning and service development.

Methodology

Permissions

The research was conducted with the cooperation of the Ministry of Health and the Research Council, both of which sanctioned the study. The American researchers were augmented by two designees from the Research Council: Rodreck Mupedziswa of the School of Social Work, affiliated to the University of Zimbabwe and Rebecca Tom of Chitungwiza Hospital (representing the Ministry).

The assistance of key individuals and institutions was invaluable. The Ministry of Health gave permission to recruit families in its hospitals. Community nurses in Bulawayo and Chitungwiza made more families available and served as needed as interpreters. Others as well helped the project by introducing the research team to prospective informants, allowing access to the facilities, and occasional interpretation services, among other assistance.

Range of Illnesses Included

It was necessary to establish boundaries on the illnesses experienced by the family members. A decision was made to include illnesses which were diagnosed as or closely resembled schizophrenia or major affective disorders. Excluded were such other conditions as epilepsy, mental retardation and anxiety disorders, among others.

Recruitment of Participants

Participants were located by a variety of approaches. No attempt was made to systematically sample the target population, an activity which would have been extraordinarily difficult under any circumstances and impossible within available time limits. Rather, the team sought to obtain persons from a variety of backgrounds – racial, tribal, social class, educational – with the objective of gaining an overview of experiences.

> *"The most common technique is judgmental sampling; that is, ethnographers rely on their judgment to select the most appropriate members of the sub-culture or unit, based on the research question"*
> (Fetterman, 1989:43).

The range of participants' backgrounds suggests that this goal was successfully reached.

In most cases the respondents had been known to psychiatric personnel and were introduced to the research team by the staff. In a few cases the staff also served as interpreters during the interviews. In most cases, however, if interpretation from a vernacular language to English was required, interpreters hired and trained by the research team were employed. The consistency of data results strongly suggest that in the presence of the interpreter and/or the preexisting relationship between the respondent and the interpreter constituted no barrier to obtaining valid and reliable results.

Because of cultural barriers most respondents in both countries declined to sign a written consent form. Instead, the study was carefully explained to them (Fetterman, 1989:130). Their implied consent was assumed by their willingness to continue the interview. In no case did any potential subject decline, nor was there any evidence that the respondents were unusually uncomfortable with the questions.

Questionnaire Development

The interviews were conducted using a structured interview schedule developed by the research team for the parallel study conducted in Malaysia. Originally over 60 questions were written, but many of them were eliminated in testing. The final set consisted of 13 demographic or informational questions, 18 open-ended questions, and two services-related questions.

Interview Procedures

The interviewers spent several weeks in the country before beginning to conduct interviews. In addition to building relationships with those persons who could help with contacting potential respondents, the time was importantly spent attempting to learn about the traditional cultural patterns of family relationships, attitudes toward disability, health practices and the like. Although some of this information had been obtained prior to arriving in the country, there was no substitute for being in the locale, listening to people and visiting psychiatric services and providers.

All interviewers were experienced social workers with backgrounds in mental and physical illness, and comfortable conducting interviews in which strong emotions might be elicited. The interviews themselves were positively received by the respondents. Although the content of the interviews tended to reflect the difficulties which the respondents face, they were uniformly pleased to participate, and often thanked the interviewers extensively for asking them even these painful questions.

Almost all interviews were conducted by two interviewers, with one person leading the interview and the second person recording the responses and asking clarifying questions. It seemed to work better that the person leading the interview be of the same gender as the person being asked the questions. However, sometimes one family member spoke English and that factor then determined to whom the questions were directed. When there was more than one respondent present the gender of the parent was the determining factor. When both parents were present the lead interviewer was usually the male of the team.

Locale

Interviews took place in a variety of locations as indicated on Table 1. The location of interviews was not a factor in determining the amount or type of information received. In general, the person with illness was discouraged from sitting in with the interview, and families were very happy to comply with and enforce this policy. They seemed to be more comfortable and free to speak up when the ill person was not within earshot.

Duration

Interviews lasted between 30 and 90 minutes, with those using an interpreter typically taking shorter time than those conducted in English.

Data Analysis

Respondents' answers were recorded on paper and later transferred to computer files. To the greatest extent possible the precise words used by the respondents were recorded. Responses to each question were grouped by categories of similar words or concepts. Data from the interviews was coded and evaluated using standard ethnographic procedures (Fetterman, 1989).

Results

The findings of these interviews may be reasonably summarised under six headings: Demographics, Course of Illness and Recovery, Patterns of Help Seeking, Coping Strategies, The Future, and What Caregivers Want.

Demographics

The demographic distribution of the respondents is essentially unexceptional. As Table 2 indicates, males are more highly represented in this sample than females. The Ndebele population, making up about 15% of the national total, is slightly overrepresented. This is due to the amount of interviewing conducted in the Bulawayo area in an effort to cover more than the Harare urban centre.

The families represent a wide range of economic, educational and social backgrounds, from professional and civil service vocations to farmers, labourers and persons who have been unemployed for a long time. Table 3 indicates that most of the primary caregivers are women, as is true in more developed countries as well. While several fathers were interviewed, only two were single parents. In general, it is women (mothers, wives, daughters, sisters) who carry the greatest burden for providing for disabled persons in this culture. However, two of the three spouses providing care are males, taking care of their wives.

Table 4 indicates the whereabouts of the person with illness at the time of the interview. Six persons with illness were presently patients, and the resident status listed is that place where they will return for aftercare. Most are either living with family or are due to be released from hospital back to family. On the other hand almost a quarter are or will be living with spouse or independently. The fact is, however, that a very large majority are not presently prepared to live independently.

Course of Illness and Recovery

For the majority of these ill persons, their life prior to becoming ill was very normal, with few showing signs of difficulties prior to onset. Indeed, the prospects for many of them seemed very bright. They were doing well in school, or had completed their education and had moved into independent roles.

As family members described the onset and progression of the illnesses faced by their relatives, it was clear that they were dealing with classic psychiatric disorders, primarily various types of schizophrenias and affective disorders. Even though most families had little information about these illnesses, they reported behaviours and thinking consistent with those diagnoses. For most of the persons with mental illness, the progression of the illness involved a gradual increase of symptomatic behaviour. For many families the assumption was that witchcraft or ancestor spirits must have been involved, but some also attributed the onset of the illnesses to stress or some environmental factor. Most respondents were not sophisticated to initially recognise the presence of mental illness in their family.

The illnesses manifested at ages appropriate for the illnesses (mean age = 23; median age = 20). The ill persons had been contending with the illness over a wide range of time: from less than three months to 25 years.

Six individuals (19%) had a recent work history, and six more had some previous work experience (see Table 5). Most, however, had never worked, either because they were too ill or because they were in a status where work outside the home was not typical (students, homemaker). Most showed little or no motivation or ability to seek employment. They were living with family members who anticipated continuing to care for them and to provide for the majority of their physical and social needs.

Patterns of Help Seeking

For 21 families (66%), the first recourse when the person became ill was to utilise the services of a religious counsellor or traditional healer appropriate to their orientation. Table 6 shows the range of first help seeking choices employed. Even with families who felt that the problem was a physical or situational one, the first recourse was usually a healer or prophet. In most cases the families found this intervention unhelpful. In a few situations, the families felt misled and cheated. In other situations the families pursued both traditional remedies and psychiatric treatments.

In response to the question: *"What has been helpful to the person with mental illness"*, it was clear that the vast majority of families attributed whatever gain had been accomplished to hospital care, medicines and aftercare (see Table 7). This finding is entirely consistent with the work of Jackson and Mupedziswa (1988:27), writing about persons with physical disability in Zimbabwe, and with Kortmann (1987:271), writing of mental illness in Ethiopia. Given the general level of frankness and candor achieved in the interviews, it is highly unlikely that the respondents were telling us "what we wanted to hear." It is more likely that these families had maintained involvement with the mental health system because of their perceptions of its value for their family member.

Coping Strategies

Most of the families found themselves isolated and alone. Despite periodic contacts with a visiting nurse or trip to a clinic, they had little involvement with or support from the mental health system.

Sources of support are reported in Table 8. Despite the prevailing belief that the extended family rallies around a sick or disabled person, it is clear that families rely on support from other family members less often than from religious activities (prayer, meditation, attendance at worship services, etc), and only modestly more than support from friends. The notion that families support one another was only incompletely seen in this study. For some, family involvement has been important, but less than usually believed. In a few cases the nuclear family with an ill person has been abandoned by the extended family and have no contact with them.

All adults want to have a life of their own, and to be free to pursue their own interests, especially after their children are grown. These families are denied this opportunity. Instead, they often feel required to forego their own desires. Often they cannot even leave the house unless there ie someone else to stay with the ill person. Since they rarely have this chance, they are denied the opportunity to work, socialise or travel. They give up their own lives in order to care for someone whom they expected to be able to become independent.

The Future

As family members, especially parents, look to the future, they find it bleak (see Table 9). Some have decided not even to think about it. Most, however, have given it a great deal of thought, but find few answers. A small number cling to the hope that the person will recover. The majority acknowledge that they have no solutions in sight and are deeply worried.

The traditional expectation seems to have been that siblings of the ill person (or some other relative) will step in to provide for the individual. In the changing world that these families face, most do not believe that the siblings will wish to do so or even be able to. These families recognise that development and mobility will preclude most of them from becoming caregivers. As families move to the urban areas, with much greater restrictions on living space, there will simply not be room for extra people. Even in the rural areas, where additional living quarters can be constructed more easily, the younger generation is increasingly going to move to urban centres or growth points. The two-income family is likely to become more of a norm in this developing society, meaning that there will be no one home to provide care and supervision for a disabled person.

What Caregivers Want

It is clear that many services that are available in the developed world but less available here would be eagerly sought in this country. Table 10 makes this point graphically. The respondents were asked to indicate if a group of services would be beneficial and then whether they thought their family member would make use of it. Since many of the respondents were not aware of the existence of such services elsewhere and therefore could not be expected to spontaneously discuss them, the services were briefly discussed with them before they indicated their reaction to each one.

Most families want services to assist them in dealing with the burdens of having a family member with the illness (Table 11). Most families do not want to provide long-term care for the person with illness. Instead, most would welcome the availability of a halfway house or residential programme, and would see that as better both for themselves and for the ill person. Families recognise the need for day time programmes, especially those with a vocational orientation. There was less agreement about the need for drop in centres or clubhouses, possibly because that is an unfamiliar concept to the families.

The government makes a small monthly disability grant to some persons, but none of these families received it. It would be extremely helpful to many who were of low income. There was little demand for practical assistance in teaching self care skills to their family member. They also infrequently desired help in emergencies. They have learned how to get the person to the hospital or clinic when this is required, despite the fact that police often require them to pay a fee to transport the ill person to the hospital. In general, their requests are for long-term, not short-term, help. They want work training and placement, a place to live and guidance toward a normal life.

For themselves, families want information about the illness. Most do not know many of the basic facts about the illness. Only 7 (20,5%) knew the name of the illness, while 27 (79,5%) could not name the condition. One gave a name, depression, but the psychiatric nurse later confirmed that the diagnosis was schizophrenia. This person's response was therefore classified as "did not know". Seventeen families (50%) could identify other family members (numbering 25) with mental illness, and one might have presumed greater knowledge as a result.

The families also wish to know more about medications: the name of the medicines and what the medications will and will not do. During one interview in which the psychiatric nurse was present, a question about medications led to the discovery that the person was taking the medication improperly, and made clear to all the importance of the family being given some training.

They also seek constructive suggestions which might help them cope more effectively. They request printed information (100%), and would also be interested in attending meetings or classes to learn more (100 %). They make it clear that these should be in their most comfortable language, and meetings and classes should be easily accessible geographically.

Finally, and possibly most important, families need support from one another. One follow-up question usually asked was, "Do you know another person in your role (mother, father, sibling,) who is taking care of a mentally ill person?". Few respondents knew such other persons, but would be eager to meet them. They could recognise the value of meeting with others to share information and to bear one another's burdens. They are willing to attend support groups, again with the provisos that they be accessible and that the language be one with which they are comfortable.

Discussion

The comments of the respondents can be viewed in two parallel dimensions: implications for practice (micro level) and implications for public policy (macro level). Of course, these categories represent simply differing ways of viewing the expressed needs of these representative families.

It is recognised that, especially in developing countries, resources to follow through on such suggestions as these will be hard to find and allocate. Nonetheless, it is useful that such needs and gaps in services be identified, in order to provide a sense of direction for overall programming, and to encourage creativity among service providers. The authors realise the fiscal implications of the following proposals, but offer them as a way of increasing the awareness of the extent of needs.

Practice Issues

It is clear that families continue to bear a heavy responsibility for providing assistance to the persons with illness. They want and need a great deal more support, education and additional services if they are to successfully assist in caring for their family members with mental illness. Families are providing for the ill persons partially from choice, but more because they see no alternative. What is more, they are doing so with minimal support from the mental health system.

Those social workers, nurses and other psychiatric personnel who come into regular contact with families should make it a point to be available to answer questions, provide advice and helpful suggestions, and generally treat them as colleagues in the business of rehabilitation and treatment. Families are currently being expected to carry a heavy burden, and it is too much to expect them to continue when so poorly equipped.

On a small scale some changes in this direction have already taken place. Several of the staff who assisted with this study report having changed their approach to families, and now try to take more time with them, addressing their needs and questions. When this becomes a universal practice families will be better able to serve both their own needs and the needs of the ill persons.

Families also report the need for other services for people trying to recover from these illnesses. They most enthusiastically endorse activity and vocational programmes. They see these as contending with the apathy and lethargy of the relatives, as well as providing some opportunity for increased self-sufficiency. In the course of the study many persons, especially those newly ill, were reported to be interested in vocational services. Many of them seemed to have the potential for eventual employment and at least partial independence.

Families also want alternative living arrangements. Especially as parents grow older, they do not wish or cannot handle the burden of providing care to an adult. If there were halfway houses and/or other residential services available, the families would encourage their use. Most felt that the persons with illness would be willing or could be encouraged to make use of these services. They would want them near enough to make visits possible, but they clearly do not want to go on making a home for them. It cannot be good for the ill persons either to be living in such a dependent and age-inappropriate fashion.

Case management, a service concept receiving wide credibility in other areas, would be very useful in this context. This service, usually provided by social workers, is designed to support mentally ill persons and their families, find or develop resources, establish and follow through on rehabilitation plans, and be available to assist in times of crisis. Case management services have the potential to increase the functional level of mentally ill persons and reduce the recidivism rate at hospitals. Since the goal is increased social functioning, it has the result of converting persons from a dependent status to that of participant in society. Many of the families are caring for persons who have had the potential for employment and much greater independence. Allowed to remain passively at home, taking their medications but otherwise unserved, such individuals lose whatever motivation they might have had. Case management works to ensure that this result is minimised among this group.

Support groups have become very prevalent in many countries of the world (Wintersteen & Young, 1988), and residents of Zimbabwe strongly endorse the need for such groups. While the efforts of the Zimbabwe National Mental Health Association (ZIMNAMH) to begin such groups is laudatory, working with groups of families could be a part of the job description of many mental health professionals.

Such support groups have the potential to deal effectively with the perennial problems of stigma and lack of public understanding. It is family groups that hold the greatest potential for increasing the awareness of mental illness and in decreasing stigma.

We propose that ZIMNAMH and the Ministry of Health explore external grant sources to secure funds to launch a major campaign to develop a network of support groups around the country, near the residential areas of the families and using their traditional languages.

While traditional methods of treatment have been reported by our subjects and in other studies to be unsuccessful in treating these illnesses, nonetheless these healers are a major culturally determined source of assistance and support. Mupedziswa (1993:111) reports that: *"...(in) some refugee camps in Zimbabwe there was some kind of an understanding between traditional healers and Western medical practitioners."* Healers are probably efficacious with many psychologically based difficulties. Continuing efforts to promote relationships with the organisation of traditional healers seems a profitable strategy, in which healers and practitioners of Western psychiatric services can determine the best roles of each and make arrangements for mutual referrals that allow each to do what that group does best (Ben-Tovim, 1985:90; Wessels, 1985: 286).

Finally, recognising the central role of religious beliefs and practices in the coping behaviour of the majority of respondents, it seems clear that a programme enhancing the knowledge of members of the clergy and offering educational and support programmes within the religious community offers an avenue for indirectly supporting and strengthening families. Again, ZIMNAMH, working within the religious institutions can be a catalyst for the development of greater understanding within religious bodies, and greater competence among clergy in dealing with mental illness.

Policy Issues

In order to follow up on any of the suggested practice proposals made above, there is a great need for increased numbers of mental health workers in all professions. In the course of this study the research team met a number of highly skilled and dedicated professionals, fulfilling their duties with competence and caring. But there are simply too few of them. The workloads of community based, as well as hospital based, staff are unreasonably high, and this can often lead to frustration and a sense of hopelessness on the part of the most able staff.

There is a particular need for an increased number of psychiatric social workers and nurses, those professionals who most frequently work with families. If such persons are expected to provide a richer level of work with families, they must experience a commensurate decrease in their current workloads.

We propose a major expansion in the numbers of positions available within these professions, that their duties be augmented to increase a concern for training and supporting caregivers, and that these positions be distributed across the country. This also suggests the definition of a career structure within which personal and professional growth may take place.

These new persons will be expected to maintain a regular contact with mentally ill persons and their families, work on the development of independent living and social skills, identify or work to facilitate employment opportunities, and creatively seek other avenues to enhance the rehabilitative potential of clients.

Public mental health policy has to date been almost completely directed toward the provision of hospital psychiatric services. Such services are important and should be maintained and strengthened, where necessary. This is where services often begin for a newly ill person brought for diagnosis and treatment. This is not where public services should end, but unfortunately it all too often is. Other than the availability of clinics and some psychiatric nursing services, aftercare of psychiatric patients is largely absent. There are too few programmes and support services for patients, and almost no attempts at respite for families. Under these circumstances frequent readmission to hospitals and the decline of patients into dependence and apathy can be predicted.

One major policy response would include a commitment to designate more governmental funds for the development of community services. Community based rehabilitation services present an opportunity to assist individuals recovering from illness (and their families) while controlling costs. Avoiding further institutionalisation presents governments with a clear financial benefit. Community programmes also prepare persons to become more self-sufficient, hence reducing their dependency and increasing their contributions to their communities.

Such rehabilitation programmes as currently exist are largely offered by non-governmental organisations such as ZIMNAMH, and funded extensively by voluntary funds. Over the long haul, it is not a useful strategy to build the range of services that this problem requires only with private funds. Rather, it is a cost-effective plan for government to encourage the development of additional services through grants to voluntary organisations, or provide the services itself. Whatever the mechanism, this is an issue that deserves the urgent attention of policy makers.

The development of additional residential services and vocational programmes should be on a national scale, and these services should be placed not only in the major metropolitan areas, but in the small towns and rural areas as well.

Further, many of the persons with mental illness are living in conditions of great poverty and are unable to care for their own subsistence needs. Many older families without enough to feed themselves are being asked to stretch their resources to cover their adult dependent children. The government currently makes some funds available to cover some of the costs of halfway house care, but persons with mental illness lose those benefits when they are ready for discharge from the programme. It should be the goal of government to provide at least something toward the food and clothing needs of persons with mental illness, as long as they remain unable to provide for their own basic needs. Such a supplement would greatly relieve the stress felt by many families. Otherwise many families will continue to find hospital care more desirable.

To some, this will seem naive and full of wishful thinking, but these should not be construed simply as valueless suggestions. As the country continues to develop economically and socially, it will be able to afford these programmes, and people will increasingly demand them. The persons with mental illness have skills and potential currently undeveloped. It is painful to watch the unnecessary decline of talented individuals, simply because there have been too few rehabilitative opportunities available to them. The families seem to sense the waste of potential among these individuals, and wish services that will make the lives of persons with mental illness more fruitful for all of society.

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TABLES

Table 1: Location of Interviews

Hospital/Clinic	9
Respondents' Home	21
Interviewers' Office	4
Total	34

Table 2: Ethnic and Gender Grouping

Ethnic Group of Informants		
Shona (English Speaking)	7	20,6%
Shona (Shona translator)	18	52,9%
Ndebele (English speaking)	4	11,8%
Ndebele (Ndebele translator)	3	8,8%
White	2	5,9%
Gender of Person with Illness		
Male	25	73,5%
Female	9	26,5%

Table 3: Respondent Relationship(s) to Person with Illness

Mother	10
Father	5
Sibling	4
Spouse	3
Aunt	1
Adult child	1
Both parents	3
In-law	1
Multiple members	6 *

* Every multiple member group contained at least one parent and one sibling.

Table 4: Residential Status of Person with Illness

Parents home & care	21	61,8%
Independent or with spouse	8	23,6%
Sibling home & care	3	8,8%
Other relatives	1	2,9%
Prison	1	2,9%

Table 5: Employment History of Persons with Illness

Recently employed	6	17,6%
Currently unemployed (had worked in past)	6	17,6%
Unemployed (never worked)	15	44,1%
Working part time (farm)	2	5,9%
Student	3	8,9%
Homemaker	2	5,9%

Table 6: Help Seeking Activities

First Resource Sought For Help	
Traditional Healers	21
Psychiatric Hospital/Clinic	9
Other Medical Hospital/Clinic	3
Religious Organisation	1

Table 7: Attributions of Effective Treatment

Medicine/Injections	26
Hospital/Clinic Services	10
Other Community Services	4
Prayer	2
Talking to Doctors	1
Learning Coping Skills	1
Stopping Drinking	1
Traditional Healers	2 *
	47 **

* These two were mentioned along with medicine or hospital.

** (Some persons listed more than once)

Table 8: Sources of Support

Religious Activities	20
Family (Extended and Nuclear)	10
Friends	7
"I must do it" Attitude	7
Agencies/Services	4
Keeping Busy	2
Avoiding Person with Illness	2
Crying	1
Drinking	1
Information	1
Nothing	1
Total	56 *

* (Some listed more than one source.)

Table 9: Expectations for the Future

Have Plans - Not Worried	3
Have No Plans - Worried	19
Have No Plans - Not Worried	5
Expect Recovery	3
God Will Help	3

Table 10a: Desired Services for the Person with Illness

	Good Idea			Person Would Use It			Has It Now
	Y	N	?	Y	N	?	
A safe place to live but not with you	25	5	2	19	9	4	2
A day program to keep active	25	3	1	21	3	5	5
A drop in or social centre	21	7	4	20	7	5	2
Home visits from a mental health professional	15	3	7	14	4	7	9
Help with meals, money or other practical things	13	18	1	13	17	1	2

Table 10b: Desired Services forYou or Your Family

	Good Idea & Would Use It			Have Used It
	Y	N	?	
Information about mental illness	34	0	0	0
Meetings about mental illness	34	0	0	0
A group to meet with other families to discuss problems	32	0	2	2
A chance to discuss your concerns with professionals	17	0	9	8
Help in knowing how to take care of the person	18	11	6	0
Help in emergencies	12	19	3	0

Table 11: Services Which Respondents Provide to Persons with Illness

	Always	Usually	Sometimes	Never
A place to live	27	0	1	6
Money to buy things	20	3	4	7
Washing clothes	10	1	5	17
Reminding to take a bath	6	3	8	17
Social contact or recreation	10	2	12	7
Getting them to a doctor or dentist	14	2	4	14