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Stress and Psychological Disorders in Zimbabwe: A Report on Patients seen in Private Practice

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SUMMARY

This report is based on the analysis of 326 case files of patients that I saw in part-time private practice over a period of five years. The aim of the investigation was to establish the stressful life events that are associated with psychological disorder. Thirteen categories of stressful events were identified. Statistical analyses revealed that these stresses were significantly associated with a number of demographic variables.

INTRODUCTION

There is a wide range of technical definitions of stress.[1] For the purpose of this study, stress will be taken to mean any undesirable life event or circumstance, which leads to a negative emotional experience such as fear, sadness, frustration or mental conflict.

Hans Selye[3,4] proposed that stress, acting through the autonomic nervous system and the endocrine

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system can bring about physiological changes that lead to medical diseases such as peptic ulcers and hypertension. These are the so-called 'psychosomatic' disorders.

Stress has also been linked to psychological disorders. According to the DSM-111-K[5], a number of psychiatric diagnoses are by definition stress disorders. These include brief-reactive psychosis, post-traumatic stress disorder, adjustment disorder and bereavement.

In mental disorders that are known or strongly suspected to have a biological basis (eg schizophrenia), stress has been argued to play a significant role in relapses.[6,7]

Not everyone who experiences stress, even in very severe form, develops medical or psychological disorders. This is because certain factors act as moderators or buffers against the harmful effects of stress. Amongst the widely researched moderators of stress are demographic variables such as age,[8] availability of social support,[9] coping style[10] and the presence of compensatory positive events, the so-called "uplifts".[11]

Research has been carried out by many scholars in an attempt to quantify stress for clinical and research purposes. A classic attempt was that of Holmes and Rahe[12] who came up with a list of 43 events. Like Selye,[3,4] they argued that any life change, whether positive or negative, had a potential for creating stress, because it increased the need for adjustment. Holmes and Rahe[12] ranked their 43 events from most impactful to least impactful by allocating to each event a life change unit (LCU) based on their research on the association between events and medical illness.

At the top of the Holmes and Rahe[12] list was death of spouse, with 100 LCU. This was followed by divorce (73 LCU), marital separation (65 LCU) and

jail-term (63 LCU). They predicted that if in the past few months, an individual had been subjected to stressors whose total impacts added up to 300 LCUs or more, that individual would risk developing a major illness within the following two years.

The impact of life events has been shown to be culture specific. For example, Schwartz et al[13] investigated life events amongst the Xhosas of Cape Town. They found that the most stressful events in decreasing order were serious physical illness (family), serious physical illness (self) and loss of home through disaster. Death of spouse, which tops the Holmes and Rahe[12] list is at number 18 in the Xhosa list of 66 events.

A useful distinction has been drawn between major life events, such as the ones mentioned in the above two lists, and minor events which have been referred to as 'microstressors' or hassles. Kanner et al[15] defined hassles as the irritating, frustrating and distressing demands that to some degree characterise everyday transactions with the environment. Examples of hassles from Kanner et al[15] include troublesome neighbours, inconsiderate smokers, not enough money for clothing, etc. The impact of these minor stresses is much greater than appears at first sight. Firstly, unlike major events which occur infrequently, hassles tend to be chronic and their effects are cumulative. Secondly, because hassles are non-dramatic they do not lead to increased social support as is the case with major events.

Stress is clearly a very important clinical variable. In Zimbabwe, apart from the recent paper by Wilson et al[17] investigating the relationship between type A behaviour and self-reported stress among Zimbabwean teachers, we have almost no research-based information about stress. There was, however, a highly insightful paper by Dr Parirenyatwa[18] published posthumously, which attempted to link anxiety with urbanisation amongst the Africans in the then Rhodesia. He proposed that four possible stresses could arise from urbanisation: financial worry without the cushioning effect of community life; fear of loss of employment and consequent loss of housing; inability to return to rural life if not adjusted to urban life; and fear of physical ill-health and its disruption of family life.

The aim of the present study was to find out which stressful events were reported by patients and to determine their relative frequencies. A second aim was to establish what relationship if any, particular stresses had with demographic variables. It would have been desirable to determine impact values for each stressor as Holmes and Rahe[12] did, as well as to link particular stresses to specific diagnoses. However, this was not feasible because during the initial clinical contacts with patients, neither rating scales of severity of stress nor research diagnostic criteria had been used.

MATERIALS AND METHODS

The subjects consisted of all the patients (N = 326) that I had seen in my part-time private practice in Bulawayo (1986–1987) and Harare (1988–Mid-1991). Most of the patients were referred by General Practitioners and only a few came from specialist physicians, psychiatrists and surgeons. The demographic characteristics of the patients are summarised in Table I.

Table I: Demographic Characteristics: N = 326

Variable	No.	pc
Sex		
Male	201	61,65
Female	125	38,35
Age		
<6 years	8	2,5
7–13 years	35	10,7
14–18	29	8,9
19–45	230	70,6
>45	24	7,4
Marital Status		
Married adults	149	45,7
Unmarried adults (>18 years)	90	27,6
Divorced	11	3,4
Under age (<18 years)	74	22,7
Widowed	2	0,6
Educational Level		
No education	2	0,61
Primary education (up to Grade 7)	70	21,47
Secondary school	48	14,72
> 'O' level	206	63,20
Employment		
Unemployed	35	10,7
At school	101	31,0
Unskilled worker	19	5,8
Skilled worker (eg clerk, secretary etc)	99	30,4
Apprenticeship or other training		
eg teachers college	12	3,7
Professionals	60	18,4

Procedures: The case files of the 326 patients were examined to extract information about demographic characteristics, symptoms, diagnosis and reported stress. The original assessment of the patients had been carried out according to a format described elsewhere, so the information was fairly standard. Briefly, this assessment format involved getting detailed information about early life factors, personality characteristics, current life situation (stress and stress moderators), coping strategies and outcome. Diagnosis was made according to the DSM-111.[20]

RESULTS

A. **Diagnosis:** The distribution of diagnostic categories to which the patients belonged is shown in Table II. Since clinical, rather than research diagnostic criteria had been used, the variable 'diagnosis' was excluded from further statistical analyses.

Table II: Clinical Diagnostic Categories (N = 326)

DIAGNOSIS	f	pc
Depression	81	24,85
Anxiety	54	16,56
Psychosexual Disorders	49	15,03
Somatoform Disorders	28	8,59
Psychosomatic Disorders	22	6,75
Organic Brain Syndrome	17	5,21
Specific Development Disorders	16	4,91
Psychoses	16	4,91
Conduct Disorder	14	4,29
Drug Abuse	13	3,99
Enuresis/Encopreses	8	2,45
Insomnia	4	1,23
Attention Deficit	4	1,23
	326	100

B. **Stressful Life Events:** Frequency counts revealed that 229 patients (70,2 pc) had reported at least one stressful factor, whereas 97 (29,8 pc) reported that they had not experienced any significant stress in the past few months.

Inspection of the life events reported showed that they could be grouped into categories. To constitute a category, an event should have been reported by at least four people (1,2 pc). Any event reported by only three people or less in the past five years of clinical practice was considered as rare and was thus excluded from further analysis. Such events were put

into the 'miscellaneous' category and were reported by 72 patients (22,1 pc) who may or may not have reported other non-miscellaneous stresses. From this procedure, 13 categories of stress were identified. These categories are shown in Table III.

Table III:Categories of Stressful Life Events

CATEGORY	f		as pc of all patients (N = 326)		as pc of patients reporting stress (N = 229)	
Family discord	58	(35)*	17,8	(10,73)	25,32	(15,28)
Marital problems	53	(53)**	16,3	(16,3)	23,14	(23,14)
Problems utilising a social skill in inter-personal situations	27		8,28		11,79	
Financial problems	25		7,70		10,92	
Job Dissatisfaction	24		7,36		10,48	
Unfulfilled ambition	10		3,06		4,37	
Divorce	10		3,06		4,37	
Loneliness (divorce or unmarried)	10		3,06		4,37	
Divorce of parents	7		2,1		3,07	
Death of family member	7		2,1		3,07	
Failure	6		1,8		2,62	
Bothered by being unattractive	4		1,2		1,75	
Problems with boyfriend/-girlfriend	4		1,2		1,75	

* frequency and percentage of adults reporting family discord
** frequency and percentages of adults reporting marital discord
f frequencies (number of cases)

The specific items for each of the major categories viz family discord, marital dissatisfaction, job dissatisfaction and social skill difficulties are enumerated in Tables IV, V, VI and VII respectively.

Table IV: Reasons Given for Family Discord

FACTOR	f	pc
Poor parenting style: (over-protective, favouritism, disciple too harsh or non-existent)	21	36,21
Family schism (two or more opposing camps in family, constant fights — verbal or physical)	8	13,80
Not wanted by step-parent	7	12,07
Witchcraft accusations	5	8,62
Illegitimate child: conflict with own mother, want to be introduced to biological father	3	5,17
Miscellaneous	14	24,13
	58	100

Table V: Reasons Given for Marital Discord: N = 53

REASONS	f	pc
Infidelity	20	37,74
No communication (partner does things without consulting; is not open about his/her feelings; does not want to discuss problems)	19	35,85
Infertility	12	22,64
In-law problems	10	18,87
Partner becomes argumentative or violent after taking alcohol	8	15,09
No longer loves husband but does not have courage to divorce	6	11,32
Fundamental differences in religion, interest	5	9,43

Table VI: Reasons Given for Job Dissatisfaction: N = 24

REASON	f	pc
No promotion: has worked for organisation for many years but no promotion; feels he is competent and deserves promotion since he trains people who are subsequently promoted over him).	12	50
Pressure at work: too many things to do	7	29,17
Inter-personal conflict at work	5	20,83
	24	100

Table VII: Problems With Social Skill: N = 27

AREA	f	pc
Dating: unable to establish or maintain satisfactory heterosexual relationship.	8	29,63
Lack of assertiveness: unable to stand up for own right or exercise authority to express self fully and clearly leading to being exploited or taken advantage of by others.	19	70,37
	27	100

C. Association between demographic variables and stressful events: 1. Age: With a cut off age of 18 years and above for adults, it was found that overall, adults report stress significantly more frequently than young people (chi = 7,02, p = 0,01, df = 1). 2. Sex: Significant differences were found between males and females with respect to number of reported stressful events (chi = 8,48, p = 0,01, df = 1). More

females than males reported marital difficulties and loneliness. Males reported job dissatisfaction more frequently. 3. Education: Amongst college students and university students, 80,35 pc reported at least one recent stressful life event. The second largest group was secondary school students of whom 75,56 pc reported stress. Those with primary or no education reported 54,16 pc. The lowest frequency of reported stress was by university graduates, with 52,38 pc.

Problems with social skills were reported by 10,71 pc of tertiary education students (College, Apprenticeship and University). The percentage for secondary and primary school was 8,52 and 4,16 respectively.

The overall association between educational level and frequency of reported stress was (chi = 17,66, p = 0,001, df = 4).

4. Martial status: There was a highly significant association between marital status and family discord (chi = 21,88, p = 0,001, df = 4). The problem of family discord was reported by 32,4 pc of people of the pre-marital age of 18* years. Amongst the single unmarried adults (>18 years), the problem was reported by 21,11 pc. Married people reported 11,4 pc and divorcés reported 9,09 pc.

Divorced people were further found to report financial problems more frequently (18.18 pc) than the married (11,4 pc), the single (5,5 pc) and the widowed (there were only two widowed people in the whole sample).

Employment Status: Professional persons were found to report problems in marital communication significantly more frequently than the other employment groups (chi = 13,84, p = 0,01, df = 4). They also complained about financial problems more (chi = 13,34, p = 0,02, df = 5).

Skilled workers comprised eight (80 pc) of the 10 people who reported frustration because of unfulfilled ambition and were thus more significantly associated with this variable (chi = 12,75, p = 0,02, df = 5). Finally, there was a significant association between job dissatisfaction and employment status (chi = 20,96, p = 0,001, df = 5).

Amongst the unskilled workers, 21,05 pc reported that they were dissatisfied with their jobs. Skilled workers reported 12,12 pc and the least dissatisfied were the professionals (11,66 pc).

DISCUSSION

Stress is clearly very prevalent amongst people seeking medical help, being found in more than 70 pc of them. However, since there was no comparable normal control group, it is not possible to determine from this study how different this frequency is from the general population.

The difficulties reported by patients were mostly in the sphere of inter-personal relationships, particularly family, marriage, assertiveness and dating. Financial difficulties and job dissatisfaction also featured quite prominently. Marital discord was the most frequent reported stressor for adults.

The reasons given for these difficulties were infidelity, poor communication and infertility. Poor marital communication was found to be significantly associated with the higher employment groups. The reason for this is unclear.

Assertiveness and dating difficulties were also more common in the higher educational groups. With respect to assertiveness, a firm clinical impression was gained that young university graduates, though competent in technical matters, were unsure about how to handle their less educated but older and more experienced subordinates.

Many expressed regret at the fact that they were expected to be more involved with management functions, like supervision and discipline, for which they were not trained, instead of doing technical work.

Frustrated ambition was reported more by skilled workers than by other employment categories. This is probably because, since most of them have at least 'O' level education and have former school-mates who went on to become professionals, they feel that they need to 'catch up' and will be considered as failures in life if they do not.

Unskilled workers, on the other hand, reported job dissatisfaction rather than frustrated ambitions. It appears that unlike the skilled workers who harbour ambition, unskilled workers feel that it is unrealistic to aspire higher because they do not even have the basic 'O' level qualification. They nevertheless resent the lowly paid and uninspiring work that they have to do.

Professionals generally have more congenial work and have achieved their academic ambitions. This problem explains why they were found to be the least dissatisfied workers in this study.

This investigation identified some of the stressful events that may be responsible for the initiation, maintenance or recurrence of psychological disorders in the lower middle and upper class members of Zimbabwean society and their dependants. Adults and females reported stress more frequently than younger people and males respectively. By far, the greatest source of distress for the sample was inter-personal difficulties.

The poorer people, especially those from rural areas, were automatically excluded from this investigation because they could not have afforded to pay the fees for a psychologist in private practice.

One hopes, however, that the data presented here will be a useful starting point for more definitive future studies. These will need to employ rating scales for assessing the impact of stressful events and a sample of the rural and urban poor who present at primary health care clinics and government general hospitals.

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