ATTITUDES TO DISCHARGE OF MENTAL PATIENTS AT THE MATSAPHA MENTAL HOSPITAL IN SWAZILAND

By

NOMCEBO MEREDITH MABUZA

A Thesis submitted in part fulfilment for the degree of Master of Arts in the University of Nairobi - 1983.

TABLE OF CONTENTS

./...

TABLE OF CONTENTS (continued)

- - - - - - - -

LIST OF TABLES

- - - - - -

This Thesis is my original work and has not been presented for a degree in any University.

NOMCEBO MEREDITH MABUZA

This Thesis has been submitted for examination with our approval as University Supervisors.

Roberta Mutiso

DR. ROBERTA MUTISO

Philista Onyango

MRS. PHILISTA ONYANGO

ACKNOWLEDGEMENT

Sincere thanks to my supervisors Dr. Roberta Mutiso and Mrs Philista Onyango for their continued support and supervision throughout the time of doing the research and the writing of this thesis.

I also wish to thank the staff and patients at the Matsapha Mental Hospital for their cooperation and patience while the research was being carried out.

I would also like to thank Dr. Mike Dlamini, Director of Medical Services in Swaziland, for granting me permission to carry out the research at the hospital.

My family has also been a pillar of strength and a source of great encouragement to me during this time and I wish to thank them all most sincerely.

My sincere gratitude also goes to my colleague, A.N.Mbabu and Miss M.Ramji whose untiring efforts made it possible for this piece of work to finally come to fruition.

Last but not least, I wish to thank my husband, Dr. N.T.Manzini for his unfailing support and encouragement always.

A word of thanks too to all my friends and colleagues in Nairobi.

ABSTRACT

This thesis is on the attitudes to discharge of mental patients at the Matsapha Mental Hospital in Swaziland. It is intended to ascertain the factors which influence patients' attitudes to discharge - namely, factors which influence some patients to want to leave the hospital while others want to remain in the hospital.

An attitude scale was constructed to measure the patients' attitudes to discharge. This was administered in conjunction with the questionnaire. The questions in the questionnaire were constructed such that they would high-light the factors likely to influence patients' attitudes. This questionnaire/ attitude scale was administered by the researcher to seventy-eight patients who had been hospitalized for varying lengths of time.

The interactionist perspective was adopted in the explanation of deviance at its outset as well as in the derivation of particular attitudes; in this case, attitudes to discharge.

The major objectives of the study were to find out the following:

(i) The basic background information on the patients;

(ii) The problems faced by patients prior to hospitalization;

(iii) The patients' views about hospitalization;

(iv) The patients' experiences during hospitalization;

(v) The relatives' responses to the patients' illnesses;

(vi) To relate all the above to the patients' attitudes to discharge.

The attitude to discharge measure had three values, namely, positive, negative and indifferent. Patients who had a positive attitude comprised 42% of the respondents. Those with negative and indifferent attitudes comprised 18% and 40% respectively.

The attitudes of the patients seem to be affected mainly by the sex of the patients, the presence or absence of children, whether he/she was told about hospitalization or not, and whether he/she feels his/her relatives want him/her back home or not.

For instance, where sex is concerned, the negative category was comprised mainly of male patients. Less than a quarter were females. Of the same patients, 64% did not have any children and 76% of them were not married; 71% said they had nowher to go if they were discharged while 76% said that they did not think their relatives would be happy to have them back home or were quite certain that they would not be welcomed back to their homes.

In addition to these analyses, five case studies were done to lend support to the statistical findings.

- - - - - -

CHAPTER ONE

INTRODUCTION

PROBLEM STATEMENT
JUSTIFICATION FOR THE STUDY

Mental illness is a social problem, which is beginning to take on greater significance and concern the faster we develop. While in traditional society the onus for the care of the mentally ill lay with the relatives and family of the patient, in modern society this is being gradually changed and the patient is now being taken to a mental hospital.

The advantage of the family taking care of the patient was that he was able to continue to live with his family and so not lose contact with his social world. Even if the patient was being treated by a traditional doctor he was never very far from his home area. Thus contact with his family was always easily maintained. In this set-up the family could be seen, however, to have been at a disadvantage in that they had the task, financial and emotional, of looking after a sick member whose date of recovery was unknown and could not even be guessed at.

Hospitals then, have come as a relief to some families, who have had a sick relative for a number of years. The hospital has, ideally, provided an environment where the patient can receive the care and treatment necessary for his recovery so as to enable him to return to his family.

However, the patient may not necessarily feel that hospitalization is for his benefit. He may feel that his family has rejected him by initiating his hospitalization. In other instances he may welcome hospitalization so as to live apart from his family which he regards as making unnecessary demands on him. The hospital may be seen as a source of refuge to these patients and the result will be that even though they have recovered sufficiently to be discharged, they may refuse to leave.

On the other hand, there may be those patients who desire to leave the hospital and so return to their families. They acknowledge the fact that they have been ill and their relatives have been very considerate towards them by having them hospitalized so that they can get better. They do not regard their hospitalization as a form of rejection by their families but rather as a sign that they still care enough about them to want to help them.

Sometimes, however, the hospital may not be conducive for them to stay in. That is, the conditions of the hospital may not be good enough for living in and this may be a cause for dissatisfaction among some patients irrespective of whether they voice feelings of rejection by their relatives or not. In other words, patients may still want to leave the hospital even though they profess to be hurt at their relatives handling of the situation regarding their hospitalization.

The aim of this thesis then, is to highlight some of the reasons given by patients as to why they would like to remain in the mental hospital as opposed to those who would like to leave. It also seeks to emphasize that the views of patients should be taken seriously on some of the things they say even though we sometimes tend to think that they are talking nonsense.

Another objective of this research is to awaken the interest, knowledge and awareness of the general public about mental illness in Swaziland; and in particular the relatives of the patients, the hospital staff and social workers directly involved with mental illness in the community; and finally the Swazi Ministry of Health and its policy makers. It is also hoped that through this research other studies of a similar nature can be undertaken.

In carrying out this study, the major concepts which were dealt with were attitude to discharge and interaction. Attitude to discharge refers to the patient's opinion on whether he wants to leave hospital or not, irrespective of whether the doctor had actually certified him as ready for discharge or not. The argument for attitude to discharge is based on the premise that it is the quality of interaction or relationships inside and outside the hospital which plays an important part in determining how the patient will feel about leaving or remaining in the hospital.

Thus the interaction perspective was adopted because of the belief that the patient's attitude will be influenced by those people closest to him through interaction, in this instance his family and during his period of hospitalization the doctors, nurses and other patients. It is what he thinks his family or relatives think about him and the way they acted or behaved towards him prior to his hospitalization which will influence his attitude. It is also his experiences within the hospital which can further make him want to leave or remain in the hospital.

The research deals with hospitalized mental patients and not those who roam the streets at large or are in private homes, of which there are none in Swaziland, or in private hospitals or those who are still at home with their relatives. However, information relating to their personal problems was obtained through the questionnaire method and interviewing and also through observation when they had visitors.

JUSTIFICATION FOR THE STUDY

Swaziland is a developing country; with the stresses and strains entailed in modernization, there has been found to be a need for a bigger and more efficient hospital for the treatment of the increasing number of the mentally ill. The investigation of patient's views on their hospitalization and their relationships in the hospital means that some valuable information and insight can be gained about the problem. This

information can be used for administrative and counselling purposes by the hospital staff and policy makers. Thus problems highlighted now, it is hoped, can be avoided in the future.

Furthermore, by establishing which factors play an important role in prolonging a patient's stay in the hospital, that is, factors which are common to those patients found to have a negative attitude to discharge, we can establish what measures to institute for the benefit of the patients. Thus those responsible for the institution and the recovery of the patients may utilize them to enact any necessary changes.

Also, at the familial and societal level, social workers can utilize the results to reinforce positive attitudes or help to change negative ones directed at persons who are mentally ill.

Besides the fact that the mental hospital at Matsapha is the only one in the country and therefore there is nowhere else this research could have been undertaken, there has been no research of a similar nature undertaken at the hospital. It is the researcher's hope, therefore, that this research will pave the way for more intensive studies on mental illness in Swaziland.

CHAPTER TWO

A. LITERATURE REVIEW

Mental illness is a phenomenon which has become of world-wide interest. It used to be believed that Africans did not experience madness. However, it has been established without doubt that mental illness is a world-wide problem. On the African continent the interest in it has been relatively recent with major works on the subject being, Field (1960); Tooth (1950); CCTA/CSA-WHO (1958)

Nonetheless, given the fact that mental illness has been around since we can recall, hospitalization of the mentally ill is still regarded as a comparatively new happening in Africa. New in the sense that it was with the realization that mental illness exists on the continent that measures were then taken to provide the necessary facilities for the care of the mentally ill. Prior to this realization, such ill individuals were catered for by their relatives and treated by traditional doctors, while in Britain, Clark (1956: 1005) states that they were kept in jails and workhouses and sometimes allowed to roam at large. The advent of hospitalization however, has changed all this.

Given the fact that hospitalization and mental illness in Africa are fairly recent topics for research one cannot doubt that a fair amount of work has already been accomplished in the area. However, the focus has been, it seems, to

overlook the patient himself in most of these studies. Though these studies are carried out about mental patients we still do not know their views about their hospitalization. We do not know how patients feel about being discharged. We take it for granted that now that they have been given medication and seem well, we have to send them home. Indeed, we gape with consternation and wonder, what has gone wrong when we see them coming back as re-admissions within less than a period of six months. Worse still after our initial surprise we adopt and develop a fatalistic and apathetic attitude towards them.

This research then is an attempt to deal with this problem. It is an attempt to seek out patients' points of view on how they feel about going home to their relatives and if not to their relatives to the larger society. It also endeavours to highlight the reasons patients may have for wanting to leave or remain in the hospital.

From the sociological point of view, in particular the Interactionist perspective, mental illness comes about because of interpersonal problems and communication breakdown (Chapman and Almeida, 1972). As a result if an individual fails to behave in the way expected of him his relationship with others goes into a state of crisis and those around him react towards him in such a way as to make quite clear that he has adopted behaviour which is unacceptable to them and their moral code. This conflict may arise in any given situation in which the individual finds himself. It may be at work, at play, at

school and so on. Theorists on the issue, however are agreed that the most likely situation for such behaviour to become most evident is in the family setting
Sampson, Messinger and Towne (1962); Laing (1978). Thus the focus here will be on the family and the individual whose behaviour has deviated from the norm or the moral code of that family and who has been called mentally ill, and who has as a result been hospitalized.

Many families of mental patients try to ignore, overlook or explain away any evidence of disturbance in the family until the problem becomes unmanageable (Sampson et.al. 1962). Alternatively they try to have the member treated in the traditional way before any attempt is made to send him to the hospital. They finally take him to hospital because the behaviour cannot be contained any longer.

However, disturbed behaviour does not just occur of its own volition. It is usually existing interpersonal situations in a given setting, such as a family setting, which trigger off the behaviour. Thus for many patients family problems figure heavily in the factors leading toward their mental breakdown.

Patients have been known to complain outright against their parents domination and insensitivity asserting that "parents only see what they want to see" Fadiman and Kewman,

(1973:27). Laing and Esterson (1978:12) assert that,

> "if we look at some experience and behaviour without reference to family interactions, they may appear comparatively socially senseless, but that if we look at the same experience and behaviour in their original family context they are liable to make more sense."

Within this family setting interpersonal problems of a marital nature may also arise. In Africa, more so in Swaziland, a man and a woman once bound together in matrimony are expected to beget children. However, the problem may arise that one of them is unable to be productive, either the man is sterile or impotent or the woman is infertile and cannot conceive. In traditional society this anomaly was well catered for. Should it be discovered that the man is sterile, his brother would secretly sleep with his wife and she would become pregnant. The husband would thus be saved from the shame that he could not beget children. In most cases he was none the wiser that the children were actually his brother's. The children as far as the community was concerned were his.

A wife, on the other hand, who was infertile was also covered in that her relatives would send her younger sister over to her husband's home to take away her shame, which her relatives also regarded as their own. The man then took his wife's sister as his second wife or the sister would give the children borne out of the relationship to her older sister. Should the sister also be unable to conceive the husband

had a right to return them to their parents and retrieve his cattle which he could then use to marry another wife. These safety values for such discrepancies do not exist in our modern society. There is no way men and women can hide the "shame" of not being able to be productive. It may worry them to such an extent that they may become mentally ill. This is so because of failure to do what society and their families expect of them. This in turn may result in a desire to remain in the hospital because they know there is no solution to their problem.

Let alone the fact of unproductivity, marital instability still exists in other forms. Most African societies are polygamous and Swaziland is no exception to the rule. It is of little wonder then that most women who are hospitalized complain of conjugal neglect by their husbands. Field (1960:150) has this to say about the situation in Ghana:

> "the patient often has the additional stress of seeing her husband take an extra and younger wife so that he may continue to beget children. Flighty young girls in their teens are particularly attractive to men who are past their own prime, and the man frequently lavishes on the young woman money and luxuries which are among the fruits of his older wife's years of labour. A number of married people come reporting (to the shrine) that the partner now refuses intercourse usually because of a new object of affection."

The anxiety which arises because of such a situation is immense and this may indeed lead to the breakdown and thus the

hospitalization of the individual. Yet again the concerned patient may desire to remain in the hospital because of his experiences at home. This desire however, may be alleviated if the patient has children whom he/she can go to on leaving the hospital. Dinitz et.al. (1964:444) in their study on predictions of hospital outcome for mental patients predicted that,

> "not only will patients return to a conjugal family perform better, but those returning to households with young children requiring attention....will do even better."

They go on to state that,

> "married females are better post-hospital performers than are single, or divorced and separated women."

The same situation should apply in the testing of attitudes, that is in ascertaining which factors play an important role in patients' views about wanting to leave the hospital. Thus it can be hypothesized that patients who are married will want to leave the hospital and this situation will b reinforced by the presence of children.

Paradoxical as this may seem, in view of the preceding literature it can be shown that married patients for instance feel an obligation to prove to themselves and their spouses that they can cope with the home situation, even though it led to their breakdown. There may also be the feeling among people with children, even though they may have problems with the

spouse, that children are there to look after their elders; so the patient with children would want to leave because of the belief that there is someone to whom he can go to on discharge. Or even the fact that he/she must leave to look after his children.

Since the family plays such an important role in the actual breakdown of the patient, it is not surprising to find that most cases referred to the hospital have been referred by members of the patient's immediate family who know the details of the patient's illness. This is not to deny that, other organizations play a part in referring patients to the hospital, but even when they do,it is usually the relative of the patients who have sought their help (Goffman, 1961).

In some cases the patient is informed that he is going to be hospitalized and in others he is quite unaware and becomes quite distraught to find he has been left alone in the hospital with no one he knows. The patient may see this hospitalization as a rejection by his family. Philips (1963:213) states that:

> "the penalty that mentally ill persons pay for being different is rejection by others in the community. This rejection is reinforced when the patient is hospitalized."

To reiterate this point Goffman (1961:227) states that,

> "a patient willingly or unwillingly goes through a routine process on hospitalization. The approach to the institution takes one of three basic forms. They come because they are implored by their families or threatened with the abrogation of family ties unless they go willingly; they come by force under police escort, they come under misapprehension purposely induced by others (mainly youths)."

Thus all along the patient had relationships and rights but now he does not even have a say in his own hospitalization. The moral aspect of this career as Goffman (1961:227) puts it:

> "typically begins with the experience of abandonment, disloyalty and embitterment. This is the case even though to others it may be obvious that he was in need of treatment and even though in the hospital he may soom come to agree."

Lambo (1965:163) is also of the opinion that an individual does not have much say in his being taken to the doctor or hospital:

> "in the African context when a person becomes ill, whether he comes from a very sophisticated urban home or from the bush the decision to see a doctor is usually made by the entire household or community and therefore the patient's own sentiments do not really matter."

Given these circumstances leading to hospitalization, the patient may feel rejected by members of his family. If the patient feels this way he will opt to remain in the hospital rather than go back home. His behaviour may be such that when he is about to be discharged he engages in "sick behaviour

so that his period of stay in the hospital is lengthened" (Goffman, 1961:55). The patient thus elicits behaviour which is congruent with a negative attitude toward discharge. It is with this in mind that Chapman and Almeida (1972:381) insist that:

> "the patient should be told that he is going to be admitted to a psychiatric hospital. He should not be manoevred to the hospital by deceit and misinformation."

Therefore, when a patient is not told that he is being taken to the hospital, he may feel angry and annoyed with his relatives for not consulting him on an issue that directly involves him. In such circumstances, he may very well want to remain in the hospital.

As has already been mentioned, the patient is not usually hospitalized at what may be termed the onset of his deviant career. It is usually after repeated efforts at containing him, which have resulted in failure, that the patient is hospitalized.

The precipitating factor leading to hospitalization is usually disruptive behaviour. It is when the patient becomes overtly destructive that measures are taken to have him hospitalized. Ordia (1958:50) of Nigeria states that:

> "lunatic asylums were merely places for the confinement of criminal lunatics and others suffering from acute mental disorders. Civil patients who were not dangerous or anti-social were either looked after at home by their relatives or by native herbalists."

Tewfik (1958:66) records the same for the situation in Uganda,

> "the majority of.....admissions to Mulago Mental Hospital give a history of sudden severe confusion, restlessness, wandering, violence, destruction of crops and arson."

Cox (1978:105) reiterates the position for Uganda but for a different mental hospital namely Butabika Mental Hospital. He states that,

> "eighty-eight per cent of patients were admitted compulsorily and 48% were brought to the hospital by the police (which) would suggest that it was psychotic patients who behaved in a socially disruptive way who were regarded as requiring psychiatric hospitalization."

This may not necessarily mean that these patients were violent as Cox did not investigate the reasons these patients were brought to the hospital. From the figures and referrals it would be plausible to suggest that the behaviour exhibited by the patients was of a violent or unacceptably disruptive nature thus requiring hospitalization.

Ugorji and Ofem-Okoi (1976:298) hypothesized that:

> "behaviour disorders recognized as mental illness by subjects (in the research) would depend on the visibility of the symptoms manifested (where the term social visibility refers to the extent to which a given behaviour is perceived as threatening to the well-being of the community)."

Having completed the research they concluded that,

> "symptoms associated with neuroses and personality disorder were significantly less perceived as abnormal."

Thus, it is individuals whose behaviour has become overtly and conspicuously deviant who are regarded as a big enough problem to warrant hospitalization. It soon becomes obvious, then that the general feeling is that the patient need not be taken seriously unless he becomes dangerous. Dangerous to whom? to himself and to others. Society must be protected so he is hospitalized.

The Mental Health Order 1978 of Swaziland (S3 and S7) states quite clearly who a mentally ill patient is. It states,

> "a mentally ill person is a person who by reasons of some mental illness is incapable of managing himself or his affairs, or who requires care, supervision and control for his own protection or for the protection of others."

He can only be discharged if the psychiatrist is of the opinion that "he is not a danger to himself or others".

It is of interest therefore, to see the kind of diagnosis that patients in the hospital are given. Cox (1978) states that patients with neurotic disorders are a very small proportion of the hospital population.

According to Tewfik (1958:66)"Schizophrenia is the most commonly diagnosed psychosis in Africa. Carothers diagnosed it in 30.4% of 609 admissions in Kenya, Smarte in 34% of 321 admissions in Dodoma and in South Africa in 52.3% of 1,215 admissions". Cox (1978:105) in his study on 94 Ugandan male patients at Butabika Mental Hospital found 37.2% diagnosed as such. In Japan, Caudill (1959:226) found it prevalent in 54% of the hpspital population. It seems to be, therefore, that many of the patients admitted to mental hospitals tend to be admitted because they are disorderly and unkempt with a tendency towards destructiveness, and on admission to the hospital are diagnosed as schizophrenic.

Looking at these two factors then: how long the patient has been ill and symptoms at hospitalization, it becomes necessary to see how these relate to attitude to discharge and also how relatives feel about having the patients back especially those relatives who have had a sick patient (or relative) for some time.

With admission to the hospital begins what Goffman (1961) terms the moral career of the in-patient. On entry into the hospital the patient is in most cases diagnosed and assigned

to a particular ward. Goffman (1961); Altschul (1973) and Caudill (1958) all agree that diagnosis can be an important factor in establishing the outcome of hospitalization and the patient's attitude to discharge. Caudill (1958:54) believes that sometimes diagnosis can function less as a useful classi-factory tool, and rather more as a security operation on the part of the staff by means of which they could feel there was little the hospital could do for the patient. This implies that once classified under a certain diagnostic label the patient will get little or no attention from the staff because he may be in the category regarded by them as being beyond treatment and cure.

This opinion is supported by Dinitz, Lefton, Angrist and Pasamanick (1968:441) in their study on predictors of case outcome in mental hospitalization. They conclude that:

> "there is little doubt that hospital diagnosis is of importance in predicting outcome...a diagnosis of organic damage is an excellent predictor of poor outcome. ...other diagnoses fail to differentiate among outcome groups."

Also with regard to hospitalization, many patients especially those who have been consulted on the issue and have given their consent, have high expectations about being hospitalized, in the sense that the notion they hold of a hospital is that it is a place where they are supposed to get treatment and so get well. However, they become increasingly disappointed in their expectations; they see the doctor only once or twice a week, if at all (Wing and Brown, 1970). It

becomes important and necessary therefore to see if these experiences will have any relation to the way the patient feels about staying in or leaving the hospital.

In summary, therefore, the literature suggests that various factors can be isolated which could play a role in a patient's views about his discharge. The factors dealt with in this review centre mainly on family relationships involving marital issues, such as polygamous marriages and responsibilities to one's family.

Also dealt with were the reactions to hospitalization by patients especially if they were not consulted on the issue. Of interest also were the reasons relatives gave for hospitalization of patients: in most instances this was as a result of aggressive behaviour coupled with a tendency to be destructive, while on admission many patients are diagnosed as schizophrenic. When in the hospital the patient finds the hospital is not as he expected. All these observations may influence the patient's desire to leave the hospital, positively or negatively.

B. THEORETICAL FRAMEWORK

Interaction theory is based on the premise that group life is essentially a matter of cooperative behaviour wherein each acting individual ascertains the intentions and acts of others and then makes his own responses (Meltzer 1972). It focuses on interpersonal relationships and how people communicate with each other and how they relate to each other.

Interaction theory sees deviance, namely mental illness as basically a social phenomenon arising because of conflict in these interpersonal relationships. The mentally ill person is deviant in that he does not conform to the standards which the society expects him to conform to. Thus the assertion that "one cannot even form the notion of order without the contrasting concept of deviance against which conformity can be measured" (Coser, 1967:111).

Deviance and conformity are seen as two opposites but which form a whole. There is no separating one from the other. Therefore, to try to understand the deviant behaviour of a mental patient one has to also look to his relationship with others prior to the onset of his deviant behaviour for the factors that may have brought it on. Stryker (1959:445) states that:

> "crises always threaten identifications for these latter will depend on stable activities of others with reference to oneself, and crises are likely to be important in the process by which identities change."

Mental illness is thus seen as essentially a breakdown in interpersonal communication. Interpersonal problems are seen to be as a result of a poor communication network which results in a failure to understand others or even to be understood. It is when this communication difficulty becomes continuous that the individual becomes isolated by the group (family) and so experiences rejection.

On experiencing isolation and rejection the individual sees his group as a threat and this brings him into open conflict with it. This may lead to his temporary or permanent isolation from its affairs sometimes in the form of hospitalization. When "he acts differently to his environment, others also react differently towards him and this latter reaction commonly, if not typically involves covertly organized action and conspirational behaviour" (Lemert, 1967:197). This is then expressed in the institutionalization of the patient.

Human beings, therefore, interpret or give meaning to each other's behaviour and actions instead of merely reacting to each other's actions. The response is not made directly to the actions of one another but instead is based on the meaning which they attach to such actions. The response an individual makes is determined by the meaning he has given

to the actions of another individual (Meltzer 1972). The mentally ill person is hospitalized, therefore, because he is seen through his attitude and behaviour to show a disregard for the values and norms of the group. He is seen to prefer to engage in behaviour which is unacceptable to the group even though this may not be so to him.

This leads us to the question of attitudes and their importance in interpersonal relationships and communication. The definitions of attitudes are indeed many and varied but they all tend to stress the negative or positive nature of attitudes and their derivation from a person's experience giving rise to aspects of behaviour. Thus Chave (1928) as quoted by Allport (1967:7) is said to have defined attitudes "as a complex of feelings, desires, fears, convictions, prejudices and other tendencies that have given a set or readiness to act to a person because of varied experiences."

In like fashion Allport (1967:7) also quotes the definition of attitudes as propounded by Bogardus (1931). Bogardus is said to have defined attitudes "as a tendency to act toward or against something in the environment which becomes thereby a positive or negative value."

Allport, himself, describes attitudes as "a mental and neural state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is

related." (Allport, 1967:7).

Thus the utility of the concept, attitude, lies in the fact that it offers an explanation for socially significant behaviour. Most of these definitions of attitudes emphasize the fact that attitudes contribute to overt behaviour. However, a correlation between attitudes and behaviour rests on the stability of individual differences - that is, a tendency for an individual to respond somewhat consistently from one situation to another. Nonetheless, Kiesler et.al. state that:

> "while our theoretical analysis of attitudes definitely commits us to a position that attitude factors should in general be correlated with some behavioural factors, it does not commit us to a position that each attitude factor should be correlated to all behavioural factors."
>
> (Kiesler, Collins and Miller, 1969:36)

Therefore, though one would expect a consistency in all expressed attitude and the resulting behaviour this is not necessarily the case because there may be other mitigating factors which have been overlooked and thus not taken into account. But this should not shake us from the premise that attitudes and behaviour have some association, even though the latter may not necessarily be overt.

Attitudes are not influenced by only one experience but by many, and experience in itself takes place in the context of social interaction. People will always associate

with each other, they invariably influence each other's thoughts, feelings and reactions even if unintentionally. Thus disturbed behaviour can be said to be "most often a response to another person, or an effort to obtain a response from another person .... Man's every action tells something to someone or is a commentary or a demand." (Leininger 1973:26).

Laing (1968:286) reiterates this position that the mentally ill persons behaviour, namely the schizophrenic, must be dealt with in relation to his fellowmen more especially his family.

Thus even when dealing with the patient in the hospital, his attitude and behaviour has to be analyzed and observed in the context of what he says about himself and in his relations with those around him. Also keeping in mind that behaviour which may appear to be out of control may actually be calculated and controlled. It may be quite intentional on the part of the patient but because of ignorance on the part of the observer this behaviour can easily be interpreted as deviant, yet it may not be.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

A. RESEARCH DESIGN

Objectives of the Study

The major objectives of the study are to look into:

(a) The nature of the problems faced by the patients prior to hospitalization;

(b) Patient's views about hospitalization;

(c) Patient's experiences during hospitalization, the focus being on their relations with members of staff and other patients;

(d) Patient's views about the hospital;

(e) Relatives' responses regarding the patients;

(f) Basic background information about the patients such as age, sex, educational level and so forth.

(g) To relate the above factors to the patients' attitude to discharge.

Hypotheses

(1) Patients who have responsibilities outside of the mental hospital will tend to have a positive attitude to discharge;

(2) Patients who were not told about the decision to have them hospitalized will tend to have a negative attitude to discharge;

(3) Patients whose relatives wish to have them back will tend to have a positive attitude to discharge;

(4) Patients who have established a rapport in the hospital will tend to have a negative attitude to discharge.

Variables

The independent variables of this study are:

(a) Responsibilities outside the hospital;

(b) Patients' reactions to hospitalization;

(c) Relatives' feelings about the return of the patient;

(d) Rapport during hospitalization.

The dependent variable is attitude to discharge.

Operational Definitions and Indicators

Responsibility outside the hospital. For the purposes of this study responsibility outside the hospital referred to the sense of obligation the patient had to get better and to go back home because of his/her status as a husband/wife, father/mother or as a bread winner for the family. Responsibility was measured by the patient's marital status, presence or absence of children and whether the patient had employment or not.

Patients' Reactions to Hospitalization: This referred to whether the patient was informed or not about admission to the hospital and his response to the action.

Relatives' Feelings about the Patient: This referred to the expressed opinion by the relatives that they would like the patient back home. It also takes into consideration whether the patient thinks he is wanted back home or not.

Rapport During Hospitalization: This referred to communication with medical staff and patients while in the hospital. This was measured by who talked to the patient about his illness, and who he felt was contributing to his recovery.

Attitude to Discharge

This referred to the expressed point of view by patients as to whether they wanted to leave the hospital or not even though they were not necessarily certified as ready for discharge by the psychiatrist. Positive attitude to discharge referred to those patients who professed to want to leave the hospital. Negative attitude to discharge referred to those patients who wanted to remain in the hospital and indifferent attitude to discharge referred to those patients who were not decided as to whether they wanted to leave the hospital or to remain there.

To ascertain each patient's attitude, an attitude to discharge measure was constructed as discussed in the methodology page 28.

B. METHODOLOGY

Site Description

This research was undertaken in the Manzini district at the Matsapha Mental Hospital in Swaziland. Manzini, as well as being a district, is also a town. It is the second largest district in the country after Hhohho. It is centrally situated and has a large industrial base. Matsapha is the area of industrial activity just five miles out of the centre of town. The Mental Hospital is situated on the outskirts of this industrial area, but is within walking distance of it. Within the same precinct are found the women's criminal prison, the tuberculosis hospital and the soldiers' barracks. Half a mile away is the men's top security prison. The hospital thus tends to have an air of tight security because of the police and soldiers who are always around.

The hospital is built of prefabricated material because it was not really meant to be long-lasting. It was in fact, part of the barracks for the Scottish Gordon Highlander who were a peace keeping force for the colonial administration prior to the country's independence in 1968. With the start of independence negotiations they were withdrawn in about 1964. After their departure, the place was then reopened as a mental hospital.

Prior to the opening of this institution persons regarded as insane or mentally ill were kept in the prison at Mbabane, the capital of the country. For medication, they were taken to the

Mbabane Government Hospital. Most of these early patients seem to have been those who had somehow strayed into Swaziland from other countries (South Africa) and then could not find their way back to their homes. Some came with relatives but somewhere along the line seem to have been abandoned for one reason or another.

In traditional times, the Swazi person who became ill was usually looked after by the traditional doctor even if it meant strapping him down with ropes if he was aggressive and violent. Indeed, there were many who were treated at home because there was always someone at home to look after the place. However, times have changed and presently the home is usually without anybody to look after it for the better part of the day because, besides the husband going to work, even the wife has to seek employment to supplement his income, while the children are often at school. As a result there is no one left at home who can take care of a sick relative. An outcome of this was that many mentally ill persons started roaming the streets and generally created havoc. Thus there was a felt need to have these people taken care of and also to help alleviate the critical overcrowding experienced by the prisons where these mentally ill persons were being kept. Therefore, in 1964 the patients were moved from the prison at Mbabane to the hospital at Matsapha where they are currently hospitalized.

Units of Analysis and Sampling

The units of analysis in this research were the patients at the Matsapha Mental Hospital in Swaziland. The staff were not interviewed but were spoken to on an informal basis. The focus of the study was on the patients' views about discharge. It dealt with interpersonal problems experienced by the patients prior to hospitalization and some of their experiences during hospitalization, and how they felt about being hospitalized.

The number of patients interviewed was seventy-eight in all. The method of sampling patients was initially random. The patients' files are well kept in the order of the date of admission, which includes day, month and year and the number allocated to the patient on the day of admission. For filing purposes the number and year are utilized. Thus those patients admitted in 1980 have a range of numbers from one to infinity so to speak. These are then arranged chronologically. It is the patient's name, however, which is used for identification purposes. Thus patients are known by their names rather than by their numbers. The patients' files are well kept and up to date, with the nurses doing the administrative work in this regard.

The researcher went through the files selecting every alternate file in the cabinet. The file number and name of the patient were noted and also the medical history. The researcher did not use a pseudo-nym for the patient because there was a need to know who the researcher was talking to during the interviews so as to coordinate the medical history with the interview.

The names were erased at the completion of the field research and ordinary numbers were utilized as identification.

The importance of this procedure was pointed out to the researcher by the psychiatric nurse at the outset of the research. She suggested that the researcher get to know the patients as well as possible before starting on the interviews.

The researcher, therefore, spent the first two weeks trying to know the patients. One week was spent on the female section and the other week was spent on the male section. During these weeks of familiarization the researcher joined in the hospital activities such as singing and playing games, listened when patients had something to talk about and also told them what the research was all about and why it was being done. By the time the researcher began interviewing the patients were quite familiar with her.

At some point the researcher found that this method of sampling was going to limit severely the number of patients who could be interviewed. It was also found that almost every second patient interviewed was too ill to talk and so make much sense, when asked a question they would ramble on about one thing or another. Some were not able to talk at all. Others would just stand up and walk away in the middle of being questioned. These the researcher tried to interview again when they were a little better. Others were still too drowsy or sleepy to respond to the questioning because they were still on heavy

doses of tranquilizers. To try to counteract these problems, the method of sampling was then changed.

The group leaders who are also the mental patient orderlies, were asked as to who in their respective groups was well enough to talk coherently and could be understood. The opinion of the group leaders was requested as opposed to that of the nurses and doctors because they were the ones in most contact with the patients. Their predictions about which patients were getting well were fairly accurate as most of the patients they pointed out were discharged very soon after. This meant, therefore, that the patients who were being interviewed were almost ready for discharge, and in fact, many were discharged. This method of sampling was opted for because it proved to be the most satisfactory in the given circumstances. It was also chosen because of the belief that irrespective of whether the patient is ready for discharge or not he will still have an opinion as to whether he wants to go home or not, be it in the long or short run. If a patient did not want to go home he would opt to remain in the hospital. For one thing it was impossible to get an opinion on the matter from those who were still very ill, thus the research had to utilize the next best method.

Relatives of the patients were also interviewed to ascertain their views about the patient's illness and whether they would like to have the patients back home or not. Some of the relatives were interviewed while on visits to the hospital.

In most cases however the researcher had to seek them out at their various homes. A number of problems arose because of this and as a result only thirty-eight were interviewed even though every effort was made to interview more. This is discussed more fully in the section on "Problems Encountered" below.

Problems Encountered

Even with the new method of sampling employed, some problems did arise more because the researcher did not have a research assistant thus many of the patients left the hospital before the researcher had time to interview them. About 15 patients were missed in this way. Each interview took about an hour, sometimes more. As a result only five or six patients were interviewed a day. On some days such as Tuesdays and Thursdays the number interviewed was even less because these were the days on which the patients did their washing and played games respectively. Taking it that only those ready for "discharge" were being interviewed, these were also the ones regarded as most competent to do the work around the hospital and to lead in the playing of the games. This was also a setback for the researcher in that at times these patients were least available for interviewing.

There were also some problems encountered in interviewing relatives. In some instances, during the interviewing of the relatives, the researcher had to leave the questionnaire with those who were found at the home so that it could be filled in when the relatives came back home in the evening. This meant

at least two trips to one and the same house, sometimes even more because the questionnaire would not be filled in. Thus a lot of time was utilized. Sometimes the patient would give the researcher directions to his home, this would involve extensive walking because of lack of transport facilities. This also resulted in a lot of time being utilized without much gain. At other times there would be no one at home or they would say the patient was not living with them when the illness started and they therefore could not furnish the researcher with any information regarding his illness.

The researcher was also frequently given directions to a patient's home, but would be unable to find the said place. The researcher was unable to get much help from the staff in this respect because they were also unaware as to where the patients came from. This was so because in most cases patients were fetched by their relatives on discharge. The patients' medical records only gave addresses of the next of kin and not where the patient actually lived. Of the ten questionnaires which were posted only one was returned.

Some patients refused to tell the researcher where their homes were altogether. Many of these were patients who did not want to leave the hospital. Other patients came from countries outside of Swaziland such as the Republic of South Africa, Lesotho, Malawi or Mozambique. One patient did not know where his home was at all. He had been in the hospital for over eight years.

Another problem which arose in the location of relatives was due to the rainy weather during this period. Most times there would be no transport to remote areas because the roads were in a very poor condition. In one way or another, therefore, the researcher's progress was impeded due to all these difficulties.

Data Collection Methods

The data collection was done by the use of a questionnaire, medical records and observation method. In preparing the final questionnaire a pilot study consisting of ten patients, five males and five females, was done with a view to testing the initial questions for relevance. On the completion of this pilot study a few questions were omitted while others were added. The questions which were omitted tended to be repetitive of previous ones and in other instances the information could be received from other questions because most of the questions were open-ended. Most of the questions were open-ended because the researcher was not in a position to anticipate the different answers which were likely to be given by the respondents. The aim was, in fact, to allow them to express themselves as much as they could in relation to the question.

The revised questionnaire was then administered to the seventy-eight patients, individually by the researcher. This questionnaire can be found in Appendix 2, page 117.

Medical records were utilized to obtain the following information: file number, patient's name, age, sex, occupation,

medical history, home district, diagnosis, referral, next of kin, date of first admission, number of times admitted, number of times absconded and the number of times seen by the doctor.

Observation method was utilized in an attempt to support verbal statements about attitude to discharge made by the patients or respondents. For instance, if a patient said he wanted to remain in the hospital his behaviour was observed to see if it supported his statement or not. This data will be presented in the form of four case studies at the end of the Findings chapter.

Besides the above, observation method was used to get an insight into the hospital, conditions and the experiences of the patients while ill in the hospital. It was also utilized so as to ascertain staff and patient relations and interactions even if on an informal basis.

Attitude to Discharge Measure

The measure for attitude to discharge was adopted from Wing and Brown's study on the Institutionalization of Schizophrenia, (1970). The questions utilized as numbers are 10, 11, 12, 16, 19 and 20 in the questionnaire (see Appendix 2). To arrive at a total score for the measure, the questions were weighted in the following way.

The weight of each variable or question was chosen on the basis of the strength of the variable and how important it was in contributing towards a positive attitude to discharge. The rationale for this decision was that if a patient gave a positive response to one question he was likely to do the same for most of the other questions because of the interrelatedness of the questions. (For weights to the various question see Appendix 2).

The responses to each question were given a value in favour of a positive attitude to discharge; from 1 to 1:5 to 2. For example, question 19: "would you like to remain in the hospital permanently?" the possible responses were as follows:

(1) Yes

(2) No

(8) Do not know

(9) No response

Response number two was given a value of 2 while response number one was given a value of 0 and response number eight was given a value of 1. Response number nine was not given a value because of the researcher's belief that it did not in any way give an opinion about attitude to discharge. However, all the patients interviewed responded to all the questions relating to the attitude measure.

Therefore, if the respondent answered "No, he would not like to remain in the hospital permanently", then he was given

a score of 12, which represents the weight of that variable multiplied by the value of the response. The other questions which comprised the measure were calculated - weighted and valued - in a similar manner.

Finally, all the highest possible scores for each question were added up with the total score being 44 points. The lowest possible score was zero as all the variables had at least one response with a zero value to it.

To ascertain the number of patients who had a positive attitude to discharge as opposed to a negative or an indifferent one, a percentage level was chosen. Seventy-five percent and above of the highest possible score was utilized as the standard mark for those patients with positive attitudes towards discharge and twenty-five percent and below for those with negative attitudes. The respondents lying in the middle, that is, from 25.45% to 74.45% were regarded as those with an indifferent attitude toward discharge, They have no strongly negative or strongly positive desire to remain or leave the hospital.

These percentage levels were chosen because the researcher was interested in finding patients with highly positive and highly negative attitudes. This would bring out more clearly, the factors which influence the patients attitudes. Taking a less stringent level would have made the resultant difference less pronounced.

Responsibility Scale

The "responsibility" scale was constructed to ascertain whether having responsibilities outside of the hospital affected the patient's attitudes to discharge or not.

The questions utilized to make up the scale were questions 4, 5, and 6 in the questionnaire. To arrive at a total score, the responses were given values ranging between zero and two. The questions were not given weights. This was because the variables were regarded as possessing equal weight in contributing to responsibility. It was the difference in the response that made up for the difference in the level of responsibility.

The value of the responses were thus chosen on the basis of their contribution towards high responsibility. This was done in the following way:

Responsibility	Indicators	Components	Values
	children	with children	2
		without children	0
	marital status	married	2
		single, separated, widowed	1
	occupation	working	2
		not working	0

A patient, therefore, who said he was married, with children and was working prior to hospitalization would score a total of six which would make him high on responsibility. While someone who stated that he was not married, did not have

children and was not working prior to hospitalization would score one and thus be very low on responsibility.

Therefore, a score of five or six was regarded as high, a score of three or four was regarded as medium and a score of one or two was regarded as low on responsibility.

This basis of scoring was that if you had all the attributes you would be high on responsibility whereas if you had some and not others you would tend to be on the medium scale and low if you had only one of the attributes.

The result was that 40% of the respondents were found to be high on responsibility while 45% and 15% were found to be medium and low respectively.

Statistical Analysis of the Findings

Frequency distributions were constructed in the presentation of the background information about the patients and also on information relating to the hypotheses.

These frequency distributions were then cross tabulated against attitude to discharge for the purpose of testing of significance of the hypotheses.

The chi-square (X^2) was utilized in this regard.

CHAPTER FOUR

FINDINGS AND DISCUSSION

This section discusses the background information about the respondents, a testing of the hypotheses, a discussion and a presentation of the case studies.

Seventy-eight patients were interviewed during the course of the research and thirty-eight relatives. As this study set out to ascertain the patients' attitudes to discharge, a measure was constructed to that effect (see Methodology and Appendix I)

Attitude to discharge had three values namely positive, negative and indifferent. Patients who had a positive attitude comprised 42% of the respondents, those with a negative attitude and indifferent attitude were 18% and 40% respectively.

A. BACKGROUND INFORMATION

The variables relating to background information will be tabulated as frequency distributions and then where necessary will be cross-tabulated against attitude to discharge in the testing of the hypotheses.

Sex of Respondents

There were thirty nine female patients interviewed against thirty-nine male patients. This equality in numbers was by coincidence and did not arise because of planned sampling procedure. It may be accounted for by the fact that ... . . .

the researcher spent an equal amount of time between the male and female sections or wards during the research.

Of the male patients only 26% had a positive attitude to discharge, 28% had a negative and 46% had an indifferent, while of the female respondents 59% had a positive attitude to discharge, 8% had a negative and 33% had an indifferent attitude. Thus in overall terms the female patients had a tendency towards a positive attitude to discharge.

Age of Respondents

The following frequency table shows the age range of the patients who were interviewed.

Table 1: Age of Respondents in Years

Frequency	Age in Years				
	Below 20	21-30	31-40	41 and over	Total
Number	8	34	16	20	78
Percentage	10	44	20	26	100

This table brings out the fact that the majority of the respondents' ages were within the 21-30 age group. Thus many of the patients were comparatively young.

Educational Background of Respondents

Most of the patients had been to school as witnessed by Table 2.

Table 2: Educational Background of the Respondents

Frequency	Educational Level in Grades						
	None	Pre-Primary	Primary	Secondary	High	College	Tot
Number	25	6	26	16	4	1	78
Percentage	32.1	7.7	33.3	20.5	5.1	1.3	100

The distribution shows that more than half of the respondents had some educational background. However, only one patient had professional training - as a teacher. The majority of the patients, 40% had some primary schooling; 20.5% reached secondary school level but many failed to complete and only 5% reached high school level.

Districts from Which the Respondents Came

Table 3: Home Areas of Respondents

Frequency	Districts					Total
	Hhohho	Manzini	Lowveld	Shiselweni	Other	
Number	17	30	9	12	10	78
Percentage	21	39	12	15	13	100

The majority of the respondents came from the Manzini district which after Hhohho has the most industries. It is also the district in which the mental hospital is situated. It is developing very fast - technically - and like most developing towns has the attraction of being capable of offering employment to job seekers. The Hhohho district is the largest in terms of industrial activity and size, but is far from the hospital thus many patients are treated in the local clinics or by the traditional doctors. The hospital psychiatrist makes monthly visits to this area.

Twelve percent of the patients came from the Lowveld, a sugar growing area. Another 15% came from the Shiselweni area presently one of the poorest and least developed areas. The hospital staff visited this area for clinics at least once a month. The respondents comprising the "other" category were from South Africa, Malawi and Mozambique. Many said they

strayed into Swaziland and some said they had come with relatives but had subsequently lost contact with them.

Information Relating to the Hypotheses and Discussion

The following is a presentation of the frequency distributions of the variables directly related to the hypotheses or the discussion section of this chapter.

Marital Status

The following table shows the marital status of the patients.

Table 4: Marital Status of Respondents

Frequency	Married	Single	Widowed	Separated	Total
Absolute	21	48	6	3	78
Percentage	26.9	61.5	7.7	3.8	100

A large proportion of the respondents, comprising 61.5% of the sampled population, were single. Twenty-one percent were married with only 7.7% and 3.8% widowed or separated respectively. There were no divorced patients even though many of them professed to have marital problems.

Of the married women interviewed 57% said they had marital problems, while 33% said they had no such problems. Ten percent stated that they were old and had a tendency to "wander away" and as a result they were hospitalized.

All the respondents in the separated category stated that their illness and subsequent hospitalization was due to their marital problems which terminated in a separation at the village level - with a local tribunal authorizing the separation. Sixty-six percent of these respondents were unable to conceive and in the case of one patient, the husband was given her sister. The patient however, could not bear to see her sister with her husband thus her collapse.

Of the widowed respondents who were all females, only one was ill prior to the husband's death, while the remaining five fell ill after. Two were suicidal thus had to be kept under close observation most of the time; because there was nobody to look after them at home they were brought to the hospital where they could be cared for. The other two had problems with their in-laws.

In the one instance, the patient had been refused permission by her in-laws to live with another man, her lover, because he had not asked for her hand officially. The lover, however, did not want to take the patient's hand in marriage because he was already married and said that he could not afford to take another wife. All this worried the patient so much that she subsequently became ill. She was discharged but returned to the hospital within two weeks because her in-laws now refused to give her custody of her children.

The other patient was a second wife to her husband. She had lived with him for a few years but he had then gone to South Africa to work in the mines there. She had continued living with her in-laws while he was away but she had been unhappy. She was hospitalized in 1965. Her husband had never been to visit her and her in-laws had also stopped doing so. She believed that her husband was dead because he had never been to visit her - though she still remembered his face in her dreams.

The patients categorized as single also complained pre-dominantly of family problems. Of this category 73% of the respondents stated that their illness was due to failure to relate adequately towards members of the opposite sex. This failure was due to being impotent on the part of some male respondents or being unable to conceive on the part of the female respondents. Other female respondents complained that on falling pregnant the fathers of their children professed ignorance or outrightly denied having made them pregnant. Having to leave school with no money to support themselves and their children, coupled with parental rejection for some, resulted in their mental breakdown due to the stress and anxiety involved in such a situation. Most of the impotent patients were diagnosed as epileptic and professed to have difficulty in relating to women, as a result, many preferred to remain in the hospital rather than leave.

Of those patients who said their illness had nothing to do with family problems, 8% were students who said they only got sick during exams, another 8% stated that they were epileptic and said that their relatives were tired of looking after them. Another 6% said that they had no relatives thus nowhere to live.

Children

The following is a distribution of the number of respondents with children and those without children.

Table 5: Respondents with and without Children

Frequency	Children		Total
	With	Without	
Number	41	37	78
Percentage	53	47	100

There was an almost equal number of patients with children versus those without. The percentage levels being 53% for those with children and 47% for those without.

Occupation

The distribution to follow relates to the occupation of the patients prior to hospitalization. Even though some patients stated that they were employed, it did not necessarily mean that they would be accepted back at their place of work on being

discharged from the hospital.

Table 6: Occupation of Respondents

Frequency	Occupation						
	Housewife	Labourer	Teacher	Maid	Student	None	Total
Number	7	34	1	4	10	22	78
Percentage	9	43.5	1.3	5.1	12.8	28.2	100

The majority of the respondents namely 44%, claimed to be labourers. This category was composed of street sweepers, garbage collectors, gardeners, seasonal workers on farms or plantations, cattle herders, watchmen and a few hand craft workers. Twenty-eight percent of the respondents had no employment at all prior to hospitalization. Only one was a teacher, the only professional in the study group. Nine percent were housewives and another 5% were maids.

Decision to Hospitalize

The respondents or patients were asked if they had been informed by the persons accompanying them as to where they were going.

Table 7: Patients Informed about Hospitalization

Frequency	Informed Yes	No	Total
Number	34	40	74
Percentage	46	54	100

There was an almost equal amount of responses for those who said they were told that they were being taken to the hospital as opposed to those who said they were not told; the percentages being 46% and 54% respectively.

Readmissions to Hospital

Most of the patients in the sample were re-admissions as indicated by Table 8.

Table 8: Number of Times Admitted

Frequency	Times admitted First	Second § Third	Fourth § Fifth	Sixth § Seventh	Eighth § above	Total
Number	27	33	13	2	3	78
Percentage	34.6	42.3	16.7	2.6	3.8	100

Sixty-five percent of the patients were readmissions to the hospital. This could be due to the fact that very little therapeutic treatment is administered at the hospital; the emphasis being on chemical based kind of treatment namely drugs. See page 74 second paragraph.

First admissions to the hospital comprised 34.6% of the sample population. Readmissions comprised 65.4% of the sample population. However, the percentages tended to decrease after the second and third admissions.

Diagnosis

The majority of the patients were diagnosed as Schizophrenic.

Table 9: Diagnosis in Hospital

Frequency	Diagnoses						Total
	Schizo-phrenic	Senile	Alcoholic	Epilep-tic	Other specify	None to date	
Number	43	5	8	8	8	6	78
Percentage	55	6	10.3	10.3	10.3	8	100

Fifty-five percent of the patients were diagnosed as Schizophrenic as witnessed by Table 9. Only 6% epileptic and the other specify categories each comprised 10.3% of the respondents. The "other specify" category included the paranoid and some women with puepera psychosis.

Eight percent had "not been diagnosed" at the time of the research because the doctor had not at the time recorded it in the files.

Contributes to Recovery

The majority of the patients were of the opinion that no one in particular contributed towards their recovery.

Table 10: Contribution to Recovery

Frequency	Someone	No one	Total
Number	17	61	78
Percentage	22	78	100

Table 10 shows that only 22% of the respondents had someone they could talk to among the members of staff about their illness. The majority, 78%, felt that no body among the members of staff was contributing towards their recovery.

However, elsewhere the respondents were asked if they got on well with members of staff. Seventy-seven percent stated that they got on reasonably well, with only 14% stating that they did not get on with the nursing staff at all, with the remaining 9% only getting along some of the time.

Hospital Fights

Many patients stated that they had never been involved in a fight while at the hospital nor had they been beaten.

Table 11: Fights

Frequency	Yes	No	Total
Number	19	59	78
Percentage	24	76	100

Seventy-six percent of the patients said they had never been involved in a fight while at the hospital, with only 24% stating that they had.

There were, however, more incidents of being beaten up while in the hospital.

Table 12: Being Beaten

	Beaten		
Frequency	Yes	No	Total
Number	32	46	78
Percentage	41	59	100

Forty-one percent stated that they had been beaten up and 59% said they had not. Reasons for being beaten up ranged from refusing to take medication, beating another patient to being beaten for stealing a group bench.

Sometimes patients were also beaten up for trying to run away. However, the rate of absconding was not very high as witnessed by Table 13.

Table 13: Abscondance

Frequency	Abscondance		
	Have Absconded	Have not Absconded	Total
Number	14	64	78
Percentage	18	82.1	100

The majority of the patients did not abscond as witnessed by the high percentage of 82.1%; only 18% had tried to abscond. Patients who tried to abscond but were unfortunate enough to get caught were locked up in the isolation cells. They did not like the isolation cells so/tried to behave appropriately as / they will be later explained in the discussion of the fourth hypothesis.

Anywhere to Live on Discharge

The patients were also asked if they had anywhere to live on being discharged from the hospital.

Table 14: Anywhere to Live

Frequency	Anywhere to Live		
	Yes	No	Total
Number	59	17	76
Percentage	78	22	100

Note: Two respondents stated that they "did not know"

Seventy-eight percent of the respondents stated that they had somewhere to live on being discharged from the hospital. Only 22% said they had nowhere to go. The majority of the latter patients also stated that their relatives did not wish to have them back, that is why they felt that they would not have anywhere to live if they were discharged.

Desire to Have Patient Back Home

Table 15: Relatives Wish to have Patient Back

Frequency	Wish to Have Patient Back		
	Yes	No	Total
Number	30	7	37
Percentage	81	19	100

Eighty-one percent of the relatives interviewed stated that they would like the patients to return home when they got better, with 19% stating that they would not. However, the 19% who said they would not like to have the patients back went on to qualify their refusal by saying the patients need not stay in the hospital permanently. They could be let out to live with someone who was prepared to have them, though they were not.

Welcomed Home

The patients were also questioned as to whether they felt that their relatives would be happy to have them back home when they were discharged.

Table 16: Welcomed Home by Relatives

	Welcome Home		
Frequency	Yes	No	Total
Number	44	4	48
Percentage	92	8	100

Note: Thirty of the respondents or patients "did not know" if they would be welcomed back home

Of the patients who did respond to the question, that is, answer positively or negatively, a large majority (92%) stated that their relatives would welcome them, while only 8% said they did not know. Table 23 shows that the majority of the

patients who "did not know" were in the negative and indifferent categories.

Moreover, these latter patients also stated that they did not know whether they would be welcomed home or not because they hardly received visitors while in the hospital.

Visitors

Most of the patients did not have visitors while in the hospital.

Table 17: Visitors

Frequency	Visitors		Total
	Have Visitors	Have no Visitors	
Number	35	43	78
Percentage	45	55	100

The majority of the patients did not have visitors at all as witnessed by Table 16. Fourty-five percent of the patients did get visitors and 55% did not.

The consequences of this are noted under the discussion of hypothesis three.

B. PRESENTATION OF HYPOTHESES

This section deals with the presentation of hypotheses. The variables relating to these hypotheses have been presented in the earlier section in the form of frequency distributions. Some of these distributions will now be tabulated against attitude to discharge and their significance, in relation to the patients' attitudes to discharge, tested.

Hypothesis One

Patients who have some responsibility outside of the mental hospital will tend to have a positive attitude to discharge.

The following table is an adaptation from tables 4, 5, and 6. The variables namely marital status, children and occupation were combined under the broader variable "Responsibility" as discussed in the Methodology Section: see Responsibility Scale page 39.

Table 18: Tabulation of Responsibility by Attitude to Discharge

Responsibility	Attitude to Discharge				
	Positive	Negative	Indifferent	N	% Respondents
High	49	14	42	31	40
Medium	42	57	42	35	45
Low	9	29	16	12	15
%	100	100	100		100
N	33	14	31	78	

$X^2_C = 13.043$

Degrees of freedom = 4
Significance = $p > .05$

Note: only one cell with expected frequency less than 5

Table 18 indicates that patients who were high on responsibility tended to have a positive attitude to discharge, while patients with a negative attitude to discharge tended to be medium on responsibility. The indifferent category on the other hand was equally distributed high and medium on the responsibility scale.

All the patients with a positive attitude to discharge did not want to stay in the hospital permanently. The most important reason for wanting to leave the hospital was that they wanted to go home to their children and families. This response was elicited by 63% of these patients. Of these

63%, only 9% said they wanted to continue living with their spouses and the 91% said they wanted to go back to their children as they were worried about them.

Of the patients with a negative attitude to discharge however, none of them mentioned any concern about their families or children. The majority of them were not married nor did they have children. Instead, rather than go back home they preferred to stay in the hospital because they felt that their relatives did not want them back. These patients who preferred to stay in the hospital were mainly the male respondents while the patients who wanted to leave were mainly female respondents. Also, it is significant to note that more female respondents said they had children than did the male respondents.

Table 19: Tabulation of Sex by Children

Sex	Children			
	Yes Have	Have None	N	% Respondents
Male	35	66	39	50
Female	65	34	39	50
%	100	100		100
N	40	38	78	

X^2_C = 7.4; 1 df; p>.01.

Thus most male patients had no children while the majority of the female patients had children. In Swaziland, as in many other African societies, it is the explicit and unquestionable duty of the women to look after the home and to raise the children. It is also the duty of the women to take care of the economic aspect of the home such as plough the fields or sell goods at the market for income purposes. She is equally responsible for the emotional care and stability of her children. These responsibilities are particularly enforced when a man has more than one wife. Each wife has the responsibility of bringing up her own children, because it is socially accepted that each wife must fend for herself lest rivalry and jealousy arise in the homestead should the man start supporting one wife at the expense of the others. Should the children lose their mother through death or should the mother become incapacitated then the children are looked after by their grandmother on the father's side. It is then the duty of the grandmother to see to it that the children are well and healthy.

If a child deviates from the norm for any reason, it is more than likely that the rebuke for the child's behaviour will be levelled at the child's mother rather than at the father. It will be the mother who has neglected to bring up her child respectfully.

It is no wonder, therefore, that the female patients in the hospital had this strong desire to leave so as to look after their children. The patients did not see their illness

as an affliction but as an illness which they could do nothing about. They did not see it as hindering their capability to look after their children - though some relatives felt that this was the case as seen earlier in the case of the woman whose in-laws refused to give her back her children when she was discharged from the hospital.

The male patients, on the other hand, knew that their wives or girlfriends were at home looking after their children. They thus had no desire to return home because they felt that their spouses were more capable of looking after the children and keeping house coupled with the fact that the majority did not have the responsibility of being father to children anyway so the incentive to leave did not exist in their case.

Hypothesis Two

Patients who were not told about the decision to have them hospitalized will tend to have a negative attitude to discharge.

Table 20: Informed About Hospitalization by Attitude to Discharge

Informed	Attitude to Discharge				
	Positive	Negative	Indifferent	N	% Respondents
Yes	30	50	62	34	46
No	70	50	38	40	54
%	100	100	100		100
N	33	12	29	74	

Note: (i) Four of the total respondents went to the hospital of their own will

(ii) $X_c^2 = 6.37$

(iii) With 2 degrees of freedom

(iv) Significance = $p > .05$.

Table 20 shows that 54% of the patients were not told that they were being taken to the hospital while 46% were told. It also indicates that the majority of the patients who were not informed about hospitalization tended towards a positive attitude to discharge; while those who were told developed an indifferent attitude to discharge. This was manifest by the large percentage of 70 and 62% respectively.

This incongruency with regard to the hypothesis might be explained by the fact that most patients with positive attitudes to discharge were of the opinion that they were sick when brought to the hospital so they were actually grateful to their

relatives. There was little resentment on the part of these patients for not being told about hospitalization. Indeed 61% of these patients felt that their relatives were right to have them hospitalized.

The area of resentment lay with those patients who had an indifferent attitude to discharge. Fifteen percent of these patients stated that they hated the thought of going to the hospital and 12.8% of them stated that they were surprised at the whole idea and refused to go but they were forcefully taken to the hospital. The possibility arises, therefore, that having been told and having given an opinion on the matter of hospitalization which was subsequently rejected or overlooked, had helped to bring about the attitude of indifference among these patients. Being told and their views not taken into consideration made the patients angry and they consequently felt cheated because they no longer seemed to have a right to decide their own fate. The patient thus feels bitter and abandoned and uncared for. He automatically takes refuge in the institution.

What the data do indicate is that patients are less resentful if they are not told about the decision to have them hospitalized. Indeed, the data seem to uphold the view stressed by Lambo (1965:163) that in an African context hospitalization was decided by the whole household without the individual's consent or his sentiments being taken into consideration. Infact, 88% of the respondents were referred to the hospital with only

12% going there of their own accord, that is, making the decision to go to hospital themselves.

Hypothesis Three

Patients whose relatives wish to have them back will tend to have a positive attitude to discharge.

Table 21: Wish to Have Patient Back Home by Attitude

	Attitude to Discharge				
	Positive	Negative	Indifferent	N	% Respondents
Yes	85	50	91	30	81
No	15	50	9	7	19
%	100	100	100		100
N	20	6	11	37	

Note: (i) Four out of six (66%) of the valid cells have expected cell frequency less than 5.00.

(ii) Minimum expected cell frequency = 1.14

(iii) Chi-square calculated = 4.63 with two degrees of freedom

(iv) Significance = $p < .05$

Table 21 shows that the majority of the total respondents, namely relatives of the patients, did wish that the patients get well and be in a position to return back to their homes. As can be seen 85% of the patients with a positive attitude had relatives stating that they would like them to return home; with only 15% stating that they would not like the patients

to go back home.

Of the patients in the negative category 50% of their relatives said they would have them back and a similar percentage said they would not like to have them back.

On the other hand, the indifferent category had relatives markedly in favour of the patients going back home comprising 91% of the responses and only 9% stated that they would not like the patients to go back home.

As can be seen from the table, a patient's attitude to discharge was not really dependent on a relative's response as to whether he wanted the patient back home or not. In fact many of the relatives of the patients with a negative attitude stated that even though they did not want the patient to return home they did not want him to remain in the hospital permanently. He could, they said, go out and live with another relative on condition the relative was willing to have him.

However, the majority that is 64% of the patients with a negative attitude stated that they had nowhere to go even if they were discharged. By "nowhere to live" the patients meant that they did not have someone with whom they could live and did not necessarily mean that they did not actually have a home. In most instances, the patients said it was the relatives who did not want them back

home and they did not want to be a nuisance to anyone.

On the other hand, the opposite was true for patients who had a positive attitude to discharge with 88% stating that they had somewhere to live on being discharged.

Table 22: Anywhere to Live by Attitude to Discharge

Anywhere	Attitude to Discharge				
	Positive	Negative	Indifferent	N	%
Yes	88	36	86	59	78
No	12	64	14	17	22
%	100	100	100		100
N	33	14	29	76	

Note: 2 respondents "did not know"

$X_C^2 = 17.42$

2 degrees of freedom

Significance = $p > .001$

Thus it was very important that the patient had somewhere he could go to on discharge for him to want to leave the hospital. It is also noteworthy that 86% of the patients who had an indifferent attitude to discharge had somewhere to go to.

Furthermore, 79% of the patients with a positive attitude to discharge were sure of being welcomed home by their relatives

when they were discharged. The remaining 21% said they did not know how their relatives would feel.

Table 23: Welcome Home by Attitude to Discharge

Welcome Home	Attitude to Discharge			
	Positive	Negative	Indifferent	No
Yes	100	33	89	44
No	-	67	11	4
%	100	100	100	
N	26	3	19	48

Note: (i) Thirty of the respondents "did not know" if they would be welcomed back home.

(ii) Four out of six (66%) of the valid cells have expected cell frequency of less than 5.00

(iii) Chi-square calculated = 15.841

(iv) With 2 degrees of freedom

(v) Significance = $P > .001$

Table 23 shows that of the patients who did respond to the question about being welcomed back home by their relatives 100% of the patients with a positive attitude to discharge were sure that they would be welcomed back home. A large majority of 89% of the patients with an indifferent attitude to discharge were also sure of being welcomed back home by their relatives. Only 11% of these patients said they would not get a good reception if they left the hospital.

Patients in the negative category, on the other hand, showed a reversal in response to the above. Only 33% of the patients who responded to the question were sure of being welcomed back home and 67% were not. The majority of the patients in the negative category, 78%, did not respond to the question.

The patients with a negative attitude to discharge were also hesitant about going home because they said their relatives did not visit them. Seventy-one percent of the patients with a negative attitude to discharge did not get visitors at all during their stay at the hospital. Of these same patients 36% stated that they felt annoyed and also hurt that they had been in the hospital for several weeks and some even months and nobody had been to visit them. They could not, therefore, say that they wanted to go back home when they did not know what reception awaited them there.

In overall terms 54% of all the respondents did not get any visitors. These patients were then asked if they would have liked their relatives to visit them or would they rather have the relatives stay away. Eighty-five percent stated that they would like to be visited. They rationalized their absence of visitors by saying that the relatives did not know that they were in the hospital, or that their relatives lived far and could not afford to visit them because of transport costs, or that the relatives were taking care of the home and had no time to visit. The remaining 15% stated that they did not care whether their relatives came to visit or not. Some stated that they had spent many years in the hospital and the relatives

had never been to visit them, it was thus not necessary for the relatives to start visiting them.

Furthermore, the respondents were not aware of their relatives' feelings as to whether they (the patients) would eventually get better or not. Forty-two percent said they did not know how their relatives felt about the issue and 36% said they believed their relatives thought that they would eventually get better.

Of the relatives interviewed, however, 42% thought that the medication the patients received was not helpful and as a result were not sure if they would get better. Fourty percent said it was helpful and 18% said they did not know because the patients relapsed so frequently. Indeed, 87% of the relatives who were interviewed did not know what type of treatment the patients received in the hospital.

However, an overwhelming majority of 82% of the relatives stated that they accepted the patient's illness and had treated him as they would any other sick member of the family. They had in turn tried to get all the medical treatment they could for the patient. Even the remaining 18% stated that they had done all they could for the patient during the initial stages of the illness. The illness had, however, been going on for so long that they had become increasingly annoyed with having to deal with the behaviour. They still accepted him as a member of the family but they would not like him to return home as he had become a problem.

Hospital Experiences

Hypothesis Four

Patients who have established a rapport in the hospital will tend to have a negative attitude to discharge.

A patient's experiences in the hospital inevitably start with the process of admission to the hospital. In this study 65% of the patients were readmissions to the hospital while only 35% were in for the first time.

Thirty-nine percent of the readmissions had a positive attitude to discharge, 16% had a negative attitute to discharge and 45% had an indifferent attitude to discharge.

On admission to the hospital all the patients went through a similar routine. Once the person accompanying them had given the details of the patient's illness to the doctor then the patients were taken to the wards where they were given hospital uniforms. Their clothes were then noted in the Patients' Property Book item by item. These were taken to the storeroom, folded and tied into small bundle with their name tag to await their discharge.

The uniforms were dark green in colour. They came in all shapes and sizes, but patients seemed to always have a size too large or a size too small. Many of the female patients' uniforms invariably had a tear under the sleeve, or the hem would be loose, or if it was a skirt it would have no belt with which

to tie it. The patient was given a length of gauze bandage with which to tie it. She would be told to look after the "belt" very carefully becasue she would not be given another if she lost it. The general sight was one of untidiness especially after the uniforms had been worn for a day or two.

The men's uniforms were of the same colour and were comprised of a pair of short trousers and a short sleeved shirt. Their general appearance was better than that of the female patients.

Jerseys were also supplied by the hospital but these were always in short supply. Patients were not encouraged to wear their own jerseys for fear that these would be stolen. As a result many patients would shiver right through the cold. Sometimes they were allowed to cover themselves with blankets but this was discouraged because they would put the blankets on the floor thus making them dirty.

If on entry into the hospital the patient was garrulous or violent he was taken to the isolation cells. Usually it was only one individual per cell except on the male section where there were more aggressive patients, thus there were sometimes two or three patients in one cell. The isolation cells were not popular at all with the patients because they were dark, cold and very drab. Most times there were no lights in the cells because the patients tended to break the globes. The light they got was from the street lights or the other wards around, but even this was minimal because the windows were so small.

Of interest about these isolation cells is that they were the only wards that were built from concrete material while the others were built from prefabricated material. This in itself signified that the patients in there were dangerous and should thus be kept in as secure a structure as possible. Indeed, patients who were in the cells were only let out when they went for meals. After meals they were taken back there without question. Thus once a little better they tried to keep out of the cells by behaving themselves.

They were however, returned to the cells if they tried to abscond. It was not surprising therefore, to find that the majority of the patients did not make any attempt to abscond as witnessed by the high percentage of 82, while only 18% had ever absconded during their stay at the hospital. Of the abscondees 93% were readmissions and the remaining 7% were first admissions.

Patients were locked in the wards early because of the fear that they would run away under the cover of darkness if they were left out too late. They were counted so that abscondees could be noted. Abscondees were always reported to the Psychiatrist the following day who in turn notified the police so that the latter could search for the offender and return him to the hospital. The High Court Judge and Director of Medical Services were also notified when a patient absconded just as they were notified when a patient was admitted or discharged from the hospital.

While in the hospital the majority of the patients were diagnosed as schizophrenic, these comprised 55% of the respondents. Six percent were diagnosed as senile, 10.3% as alcoholic, another 10.3 as epileptic and 8% had not been given any diagnosis at the time of the research. The remaining 10.3% were patients who had been paranoid or with pueperal psychosis. The diagnoses were thus all of a psychotic nature and no cases of neuroses were found. The finding was congruent with that brought out in the earlier sections of this thesis namely the literature review. Various authors such as Ordia (1958), Tewfik (1958), Cox (1978) and Ugorji and Ofem-Okoi (1976) all agreed that most patients found in mental hospitals were there because their behaviour was socially disruptive and seemed to be of a threatening nature to the community. The majority of these patients were then subsequently diagnosed as schizophrenic

The medical treatment received by the patients in this study was mainly of a chemical nature. Ninety-six percent of the patients received as part of their treatment tablets and injections. Only 4% received psychotherapeutic care while in the hospital as well as tablets to help stabilize their condition. The most commonly used drugs were Chlorpomazine, Melleril and Stellazine. Ortane was used for those patients who had developed side effects such as shaking hands, stiff shoulders, protruding tongue or constant head jerking.

As a result of the chemical nature of the treatment received by the patients, 78% stated that no member of staff was contributing

towards their recovery in an emotional way, that is, by talking to them and trying to help them understand the nature of their problem and how to try to overcome it. Instead they felt that the tablets and injections were helping them to get better. As most of the patients were readmissions they were sceptical about the effectiveness of the medication. They felt that as they had been to the hospital before and they had thought that they had been cured it was not likely that the medication would do them much good as they became ill again when they stopped taking it. The prospect of taking medication for the rest of their lives was a daunting prospect to most of them. Moreso, when they were discharged, they found that the problems they had experienced at their homes and which they felt had culminated in their mental breakdown were still there and they still found no way of getting around them or solving them.

Fifty-eight percent of the patients stated that nobody spoke to them about their illness while in the hospital. Thirty-seven percent said an orderlie or an attendant spoke to them, and only 1% said the nurses spoke to them and the remaining 4% said the doctor spoke to them. The latter were the same patients who had received psychotherapeutic treatment as a form of medication.

The relatively "high" percentage of 37 for patients who said an orderlie or an attendant spoke to them was not surprising in view of the fact that these members of staff were the ones in most contact with the patients. The patient population was

divided into groups and each group had two group leaders who were orderlies. The orderlies had no nurse training and little education. Their main duty was to see to the supervision of the patients as they cleaned the wards, did the washing, played games or when they went for meals. A group leader knew the patients in her group by the colour of headscarf they wore in the case of female patients and by neck ties in the case of male patients. These were then her responsibility and reported to her or asked her permission if they wanted to do anything.

The attendants, on the other hand, were basically in charge of the wards and if there was no qualified nurse on duty they would take the patients to the doctor for routine check-ups. They could also administer drugs if the necessity arose. They were a notch higher in rank than the orderlies because of their experience in the hospital but they also had no training and minimal education.

Thus patients' interaction with members of staff was minimal. Interaction between staff and patients was, in fact, comprised mainly of patients receiving orders to do one thing or the other, patients receiving medicines or just sitting down next to the orderlies. Singing of traditional or church songs occured now and again and the orderlies would join the patients in this. This was not witnessed on the male section. In fact, on talking to some of the group leaders - on an informal basis - the general impression received by the researcher was that they felt that

it was not really for them to question the patients about their problems, rather it was the duty of the doctors, social worker and even the researcher to find this out. This did not, of course, mean that they did not lend a sympathetic ear when the need arose.

Nurses, like the doctors, hardly had any "real" contact with the patients except when administering medicines during meals or when taking patients to the doctor. They always gave the impression of being administrative assistants rather than nurses. They were always seen to be keeping medical records up to date, writing monthly reports on the patients or taking the patients to the doctor.

Whenever patients went to see the doctor the nurse on duty was required to be there for interpretation purposes and to give the doctor a résume of the patients progress since the last time they were seen. The nurses sometimes received this information from the group leaders before the patients were taken to the doctor's office. It was the orderlies, however, who were seen by the patients as contributing most of their mental recovery in terms of staff care.

The issue however, was to see if having someone to talk to while in the hospital contributed in any way to a patient wanting to leave or to remain in the hospital.

Table 24: Contribution to Recovery by Attitude to Discharge

Contributes to Recovery:	Attitude to Discharge				
	Positive	Negative	Indifferent	N	%
Someone	18	14	29	17	22
No one	82	86	71	61	78
%	100	100	100		100
N	33	14	31	78	

Note: (i) One out of six (16%) of the valid cells have expected cell frequency less than five.

(ii) Minimum expected cell frequency 3.05.

(iii) Chi-square calculated = 1.66 with two degrees of freedom.

(iv) $p < .05$

According to table 24 the relationship between the two was non-significant. Indeed, of all the respondents only 22% had someone who spoke to them about their illness while in the hospital.

Contrary to what was hypothesized, having contact with the nursing staff and being able to have someone to talk to while in the hospital did not play any role in this particular study because the majority of the patients stated that nobody spoke to them.

Wing and Brown (1970) noticed in their study on the Institutionalization of Schizophrenia, that patients who were in most contact with the nurses and to whom the nursing staff were very friendly did not want to leave the hospital because they had become dependent on the nursing staff. However, even those who had almost complete lack of contact with the nursing staff also displayed a strong reluctance to leave because they were allowed to do things for themselves such as make tea or coffee, go forwalks, watch television, have radios and so on. They were allowed to behave almost as if they were at home but without the stresses and anxieties which had resulted in their illness.

This was not however the case in this study. First of all the patients felt that nobody was contributing towards their recovery. Rather they felt that the medication they were given was most instrumental in their recovery. Secondly, unlike the patients in the Wing and Brown study the patients in this study did not have all the facilities that would otherwise help to induce them to remain in the hospital. Patients had no television set they could watch in the evenings. They were not allowed to take walks on their own and, in fact, did not go for walks even with members of staff. Though they had a hospital radio it was always kept in the office and not for use at their convenience.

C. DISCUSSION

The aim of this research was to find out some of the reasons patients had for wanting to leave or remain at the Matsapha Mental Hospital. This involved looking at whether the patients wanted to leave the hospital because there was a need to do so in terms of having responsibilities at home which they wanted to fulfill. It also dealt with how patients felt about being hospitalized by their relatives, whether they were told that they were being taken to the hospital and if so did they feel that their relatives had done the right thing to have them hospitalized. It dealt with some of the patients' hospital experiences especially communication with the hospital staff. These factors were then tabulated against attitude to discharge to see if they had any significance towards helping to form the latter.

The hypotheses were then geared in this direction in an attempt to show if the above proposition had anything to do with attitude to discharge.

The hypothesis relating to family relationships was supported by the data. It was shown that patients who were high on responsibility tended to have a positive rather than a negative attitude to discharge. The most important factor influencing high responsibility was the presence of children in a relationship. The majority of the patients with children, who happened to be mainly women, felt it was essential for them

to leave the hospital so as to be with their children. The urgency or desire to leave was attributed to societal expectations which the patients felt they had to fulfill as brought out in the discussion of the first hypothesis earlier.

The data also showed that about 80% of the patients complained of family problems. The men complained of impotency or of being unable to maintain relationships with women and all of these were single men with negative attitudes to discharge. Many of the married women complained about their husbands taking second or third wives and then neglecting them - emotionally - as a result. In Swazi tradition no matter how many wives a man had he was required to maintain his sexual and emotional affinity with each wife. It became a matter of concern if he did not do this and action could be taken at a communal level to restore relations. Even though some women said they had had meetings with their elders it had not made any difference and their husbands had continued to ignore them. Thus they wanted to leave not to see their husbands, who had caused them much pain, but their children.

The women who were single also complained predominantly of neglect by the fathers of their children. These patients stated that they had hoped their lovers would marry them, but they had been left for new girls. They had subsequently become frustrated and ill. Some had to leave school and were rejected by their parents because they had become pregnant. Life had seemed to be, all of a sudden, comprised of a bad turn of events.

Thus, for these women, leaving the hospital was not to be with a lover or spouse but to be with the children they had conceived during the courtship. They always felt that they could find employment so as to look after their offspring.

However, as seen in table 6, the type of employment the patients were engaged in was not always the most lucrative. Fourty-four percent of respondents said they were labourers doing jobs such as gardening, cattle herding, street sweeping or garbage collecting. Even if they had wanted to get better paying jobs this would have been almost impossible because 31% had no education at all and the remaining 69% who had been to school, had been only for a limited period. As a result only 1% of the respondents had any professional training and could hope to earn a better wage than most when he found employment. Otherwise, none of the other patients had gone beyond standard seven at school.

Although some patients did say they would not mind going back to school (the students in the sample), not many would have been able to do so as 90% of them were over the age of twenty-one with only 10% under twenty. Therefore, it was most unlikely that they would have been in a position to better their educational status and thus their chances of better jobs.

The study also showed that 65% of the respondents were readmissions to the hospital with the remaining 35% being admitted for the first time. Furthermore, it was seen that patients were

not diagnosed or classified as neurotic; rather the classifications were all of a psychotic nature. These classifications ranged from schizophrenia, paranoia, alcoholic to senile and epileptic. Patients were not aware of the meaning of these classifications in a medical sense. They said that they had been told that they were mad or insane, they did not know what it meant to be schizophrenic or paranoid. They said they had been hospitalized for various offenses such as burning people's houses or clothes, beating children, shouting at people or singing at odd hours of the night, blocking traffic on the roads, talking to themselves or being mute and also wandering away and getting lost not knowing where they were going. Most of the patients were diagnosed as schizophrenic and a few older ones as senile.

These diagnostic labels were for use mainly by the two doctors. They had no relevance in the day to day nursing care of the patients by the orderlies or attendants. If the nurses felt that there was nothing that could be done for a particular patient it was not because he had been given a certain label but because they had observed him from day to day and seen the progress he was making. Nonetheless, the hospital routine for check-ups, by the doctor, was such that even chronic patients were examined whether it be once in six months or once a year.

Many patients who were admitted to the hospital were referred there by their relatives. These comprised 88% of the respondents. Similarly 90% of the respondents were accompanied to the hospital. Fifty-four percent of the patients

were taken in police cars. Of the patients who were accompanied to the hospital 46% were told by whoever accompanied them that they were going to the mental hospital and 54% were not informed. Table 10 indicated that patients who were told that they were being taken to the hospital turned out to have indifferent attitudes to discharge, while patients who were not told where they were going to had predominantly positive attitudes to discharge.

Goffman (1961:227) stated that patients usually went to hospital under the threat of force or because they had been threatened with the breaking of family ties if they refused to go to hospital. It was found in the present study that the majority of the patients had no say in their hospitalization. Those patients who had given an expressed opinion on the matter of their hospitalization and whose opinions had been rejected or overlooked felt that those involved in their hospitalization had been disloyal to them. This was made worse by the fact that they were then forced to travel to the hospital with the police making them seem criminal rather than ill.

The result was that they felt bitter and abandoned by their relatives for having mortified them. They subsequently did not care whether they went home or not because they were not sure of their relatives loyalty. It became an issue of - if they come and fetch me, well and good; if they do not then at least I have some where to stay. Therefore, patients who were told that they were being taken to the hospital tended to have

an indifferent or negative attitude to discharge, while those who were not told tended to have a positive attitude to discharge. Most of the latter group felt that hospitalization was for their benefit so they did not mind.

Even though these patients felt that hospitalization had been for their benefit, most of them did not necessarily like the hospital itself. Eighty-eight percent of the patients with a positive attitude to discharge said they did not like the hospital at all and only 12% said they did. But even the 12% who said they did like the hospital were quick to add that they only liked it because they got better and were thus able to go home. On the other hand, 78% of the patients with a negative attitude to discharge stated that they liked the hospital very much and only 22% said they did not. The reaction from the patients with an indifferent attitude was mixed with 42% saying they liked it and 58% saying they did not like it.

As a result of this 76% of the patients with a positive attitude had various complaints about the hospital while 86% and 52% of the patients with a negative or indifferent attitude respectively did not have anything to complain about. Of the patients who did complain,their complaints were mainly about the cold and dreary wards, the jail-like atmosphere of the hospital, distasteful and monotonous food, being beaten, the isolation cells and one or two complained about the cheeky nurses and patients who were always bothering them.

Seventy-seven percent of the patients said they got on reasonably well with the staff as long as they did what the staff wanted them to do. Twenty-four percent said they had been involved in a fight while in the hospital, but all these had been with other patients. The fights had been over soap, jumping the queue while waiting for food, stealing tobacco, over boyfriends and girlfriends and one patient who had water thrown over him by another patient.

There were, however, more incidents of being beaten. Fourty-one percent said they had been beaten up while in the hospital. Only 14% of these claimed to have been beaten up by a member of staff. The reasons for being beaten up were that they had refused to take their medication, stolen someone else's food or were caught while trying to abscond. The other 86% said they had been beaten up by fellow patients over incidents such as stealing tobacco, stepping on another patient, stealing a group bench so he could sleep on it and some said they had forgotten the reasons. In overall terms, most of the patients had never been beaten nor had they been involved in fights.

In addition to being referred the majority of the patients were accompanied to the hospital. Relatives alone accompanied 36% of the respondents. Relatives were comprised of parents, brothers and sisters, cousins, nieces and nephews, spouses, aunts and uncles, one's children and in-laws. The police alone accompanied 31% of the respondents while police together with a relative brought 23% of the respondents. The police were

thus involved in at least 54% of the admissions to the hospital. Thus the patients were almost always brought in to the hospital with the threat of force hovering above their heads, by the presence of the police. Even if they refused to go they would invariably end up at the hospital because the police would be there with their Land Rovers to make sure that they got there.

Another area of resentment for the patients could arise from the fact that on admission to the hospital they were seldom, if ever unless they came on their own, allowed to give details of their illness to the doctor. The medical history was usually taken from those escorting him. The police, if there was no relative were not really informed about the patient's illness and its onset because they had been with the patient for only a few hours before he was transported to the hospital. They would, however, state the reasons why they were asked to take the patient to the hospital or why they decided to arrest him and have him hospitalized. The reasons for arrests ranged from being aggressive, beating people on the streets, burning clothes and houses indiscriminately, walking around naked or aimlessly to talking to oneself or not talking at all.

Sometimes patients would hear what the police or the relatives were saying and would intervene and say that the statements being made were untrue. Their shouts would go unheard and the discussion about them would go on as if they were not there.

Having given the medical history of the patients the referees would leave the patients in the hands of the staff namely the nurses. The nurses would then take the patients to the wards. The patients were then told to remove their clothes and they would be given the hospital uniform to wear. The patients' clothes would then be noted in the Patients' Possession Book item by item, folded and tied into a small bundle with his name tag on it and stored away in the storeroom to await his discharge.

If on entry into the hospital the patient was garrulous or violent he was taken to the isolation cells. The isolation cells were dark, cold and very dreary. There were no lights most of the time because patients were said to break the globes. The light that filtered through the small windows was from the street lights or the other wards around. Patients in the isolation cells were seldom given blankets to sleep on. Some members of staff felt that this was not necessary because the patients apparently did not feel cold when they were in the acute state of mind and also because some of them were incontinent.

Having gone through a similar routine before and sometimes on several occasions, and a routine which was not pleasant for them gave rise to an indifferent attitude to discharge. Indeed 74% of the patients in the indifferent category were readmissions. They had thus been through the routine of hospitalization before and knew what it entailed.

In conclusion, therefore, it can be seen that patients who were not told about hospitalization did not tend to have a negative attitude to discharge, rather the opposite occured with patients who were not told tending to have a positive attitude to discharge. Patients who were told about the decision to have them hospitalized tended to have an indifferent attitude to discharge.

D. CASE STUDIES

This section is a presentation of four case studies. The case studies highlight the statistical aspects of the study. They bring out quite clearly in a descriptive way what would otherwise be very difficult to convey statistically.

Case Study One

This lady was first admitted to the hospital in 1970. She has had eight readmissions since then. She was twenty-six years old at the time of her first admission. She is married. She had five children but two died. She was not employed prior to her hospitalization. As a housewife she stayed home to take care of the children. At school, she managed to complete standard four.

She was referred to the hospital by her husband and the police as escorts. She was referred to the hospital because she could not sleep at night, was insulting and violent to people, misappropriated money and property. She also had a tendency of disturbing the children while they were asleep.

She was subsequently diagnosed schizophrenic. Her average length of stay at each admission was about three months.

At the time of the interview in November 1980 she sounded quite coherent. She had been in the hospital for about two weeks on this last admission.

She complained that she did not like the hospital food because it tasted very "bad as if it had been cooked for dogs". She bought her own bread and milk whenever she could, usually after her sister had come to visit her and had left her some money. The thought of the isolation cells was abhorent to her. She said, "they are very cold and horrible places to be in."

The nurses sent her to the hospital shop quite frequently. She did not mind this because it meant she could get away from the wards a little. She always wanted to leave the hospital so that she could go home to plough her fields while there were rains as well as to look after her children. She said, "I can't expect my mother to bring me up and my children as well."

The patient's most outspoken concern was about her husband. He had taken two more wives. She did not get along well with these other wives because she believed that they bewitched her and killed her children. To keep her husband from sleeping with these other wives, when she was home, she would put some of her sleeping tablets in his tea when he came to her hut then he would fall asleep and would not be able to go to the other wives' huts. The sleeping tablets were the prescriptions...

she was given to take home with her. The patient said that the doctor had asked her if she wanted a divorce from her husband and she had replied in the affirmative. However, she had heard nothing about the matter since then; she said perhaps the doctor had been fooling her.

One day her husband came to the hospital to ask for her discharge. When she realized that he had not come just to visit her, but to take her home she literally became ill. She did not want to go back home with him. She became garrulous, and very excited. She would feign weakness and lie down on the cement floor. Then all of a sudden she would sit up and start talking animatedly. When the husband saw her doing all this he made a comment to the effect that he was not taking her anywhere because she was still very ill. He left without her.

The moment the husband had left the patient was herself again, at least the self we were used to seeing in the hospital. She started talking to the patients and staff; quite pleased with herself that she had fooled her husband.

A week or two later her mother came to the hospital to ask for her discharge. The patient left with her mother.

Unfortunately, her sister informed the researcher that the patient was on the point of a relapse because her husband had insisted that she be returned to him. There was nothing they could do about this because all the "lobola" - cattle

given by the groom to the bride's family - had been used so they had no cattle to return to him and so reclaim the patient.

The patient had not yet returned to the hospital at the time of the researcher's departure.

Case Study Two

This gentleman's history of mental illness dates back to when he was still very young, almost a child. However, he was admitted for the first time at the age of twenty-one in 1977. He had not been out of the hospital since that time except for a brief period of about one month in 1979 when he absconded.

He was referred to the hospital because he had set fire to some houses, fought with his brothers' wives and beat their children for no apparent reason. He was diagnosed epileptic.

The patient stated that both his parents were dead so he had to live with his brothers who had taken over the care of the home. He had no desire to return home because his brothers did not like him. He said,

> "when I get the fits I tend to beat people. I used to beat the children so my sisters-in-law said they would rather go away if I remained in the house. So how can I go back there."

His brothers did not visit him while he was at the hospital. They refused to have anything to do with him.

This patient believed that he had been bewitched and so would not get better until he had seen a traditional doctor. He said,

"I am awaiting death and that is all."

He also professed to have a problem with forming and maintaining relationships with the opposite sex. As a result of this he said,

> "I don't even think about women any more because I don't feel anything for them. It isn't the pills, but the illness which has caused this."

He expressed a desire to go to an orphanage rather than to go back home if he could not remain in the hospital. When asked as to what he liked most about the hospital, he replied,

> "To be able to stay here alone and to keep away from my enemies who are my brothers."

He liked everything else about the hospital though he did not state what in particular. He got on very well with the nurses and patients; liked them all very much as they were his friends.

Case Study Three

This patient's illness dates back to when he was a child while still herding cattle. He was first admitted to the hospital in 1975 but was subsequently discharged after two months. He was then readmitted again in 1978 and had not been

discharged since. He had no history of absconding.

The first time he was referred to the hospital was by a cousin who said that the patient complained of headaches and had fits. He had also stabbed a person but was unaware of doing so.

On the second occasion, he was referred by his brother because he had tried to burn his hut.

The patient believed that his brother had poisoned his mind so that he (the brother) could take the patient's wealth given to the latter by their father. He said,

> "My brother took me to an "inyanga" - traditional doctor - and I think they were trying to strengthen themselves by using me. Even when I speak to a woman she disregards me and treats me as if I don't exist. They took my soul and put it in the inheritance so that they could have it all."

He further related a dream he had had prior to the recent illness.

> "When I was proposing to a girl I saw my brother's shadow so I stopped midway. I could not go further. My brother had taken the heart out of me to continue. I never saw the girl again. Now I can't even propose to girls."

He was of the opinion that only a traditional doctor could cure him because the medications he received in the hospital "do not make me feel any better, they make me feel worse." The patient expressed fears about going home and stated that

he was happier in th· hospital.

At some point the patient was certified as ready for discharge. The hospital ambulance was on an errand in his home area so he was told he could go home. As they were approaching the patient's home he started fighting with the attendants in the ambulance. He refused to get out of the vehicle. He was subsequently taken back to the hospital.

The patient was being taken to his brother's house. He did not think this was a good idea because he believed that he always got sick at his brother's house, so he tried to avoid being taken there.

Indeed, the brother had come to visit the patient but had refused to take him home saying he would tell his mother to fetch him. The animosity between them was such that even the patient expressed well-being if the brother did not visit him.

On interviewing the brother he categorically stated that he did not want the patient back at his home because he was a problem. He even went so far as to state that people like the patient should be looked after by the government because they were a problem at their homes.

Case Study Four

This patient was first hospitalized n 1977 when she was twenty-five years old. She had four readmissions since

then the latest being in December 1980. She absconded in January 1981 and had not returned at the researcher's departure.

Educationally, she completed standard one but did not continue after that. She had six children but two died.

She was referred to the hospital by her father who stated that the patient was violent, spoke senseless things, sang senseless songs and would wriggle her body and arms restlessly. Her average length of stay in the hospital at any particular admission was two and a half months. She was diagnosed schizophrenic.

She was interviewed in December 1980, two weeks after her admission. She was one of the patients who stood up several times to walk away while she was being interviewed. When questioned as to what she liked most about the hospital she retorted,

"I do not like anything about the hospital."

She further complained that it was so ridden with lice and even though efforts were made to get rid of them they were so many that they would not die. She thought that the isolation cells were very bad and the atmosphere was as though they were all in a jail rather than in a hospital. She did not get along at all with the nurses and patients. The nurses would talk to her only if they wanted to send her, while the patients frightened her because they fought too much.

The patient said that her illness started after the delivery of her sixth baby. When she gave birth to the child her husband fell in love with another woman. This other woman then told her to "leave this house or you will go crazy." The patient continued,

> "so I left the house. The baby was left with her and my husband. I was still breastfeeding the baby."

The husband took all four children. She wanted her children back but her husband would not let her take them because he had paid "lobola" for her so he had a right to all the children. She felt that the other wife was not looking after the children well. She was, however, in a dilemma because even though she wanted the children to be with her she did not have a steady job to be in a position to provide for them.

After her last discharge she went to see her children. She found that one of the girls had been given a corset by the other wife to wear to school. Seeing this corset belonged to this wife, the patient felt annoyed and angry as to why, "this woman should give my child her corset. I then started abusing her and telling her she was an evil woman." The patient was subsequently returned to the hospital. On admission she requested that this other wife be called to the hospital and asked as to her intentions for giving the child her corset. This had not been done.

The patient did want to live with her husband as well as the children. Seemingly, however, the husband had refused to have her back because during one of her periods of illness she had gone to an "inyanga" who had told her that she was being bewitched by her mother-in-law. She had then gone back home and accused the mother-in-law of this. The husband thus refused to have her back for these accusations against his mother. He insisted that they should all go to the "inyanga" to exculpate his family from these accusations of witchcraft. Should these accusations not be true her family would have to pay for defamation of character before he could take her back.

However, the patient felt that the above was not correct and in fact had never occured. The only reason she could think of as to why her husband did not want her back was because "he was made to eat by the woman he was living with." This meaning that, the other wife had bewitched him so that he had come to hate the patient and did not want to have anything to do with her.

She always spoke about going home to see her children.

Case Study Five

This patient first became ill in late 1977, but was hospitalized for the first time in 1978. He had been readmitted to the hospital five times since then, but has never been discharged. He absconds all the time. The longest time he

ever spent as an in-patient was three weeks.

He was thirty-seven years old, was not married but lived with a widow and their seven children; two being his with the woman and five being the woman's from her first marriage. He completed standard five at school, and did not continue with form one. He was diagnosed alcoholic psychosis.

His main concern was with money. He said he wanted to fetch his money which he had left in Johannesburg , South Africa, while working in the mines. Besides fetching his money he also wanted to find employment so that he could support his family. He said,

> "I cannot afford to stay in the hospital because my children would starve. My brothers will not help me to look after them but they will come to me when I have money otherwise they don't care about me. They are all crooks."

When asked as to what he liked about the hospital he said he did not like anything about it.

> "I got beaten for nothing and I am always made to sleep in the isolation cells. They lock you up all day in there. I only appreciate the fact that they treat us and make us better."

He stated that he only wanted to go home so that he could help his wife to look after the children.

He was taken ill because he was worried about finding money to feed his large family. Even though his family

brewed local beer to try to raise money this did not help much because some of the children were now attending school and they needed more money. His problem was that when he became too worried he had a tendency to drink too much of the beer which then made him ill.

His elder brother was also an alcoholic while his younger brother who was also at the hospital was a marijuana addict.

CHAPTER FIVE

CONCLUSIONS

Given the preceding facts from the research it was concluded that the typical patient with a positive attitude to discharge was a female patient who had children and had somewhere to live on discharge from the hospital. Her relatives wanted her back and she was aware of this. She was not necessarily married; thus the expressed desire to leave the hospital was not for the sake of a spouse but for the sake of her children. Moreso she felt that her spouse or boyfriend was responsible for her breakdown.

This typical positive attitude patient was young with an age range of below thirty years. She had been admitted to the hospital more than once and was likely to be serving a second or third readmission. She was diagnosed as schizophrenic.

She received a fair amount of visitors while in the hospital and this helped to keep the continuity of the family relationship going. She thus felt that she had not been rejected by members of her family because of her illness. She looked forward to having visitors when she could because they brought her news about home and her children.

Even though, she may have been upset about being hospitalized she realized that her relatives did not do it to get rid of her as such but to help her. She felt that they still cared

for her and all things considered it was the best way out of the given circumstances. She thus came to believe that her realtives did the right thing and indeed helped her by having her hospitalized. Ironically, she was not informed about the hospitalization, but she did not mind this because she believed her relatives did it without malice and with her interests at heart.

She obviously disliked the hospital and wanted to leave as soon as possible. She said she would go home immediately if the doctor said she could so. She did acknowledge the usefulness of the hospital as a place where she could get better. Not because the staff treated her exceptionally well, but because they gave her medication which she felt helped her a great deal. This positive attitude patient was optimistic that she would eventually be cured but was somewhat baffled by the relapses.

The typical patient with a negative attitude to discharge on the other hand, was a male patient also below thirty in age and commonly received a disgnosis of schizophrenia, paranoia or epilepsy.

He had attained a minimal level of education, was single and without any children. He was also unemployed prior to hospitalization. He had also been admitted to the hospital more than once, but unlike the patient with a positive attitude he liked the hospital very much. He was not interested in leaving

the hospital at all and wanted to stay there permanently. Once in the hospital, he did not get any visitors and did not want anyone to visit him, rather he preferred that they stayed away. He was not interested in how his relatives were because, he said, they did not care about him. He said his relatives did not want him back home and would not welcome him, thus he felt he did not have anywhere to go. Infact, even if the doctor advised him that he was well enough to go home he said he would refuse to do so.

He did not know whether the medication he was receiving was making him better or not but he did believe that he would eventually get cured. Nobody spoke to him about his illness in the hospital and he said no one was contributing to his recovery. Though he did feel that staying in the hospital was better than going home and being illtreated and becoming ill again.

The patients with an indifferent attitude to discharge were more divided in their reactions. There was an almost equal chance that it would be a male or female patient between the age of twenty-one and forty. They were single with a likelihood of no children. They were also likely to be in the hospital on a second or third admission. The diagnoses were more varied but the majority were still schizophrenia. They liked the hospital and wanted to leave eventually but not soon or immediately. Though they would leave if the doctor insisted that they do so.

The majority did have somewhere to live when they did eventually leave but they were not sure about their relatives' response to their homecoming. Moreso because they did not get many visitors. Unlike the patients with a negative attitude they said they would like to have visitors and were still interested in their families.

Unlike the patients with a positive attitude they were informed by their relatives or whoever took them to the hospital where they were being taken to. When they voiced their opinion on the matter or refused to go they were taken forcefully. They did not think their relatives were right to have them hospitalized; even though some said they did feel better than when they were first admitted. However, the fact that they were hospitalized against their will made it difficult for them to acknowledge that their relatives did not want to get rid of them. Many of them felt that they were old enough to be able to make decisions about themselves. Perhaps with time they would come to acknowledge that their relatives were being helpful.

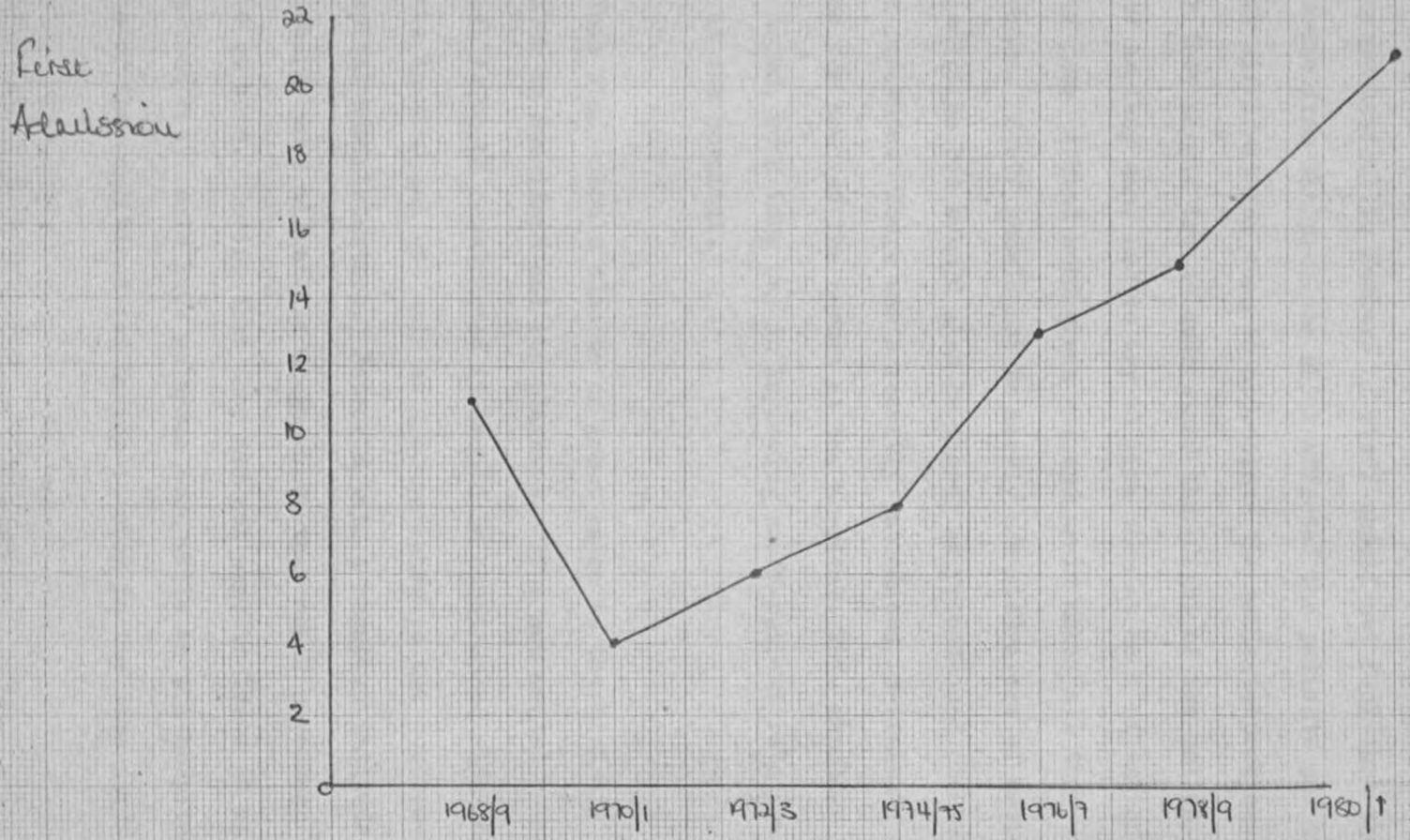
RECOMMENDATIONS

During the course of this research, it became obvious that, in some instances the factors which led to patients refusing to leave the hospital, could be directly related to the reasons why patients were hospitalized. This was so in the sense that, in the majority of the cases studied the patients had a family or interpersonal problem which they felt culminated in their mental

breakdown. When questioned as to why they did not want to go home, the patients with a negative attitude to discharge stated that they had nowhere to go if they left the hospital, their relatives wanted to get rid of them, or that they always became ill at home and so it was better to remain in the hospital. These reasons given above all refer to the problems the patients encountered prior to their hospitalization.

This realization is important in that besides dealing with the effects of hospitalization, the research has also highlighted the basic causes and the problems these could lead to for the patient, his family and the government. With this in mind it is hoped that this study can be of value to various segments of the Swazi population such as social workers in their role as counsellors and advisors to people with such problems. This study may help the social workers to help people to sort out and solve their differences before they culminate in illness. They can, thus, give counsel to both relatives and patients in this regard. Indeed, this is necessary as can be seen by the following graph. (See following page).

The graph shows that there has been a gradual increase in first admissions to the hospital since 1970-71; with the most admissions being in 1980 and the early months of 1981. This indicates that either mental illness is on the upward trend in the country or that more people are making use of the hospital facilities. If the former is true then the role of the social worker can only be reinforced.


First Admission
22
20
18
16
14
12
10
8
6
4
2
1968/9
1970/1
1972/3
1974/75
1976/7
1978/9
1980/1
Year

If the latter is true then there is no reason to underestimate the role the members of staff at the hospital have to play in their capacity to rehabilitate the patients. As the study pointed out most of the patients' problems were of a social nature. It would be useful for members of staff to try to appreciate these problems and to understand the patients more fully and more sympathetically. Members of staff should not feel that they are immune from the problems which affected the patients and thus make it difficult for them to appreciate the patients' problems. Rather they should try to understand the plight of the patients as best as they can, and to try to give them as much attention as they can. A kind word given now and again makes all the difference. Staff should not be merely administrators of medicine and discipline but should also be there, as friends and counsellors to the patients. There was a recently introduced in-training service for some of the nurses at the hospital. This should, it is hoped, go a long way in improving staff-patient relationships at the hospital.

This study should also be of great value to the Ministry of Health in Swaziland and its planners. If a new mental hospital is to be constructed it should be constructed with the patients in mind and not only as a convenience to the government or hospital administrators. Patients with a negative attitude to discharge were all at the stage where they could have been told to go home. Seeing that they did not want to leave it is likely that they would have relapses even while in the hospital - because of the conditions and having to stay in the same wards

with very ill patients.

The suggestion being made here is that the construction of the new hospital should be such that those patients who have nowhere else to go or whose problems continuously recur with no hope of being solved could be allowed to stay on at the hospital - having their own section. They should have gardens where they can work and sell their produce. There are many other occupational crafts they could participate in, such as pottery, flower-making, basket and mat-making, woodwork or carpentry, sewing and knitting, crocheting and so on. In this way the patients will have somewhere to live and help to contribute towards their upkeep so that they are not seen to be,"burdens" on society as they are sometimes made out to be. All this can be done with considerate and careful planning.

Swaziland is a very small country with a population of just slightly over half a million. At any given time the hospital has an occupancy of at least 200 patients. In the sample population, for instance, 34.6% of the patients were being admitted to the hospital for the first time and all these were 1980-1981 (early) admissions. Also of interest, is that the age range of 64% of the hospital patients lies between twenty-one and forty-years. This becomes a critical situation. Critical in the sense that though the proportion may not seem so large in terms of the whole population, it does cause some concern and is food for thought because many of the people falling ill are in the age group seen as most lucrative to

any country's development. Lucrative in the sense that they are able-bodied and strong and given the opportunity could contribute towards the country's development be it socially, politically or economically.

The issue of mental illness should be considered seriously in any development strategy because it is more often than not an offshoot of rapid technological development and social change. Some people find it very difficult to cope with these rapid changes and as a result their lives are adversely affected. The mental hospitals are in turn inadequately staffed or ill-equipped to deal with the rising problems. Very often mental hospitals have to find their own ways of raising finance for their projects because they have either not been catered for in the Ministry's budget or because funds allocated to it are too little. It thus becomes difficult for it to fulfill its objectives.

The field of mental illness is very interesting and enlightenin as regards human behaviour. It is the researcher's hope that this study, which is the first of its kind in the country, will encourage other students and researchers to learn more about the illness especially in the context of Swaziland. The major difficulty experienced by the researcher during the course of the research was that therewere no works of reference which could be utilized to get better insight into the whole problem of mental illness in Swaziland. It is the researcher's hope, therefore, that more research in this line can be undertaken.

Futuristically, it would be of interest to see whether long term patients with positive attitudes to discharge change attitudes and eventually profess to want to remain in the hospital on a permanent basis and the reasons for this change of opinion. This is a plausible suggestion in that these patients may find that their problems seem unsurmountable and thus may seek to remain in the hospital because they have come to see it as a source of refuge.

BIBLIOGRAPHY

ALLPORT, G.W.
"Attitudes". P. I-I3 in Fishbein M. editor. Readings in Attitude Theory and Measurement. John Wiley and Sons, Inc. New York I967.

ALTSCHUL, A.
Patient-Nurse Interaction. Longman Group Ltd. Edinburgh I972.

CHAPMAN, A.H. AND ALMEIDA, E.M.
The Interpersonal Basis of Psychiatric Nursing. G.P. Putman's Sons. New York I972.

CLARK, D.H.
"The Functions of the Mental Hospital" p. I005-I009 in The Lancet Volume 27I I956.

CAUDILL, W.
"Observations on the Cultural Context of Japanese Psychiatry" p. 2I3-24I. in Opler, M.K. editor Culture and Mental Illness: Cross-Cultural Studies. The Macmillan Company. New York I959.

CAUDILL, W.
The Psychiatric Hospital as a Small Society. Harvard University Press. Cambridge Massachussetts I958.

COSER, L.
Continuities in the Study of Social Conflict. The Free Press. New York I967.

COX, J.L.
"Psychiatric Diagnosis of 94 Ugandan Male Patients Admitted to Butubika Mental Hospital". p. I03-7 African Journal of Psychiatry Volume 4 No. 3 and 4 September I978.

CCTA/CSA-WHO
Meeting of Specialists on Mental Health. Bukavu I958.

DINITZ, S ; LEFTON, M ; ANGRIST,S; PASAMANICK, B.
"Psychiatric and Social Attributees as Predictors of Case Outcome in Mental Hospitalization" p. 437-445 in Spitzer, S.P. and Denzin, N.K. The Mental Patient: Studies in the Sociology of Deviance. McGraw Hill, Inc. New York I968.

FADIMAN, F. and KEWMAN, D. editors
Exploring Madness: Experience, Theory and Research. Wadsworth Publishing Co. Inc. Belmont California I973.

FIELD, M.J.
Search for Security: An Ethno-pschiatric Study of Rural Ghana. Faber and Faber, London I960.

FROST, M.
Nursing Care of the Schizophrenic Patient. Henry Kimpton Publishers. LondonI974.

GOFFMAN, E.
Asylums. Doubleday and Co. Inc. New York I96I.

KANDO, T.M.
Social Interaction. The C.V. Mosby Co. Saint Louis I977.

KIESLER, C.A.; COLLINS, B.A.; MILLER, B.N.
Attitude Change: A Critical Analysis of Theoretical Approaches. John Wiley and Sons. Inc. New York I969.

LAING, R.D. and ESTERSON, A.
Sanity, Madness and the Family. Penguin Books Ltd. Harmondsworth I978.

LAMBO in discussion on "Social Aspects of Ideas about Treatment" p. I37-I68 in de Reuck, A.V.S. and Porter, R., editors. Tra nscultural Psychiatry. Ciba Founda tion Symposium London I965.

LEININGER, M.M. editor
Contemporary Issues in Mental Health Nursing. Little Brown and Co. Boston I973.

LEMERT, E.M.
Human Deviance. Social Problems and Social Control. Prentice Hall Inc. New Jersey I967.

MELTZER, B.
"Meads Social Psychology" p. 4-22 in Meltzer, B. and Manis, J. Symbolic Interaction: A Reader in Social Psychology. Allyn and Bacon Inc. Boston I972.

ORDIA, A.
"A brief Outline of the History and Development of Mental Health Service and Facilities in Nigeria for the Care and Treatment of Mentally Ill Patients" p. 50-5I in CCTA/CSA-WHO Meeting of Specialists on Mental Health Bukavu I958.

PHILIPS, R.
"Rejection: A possible Consequence of Seeking Help for Mental Disorders" p. 2I3-225 in Spitzer, S.P. and Denzin, N.K. The Mental Patient: Studies in the Sociology of Deviance. McGraw Hill, Inc. New York I968.

SAMPSON, H.; MESSINGER, S.L.; and TOWNE, R.D.
"Family Processes and Becoming a Mental Patient" ch I9 in Spitzer, S.P. and Denzin, N.K. The Mental Patient: Studies in the Sociology of Deviance. McGraw Hill Inc. New York I968.

STRYKER, S.
"Symbolic Interaction as an Approach to Family Research" p. 435-447 in Meltzer, B. and Manis, J. Symbolic Interaction: A Reader in Social Psychology. Allyn and Bacon Inc. Boston I972.

SUDNOW, D.
Passing on: The Social Organization of Dying. Prentice Hall Inc. New Jersey I967.

SWAZILAND, Mental Health Order I978
Swaziland Government Gazette Supplement) Volume XI Mbabane. August II I978, No. 90I.

TEWFIK, G.I.
"Problems of Mental Illness in Uganda" p. 62-68 in CCTA/CSA-WHO Meeting of Specialists on Mental Health Bukavu I958.

TRICK, L. and OBEARSKAS, S.
Understanding Mental Illness and its Nursing.
Pitman Medical Publishing Co. Ltd. London I976.

TOOTH, G.
Studies in Mental Illness in the Gold Coast.
His Majesty's Stationery Office, London I950.

UGORJI, R.U. and OFEM-OKOI, U.E.
"The Concept of Mental Illness Among the Yakkur of Nigeria" p. 295-298. in African Journal of Psychiatry Volume 2 I976.

WING, J.K. and BROWN, G.W.
Institutionalism and Schizophrenia: A Comparative Study of Three Mental Hospitals.
Cambridge University Press. London I970.

Appendix 1

QUESTIONS FOR ATTITUDE TO DISCHARGE MEASURE AND THEIR TOTAL SCORES

Question Number in Questionnaire	Question	Weight of Question	Value of Response	Score
10.	How do you like it in the hospital?	2		
	1. Very much		0	0
	2. Not very much		2	4
	3. Not at all		3	6
	8. Do not know		1	2
11.	Would you like to leave?	5		
	1. Yes		2	10
	2. No		0	0
	3. Do not know		1	5
12.	If you want to leave do you want to leave as soon as possible?	4		
	1. Yes		2	8
	2. No		0	0
	8. Do not know		1	4
16.	Would your relatives welcome you back if you left the hospital?	1		
	1. Yes		2	2
	2. No		0	0
	3. Do not know		1	1

Question Number in Questionnaire	Question	Weight of Question	Value of Response	Score
19.	Would you like to stay in the hospital permanently?	6		
	1. Yes		0	0
	2. No		2	12
	8. Do not know		1	6
22.	If the doctor advised you to leave would you agree?	3		
	1. Yes		2	6
	2. No		0	0
	8. Do not know		1	3

Note: The highest possible score was 33 and the lowest possible score was 0.

Appendix 2

QUESTIONNAIRE

Good Morning/Afternoon.

I am a student from the University College at Kwaluseni, but I am currently studying in Nairobi, Kenya for my Master of Arts degree. To fulfill the full requirements of the degree I have to do some research. I have chosen a topic dealing with mental illness. My interest is to ascertain the reasons patients have for either wanting to remain in the hospital or wanting to leave the hospital. Kindly help me in this regard by answering the following questions for me as adequately as you can. Thank you.

Name - Identification: .....

1. Sex: .....

2. Age: .....

3. Level of Education

1. None
2. Grade 1-2
3. Std. 1-2
4. Std. 3-5
5. Form I-III
6. Form IV-V
7. College/University
8. Do not know
9. No response

4. Marital status

1. Married
2. Single
3. Divorced
4. Widowed
5. Separated
8. Do not know
9. No response

5. Number of children

1. None
2. 1-2
3. 3-5
4. 6-8
5. 9-10
6. 11 and above
8. Do not know
9. No response

6. What was your occupation before you were admitted?

1. Housewife
2. Scholar
3. Labourer
4. Teacher
5. Other specify
6. Maid
7. None
8. Do not know
9. No response

7. Number of admissions

1. First
2. 2-3
3. 4-5
4. 6-7
5. 8-9
6. 10 and more
8. Do not know
9. No response

8. Diagnosis

1. Schizophrenia
2. Senile dementia
3. Alcoholic psychosis
4. Chronic schizophrenia
5. Pueperal psychosis
6. Paranoid
7. Other specify
8. Do not know
9. No response

9. Home district

1. Hhohho
2. Manzini
3. Lowveld
4. Shiselweni
5. Other specify

10. How do you like it in the hospital?

1. Very much
2. Not very much
3. Not at all
8. Do not know

11. Would you like to leave?

1. Yes
2. No
8. Do not know

12. If you want to leave do you want to leave as soon as possible?

1. Yes
2. No
8. Do not know

13. For how long would you wait if answered "2" above"?

1. A week
2. Two to three weeks
3. One month to three
4. Four months and more
8. Do not know
9. No response

14. Have you anywhere to live if you get out?

1. Yes
2. No
8. Do not know
9. No response

15. Where will you live if answered "Yes" above?

1. With parents
2. At my own home
3. With my spouse
4. With my in-laws
5. With my girl/boyfriend
6. With my brother/sister
7. With friends
8. Do not know
9. No response
10. Other specify

16. Would your family/relatives welcome you if you left?

1. Yes
2. No
8. Do not know
9. No response

17. Why if "no" above

1. My family does not care about me
2. Because they do not visit me now
3. They chased me away from home
4. I have no family or relatives
5. They say I am a nuisance
6. Other specify
8. Do not know
9. Not applicable

18. If you want to stay how much longer do you want to stay?

1. For good
2. Six months
3. A month to five
4. A few weeks
5. A few days
8. Do not know
9. No response

19. Would you like to make your home here permanently?

1. Yes
2. No
8. Do not know
9. No response

20. Why if answered "No" above?

1. The food here is not good
2. Want to go home to my children
3. Want to build myself a home
4. Want to return to my spouse
5. Want to go home to my parents
6. Want to see traditional doctor
7. Want to find work
8. Do not know
9. No response
10. Other specify

21. Why if answered "yes" above?

1. I have nowhere to live
2. My relatives do not like me
3. They treat me well in the hospital
4. I always get sick at home
8. Do not know
9. Not applicable
10. Other specify

22. If the doctor advised you to leave would you agree?

1. Yes
2. No
8. Do not know
9. No response

23. What type of treatment-medication have you been getting in the hospital?

1. Pills only
2. Injection only
3. Pills with injection
4. Electroconvulsive therapy with pills and injection
5. Psychotherapy
8. Do not know
9. No response

24. What do you think this treatment does for you?

1. Makes me weak
2. Makes me better
3. Makes me happy
4. Makes me sleepy
5. Makes my shoulders stiff
6. Makes me feel worse
7. Other specify
8. Do not know
9. No response

25. Do you think this treatment can help you to get cured?

1. Yes
2. No
3. Helps sometimes
8. Do not know
9. No response

26. Does anybody tell you what is wrong with you?

1. Yes
2. No
3. I know
8. Do not know
9. No response

27. Whom do you find it easier to talk to in the hospital?

1. Doctor
2. Nurses
3. Orderlies
4. Other patients
5. Attendants
6. No one

28. Do you think your illness is getting better?

1. Yes
2. No
8. Do not know
9. No response

29. If you feel you are getting better who is contributing to your recovery?

1. Doctor
2. Nurses
3. Orderlies
4. Attendants
5. Pills
6. No one

30. If you feel you are not getting better who is contributing least to your recovery.

1. Doctor
2. Nurses
3. Orderlies
4. No one
5. Other patients
6. Other specify
7. Do not know
8. Not applicable

31. Who makes up your bed for you?

1. Myself
2. Other patients
3. Attendants

32. Do you wash yourself?

1. Yes
2. No
8. Do not know
9. No response

33. Do you do any manual work in the hospital?

1. Yes
2. No
8. Do not know
9. No response

34. Who decided that you should come to the hospital?

1. Myself
2. Police
3. Spouse
4. Brother/sister
5. Parent
6. Relative
7. Friends
8. Do not know

35. Who actually accompanied you to the hospital?

1. Relative
2. Friends
3. Police
4. Relative and Police
5. Alone
6. Do not know

36. If you were accompanied did the person who brought you tell you where they were taking you to?

1. Yes
2. No
8. Do not know
9. No response

37. How did you react if you were told?

1. Nothing, I also knew where I was going
2. Kept quiet
3. Agreed to go but hated the thought
4. Was very angry
5. Was very surprised
6. Wanted to leave immediately
8. Do not know
9. Not applicable

38. How did you react if you were not told.

1. I did not do anything
2. I did not like it, but kept quiet
3. Nothing, I knew I was ill
4. Felt sad to be left there
5. Was very angry
6. Was very surprised
7. Wanted to leave immediately
8. Do not know
9. Not applicable

39. If you were accompanied do you think whoever brought you did the right thing to bring you here?

1. Yes and No
2. Yes
3. No
8. Do not know
9. No response

40. Why if answered "yes" above?

1. Helped me because I feel better now
2. I am on medication and it makes me well
3. I was sick
4. They had failed to manage me on their own
8. Do not know
9. No response

41. Why if answered "no" above in number 39?

1. They wanted to get rid of me
2. They do not even visit me
3. Have nowhere to go they will not fetch me
4. I do not like the hospital
5. There was nothing wrong with me
7. Other specify
8. Do not know
9. Not applicable

42. If you were brought to the hospital by your family what did they say was wrong with you?

1. They did not tell me anything
2. Said I was sick, mad
3. Said I was quarrelsome and violent
4. I wander off not knowing where I am going
5. Stealing people's things
6. I am infertile
7. Other specify
8. Do not know
9. No response

43. Does your family think that your illness can be cured?

1. Yes
2. No
3. Do not say anything
8. Do not know
9. No response

44. How often have you been visited since you were admitted

1. Once
2. Twice
3. Thrice
4. Four times and more
5. Not at all
8. Do not know
9. No response

45. If you are visited who visits you?

1. Parents
2. Brother/sister
3. Relative-specify
4. Friends
5. Variety of the above
7. Other specify
8. Do not know
9. No response

46. Do you look forward to these visits: would you like them to visit?

1. Yes I look forward to the visits
2. I would like them to visit
3. Would like them to visit but they do not have money to do so
4. I would prefer that they stay away
7. Other specify
8. Do not know
9. No response

47. If you prefer that they stay away, why do you feel this way?

1. They do not care for me
2. It is expensive to come here
3. Have been here many years, and still they have not come, why come now
4. They tell too many lies - bewitch me
5. Do not want to be disturbed here. I am fine
6. This is a bad place, they live well at home
7. Other specify
8. Do not know
9. No response

48. Do you think that your relatives are eager that you should leave the hospital?

1. Yes
2. No
3. They are, but I do not want to leave
4. They would be happy only for a short while
7. Other specify
8. Do not know
9. No response

49. Are you interested to know what happens to your family while you are here in the hospital?

1. Yes
2. No
3. Do not care about them
4. I know they are well
5. I have no relatives or family
7. Other specify
8. Do not know
9. No response

50. Do you like the food in the hospital?

1. Yes
2. No
8. Do not know
9. No response

51. If "no" what do you not like about it?

1. It is too monotonous
2. It upsets my stomach
3. It is not well cooked
4. There aren't enough vegetables
8. Do not know
9. No response

52. Which do you like better - hospital or home food?

1. Home
2. Hospital
3. All the same to me
8. Do not know
9. No response

53. What do you like most about the hospital?

1. The treatment given to us
2. Nothing
3. We can sleep a lot
4. We get better
5. The food
6. Playing games
7. Other specify
8. Do not know
9. No response
10. A combination of some of the above

54. What do you not like about the hospital?

1. Nothing in particular
2. Lice and the wards
3. All of it, it is a jail
4. Too many people
5. Food is not good
6. The isolation cells
8. Do not know
9. No response
10. Combination of some of the above

55. How do you get on with the nurses?

1. Get on well
2. Do not get along at all
3. Get on but not all the time
4. Get on with only a few
7. Other specify
8. Do not know
9. No response

56. How do you get on with the patients?

1. Get on well
2. Do not get along at all
3. Get on but not all the time
4. Get on with only a few
7. Other specify
8. Do Not know
9. No response

57. Have you ever been involved in a fight?

1. Yes
2. No
8. Do not know
9. No response

58. If "yes" what was the reason?

1. Patients threw water on me
2. Fighting over boy/girlfriend
3. Stole my cream
4. Pushed while waiting in line
5. No reason
7. Other specify
8. Do not know
9. No response

59. Have you been beaten?

1. Yes
2. No

60. If "Yes" what was the reason?

1. Ran away with group bench
2. Pushed patient off chair
3. Fighting for tobacco
4. Stepped on patient by mistake
5. Was kicked by patient
6. No reason
7. Other specify
8. Do not know
9. Not applicable/no response