To Establish the Relationship between Socioeconomic Status to Mental Illness

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Abstract

It is cardinal to note that several studies have revealed that there is a robust relationship between socioeconomic status (SES) and general physical health. These findings that can be generalized to Zambia. Zambia which is one of the most urbanized countries in sub-Saharan Africa, there are assumptions that it is possible that social, and economic factors may contribute to the mental health of the people. The purpose of this study is to establish the relationship between socioeconomic status, home environment, and mental illness in Zambia. In order to guide the paper, the aim was to establish the relationship between socioeconomic statuses to mental illness. A quantitative methodology was used whereby data was collected using questionnaires from the respondents.

The results established that low school accessibility is associated with higher risk of mental illness among younger men (20–31) and women (20–45), while it is a slightly protective factor for elderly individuals of both sexes. The association between social inequalities and the manifestation of psychological instability symptoms has been observed in relation to unemployment, lower education, low income and some material deprivation and most severely affects women of low SES, children, adolescents and the elderly. In the data, a low level of education and inactivity shows the strongest effect on the incidence of mental disorders, particularly among unemployed men.

Keywords: Social economic status, Mental illness, Physical health.

Introduction

Socioeconomic status (SES) can be looked at as a theoretical construct encompassing individual, household, and/or community access to resources (Adler et al., 2000). However, it is usually conceptualized as a combination of economic, social, and work status, measured by income or wealth, education, and occupation, respectively (Pollack at al., 2007). In this vein, SES has been linked to a wide range of health-related exposures and outcomes, including undernutrition, chronic disease, infection and mental health disorders. For instance, evidence has shown that the poorer one's socioeconomic conditions are, the higher one's risk is for mental disability and psychiatric hospitalization (Pickett et al, 2006). In light of the above, it is critical to make mention that mental illness tends to be on the increase in Zambia both in the rural and in the urban areas. Like many other developing countries, Zambia experiences a number of challenges around mental health including shortages of mental health facilities and professionals especially in the developing countries, stigma associated with the illness, lack of adequate policies, inadequate resources, among others (Siwo, 2018).

Although there are psychiatric units within seven general hospitals across the country, and the mental health policy in the country has made a commitment to integration, mental health services in Zambia are largely delivered at Chainama Hospital in Lusaka, the only mental health hospital in the country (Siwo, 2018). In addition, there is a dearth of research on mental health generally in Zambia (Kapungwe et al., 2010) with currently no research having been conducted on issues around integration of mental health with primary health care and thus the importance of this study. The major aim of this paper was to establish the link between Socioeconomic Status and mental illness. The study further wanted to establish the relationship between home environmental and mental illness in Lusaka, Zambia.

Most studies that have been carried out to investigate factors influencing mental illness have concentrated on sex, age, and ethnicity rather than SES (American Psychology Association, 2011). Therefore, there is needed to

get a comprehensive understanding of how SES influences mental illness. Thus, conducting this study in a developing country like Zambia would contribute to a more comprehensive understanding of how SES influences mental illness. This could further policy and provision of mental health services in Zambia. Therefore, there it is essential to better understand of this relationship for the purposes of planning preventive activities and health care provision.

Literature review

Suffice to note that mental illnesses worldwide are accompanied by another pandemic, that of stigma and discrimination (Kapungwe et al., 2010). In many instance, mental illness tends to strike with a double-edged sword, with those affected having to deal with the symptoms and disabilities of their illness on the one side, and widespread stigma and discrimination on the other. There have been a great number of studies that have been done on mental health in the western worlds (Crisp et al., 2000; Jacob et al., 2007). However, there has been very few studies conducted in Africa have suggested that the experience of stigma by people with mental illness may in fact be common.

For example, in their study investigating knowledge and attitudes of the general South African public towards mental illness, Hugo and colleagues found that knowledge was low and stigma was high. Such stigma appeared to be associated with the fact that mental illnesses were understood as a lack of willpower, and stress-related, rather than medical illnesses (Hugo et al., 2007).

Another example can be seen in Nigeria, where the first large-scale, community representative study of popular attitudes towards mentally ill, found stigma to be widespread, with most people indicating that they would not tolerate even basic social interactions with someone with a mental illness (Gureje et al., 2005). These preliminary findings thus confirm Corrigan and Watson's assertion that the lack of empirical data in African countries may explain the speculation that stigmatisation and discrimination towards mental illness is less common in these societies. More studies on the continent are needed in order to avoid ill-informed assumptions, and to prevent uncritical transposition of findings from western contexts to Africa, given cultural and structural regional differences.

Relationship between Socioeconomic Status and Mental Health

Results from previous studies show strong associations between mental health for instance, social relations, income, working conditions and critical life events.

Korkeila et al. (2003) conducted a study in order to present background work for developing a number indicator of mental health indicators to be included in part of an all-inclusive health monitoring system in Europe. A functional model of mental health was used to delineate variables essential for mental health indicators. The study ended up with a number of mental health indicators that could heighten the visibility of mental health problems in the European setting. This review included different studies that employed various methodologies rendering it difficult to compare the results. Furthermore, the socio-economical setting is very different from the Zambian setting.

Previous studies have followed two main research approaches to decide the temporal order between mental illnesses and SES. The first depends on old self-reports of study participants. For instance, a study by Kessler (2005), to determine the temporal order between mental disorders and school dropout by trusting on the study participants' ability to remember their mental state prior to major educational moves, such as high school completion and college entry. On average, the study participants were asked to recollect their mental state fifteen years before the study time. Such studies relying on retrospective self-reports find evidence for the selection perspective to the extent that study participants who were unsuccessful in making major educational transitions recounted an overrepresentation of anxiety disorders, mood disorders and conduct disorder that pre-existed their school dropout.

It is important to note, conversely, that findings based on such analyses utilization in this research design are based on the assumption that retrospective self-reports of the incidence and timing of childhood and adolescent mental illnesses are valid and reliable. This is very debatable. To avoid such a pitfall, participants should only be asked to recollect and retell their very recent and current episodes respectively.

Furthermore, information collected from mental health workers as well as relatives of patients would help verify data.

Research Methodology

This research used a combination of descriptive and analytical methods. The combination of the research designs was necessary because of the nature of the study. It was considered to be appropriate because this type of study gave an insight about the nature and causes or clear picture of a certain problem or situation. This study employed a quantitative approach. The quantitative inquiry investigates the quantities by finding out what happens, how it happens and importantly why it happens the way it does (Creswell, 2005).

The research was conducted in Lusaka Province of Zambia. The research was carried out from Lusaka district. Lusaka is an administrative town of Lusaka district. There were reasons for choosing to conduct the research in Lusaka province. First, it was where the researcher works from. Secondly, the provinces had a number of urban Health Centres which offer mental health services at primary level. Third, there were a high number Enrolled Psychiatric Nurses, Registered Mental Health Nurses and Clinical Officers who offer services to the mentally ill in the area. Fourth, there were libraries and communication facilities which enabled the researcher to conduct detailed research.

The study population consisted of nurses and clinical officers in health centres (stratified by rural-urban); mental patients; and relatives to the mental patients who escorted them for reviews at the Out-Patient Department / filter clinic at Chainama Hills Hospital. Purposive sampling was used to select the health centres and medical personnel in these facilities; whereas the mental patients were selected on voluntarism basis by their relatives. There relatives had to consent for them to be part of the study.

A sample size comprised of 10 mental health workers (nurses and clinical officers); 100 mentally ill patients between the age of 15 - 60years and those who have been diagnosed with HIV and are currently on medication; and 100 relatives. Data collections tools included structured questionnaires for mental health workers; and semi-structured interview guides for mental patients and their relatives.

The collected data was checked for accuracy, consistence and completeness before subjected for analysis. The study performed both qualitative and quantitative analysis procedures. Qualitative data was analysed using content analysis through narratives to interpret the findings given. On the other hand, quantitative data was analysed using a Statistical Package for Social Sciences (SPSS) and Microsoft Excel. The data was presented in tables, pie charts, bar charts and graphs according to the need.

All ethical issues were taken into account during the investigation. For instance, for the interviews of the study, informed consent and assent (in the case of the mental patients) was obtained from all participants after the objectives and the methodology of the study have been explained to them. Prior to obtaining consent, participants were assured of privacy and strict confidentiality of information provided by them which would not be revealed to any third party. Further, all responses were coded, thus allowing for respondents to remain anonymous in order to further assure confidentiality.

Data analysis

The study targeted a total of 10 mental health workers and 100 mental PLWHA and their relatives. However, the study only managed to capture 90 mental PLWHA. The study established that majority of the mental health workers were female (60%, n=6); nurses (70%, n=7); between the ages 25-35 years (50%, n=5); earned an income below ZMK 5, 000 (50%, n=5); and were residents from a high-density area (70%, n=7) (*see table 1*).

Table1.: Background Characteristics for mental health workers

Gender	Frequency (n)	Percentage (%)
Male	4	40
Female	6	60
Age		
Below 25 years	3	30
25-35 years	5	50

Above 35 years	2	20
Occupation		
Nurse	7	70
Clinical Officers	3	30
Income		
Below ZMK 5, 000	5	50
Between ZMK 5, 000 - ZMK 10, 000	4	40
Above ZMK 10, 000	1	10
Residence		
Low density area	2	20
Medium density area	1	10
High density area	7	70
TOTAL	**10**	**100**

Source: Field Data

The study further established that majority of the mental PLWHA were female (55.6%, n=50); between the ages 25-35 years (66.7%, n=60); had never been married before (66.7%, n=60); had an education attainment of primary level (61.1%, n=55); and were from a high density area (85.6%, n=77) (*see table 2*).

Table 1. Demographics Characteristics of Mental PLWHA

Gender	**Frequency (n)**	**Percentage (%)**
Male	40	44.4
Female	50	55.6
Age		
Below 25 years	20	22.2
25-35 years	60	66.7
Above 35 years	10	11.1
Marital status		
Never married	60	66.7
Ever married	30	33.3
Education attainment		
Primary	55	61.1
Secondary	25	27.8
Tertiary	10	11.1
Occupation		
Employed	20	22.2
Not employed	70	77.8
Residence		
Low density	3	3.3
Medium density	10	11.1
High density	77	85.6
TOTAL	**90**	**100**

Source: Field Data

The study endeavoured to assess the type of mental disorders that were prevalent among the patients that participated in this study.

Table 3. Prevalence of Mental Disorders by Type

Types of Anxiety Disorder	Frequency (%)
Agoraphobia	8 (8.9)
Social phobia	19 (21.1)
Specific phobia	7 (7.8)
Panic disorder	6 (6.7)
Mixed anxiety depressive disorder	16 (17.8)
General anxiety disorder	9 (10.0)
Anxiety disorders unspecified	25 (27.8)

Source: Field Data

Table 3 shows that the most prevalent mental disorder that was recorded were unspecified anxiety disorders (27.8%, n=25). However, of those that were specified, the most prevalent was social phobia (21.1%, n=19); mixed anxiety depressive disorder (17.8%, n=16); general anxiety disorder (10.0%, n=9). The rest were below ten percent of the total number of mental PLWHA.

Suffice to note that all the mental health workers that were selected in this study had undergone some training on handling mental patients. However, the study endeavoured to enquire on how these mental health workers perceived their interactions with Mental PLWHA. Figure 1 below shows that 70% (n=7) felt comfortable with the interaction they had with mental PLWHA. However, 20% (n=2) surprisingly felt uncomfortable with their interactions with the mental PLWHA. They asserted that it is somehow risky on their health and well-being in some cases.
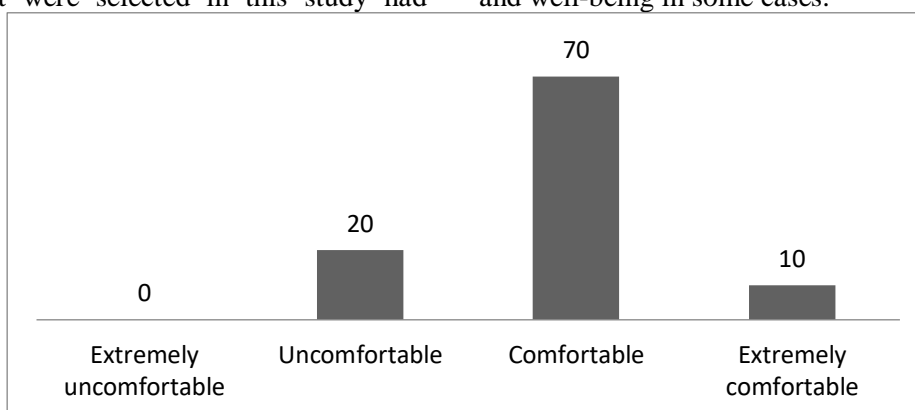

Figure 1. Perception on treating and interaction with Mental PLWHA

Source: Field Data

A correlation analysis on the demographics of Mental PLWHA and types of anxiety disorders (being the most prevalent mental disorder recorded) was conducted (*see table 4*)

Table 4. Correlation analysis on the demographics of Mental PLWHA

Anxiety Disorders Versus Variables	Correlation coefficient (r)	p value
Gender	−0.55	0.260
Religion	−0.11	0.844
Younger age	−0.62	0.039
Unemployment	0.78	0.004
Lack of family support	0.70	0.181
Education	0.81	0.412
Married status	0.18	0.002
Duration of HIV illness	0.831	0.327
Negative history of mental illness	−0.891	0.021
HIV test counselling	−0.77	0.188

It was established that there was a strong correlation coefficient of education (0.81), unemployment (0.78), lack of family support (0.70) and duration of HIV illness (0.83) on anxiety disorders.

Conversely, correlation analysis was used to measure the association of the SES and environmental characteristics of the mental PLWHA to assess the possible correlates between the independent and dependent variables. It was established that there were high positive correlations between family support (0.93), stigma in the home (0.89), income (−0.87) and education (0.83) on the mental health of an individual.

Furthermore, there was also a higher correlation with regards to history of mental illness (0.801). Moderate positive correlations were deduced with regards to residential stability (0.78), education status in the home (0.77) and technology (−0.55). No correlations were found with regards to rural (0.21) and urban density (0.22) (*see table 3*).

Among built environment indicators for men, accessibility by public transport and urban density seem to influence the variations of mental disorders only after age 50. For women, the protective impact of accessibility by public transport is statistically significant in each age group, and urban density only has a protective impact after the age of 50.

Table 5. Correlation Analysis on Mental PLWHA

Mental illness versus variables	Correlation coefficient (r)	p value
Family support	0.93	0.114
Stigma in the home	0.89	0.301
Income	−0.87	0.047
Education	0.83	0.251
Rural	0.21	0.002
Urban density	0.22	0.018
Residential stability	0.78	0.381
Education status in the home	0.77	0.290
History of mental illness	0.801	0.017
Technology	−0.55	0.098

Discussion

In Lusaka, the incidence of mental instability symptoms among adults, as measured by any prescription of antidepressant drugs, decreases with the improvement of some specific features of the urban built environment. This is primarily related to the protective effect of urban density and of accessibility by public transport, with stronger effects evident among women and older adults. This association is true irrespective of the individual level of social disadvantage and the degree of challenges in the neighbourhood.

The association between social inequalities and the manifestation of psychological instability symptoms has been observed in relation to unemployment, lower education, low income and some material deprivation and most severely affects women of low SES, children, adolescents and the elderly (Muyeya, 2004). In the data, a low level of education and inactivity shows the strongest effect on the incidence of mental disorders, particularly among unemployed men.

Physical disorder refers to a perception of urban decay as measured by complaints to local authorities and is strongly related to a sense of safety (Myer et al., 2008). This has been identified in the literature as one of the key determinants of health outcomes, particularly mental health. As information about the social environment is drawn from reported complaints, it is important for the researcher to be cognisant of the possibility of a bias that is due to over notification or misclassification.

Aspects of the home environment have been primarily identified through physical indoor housing and working conditions. Home and work environments are the built environment determinants with strongest health effects, since these are the places where people spend the

majority of their time. Some of the direct effects on health due to the outdoor urban environment are more difficult to isolate and are recognized to be of minor intensity. In addition, the urban built environment can have an important impact on mental health through indirect pathways.

Recommendations

- Home and work environments have to be stress free spaces since most people spend the majority of their time there.
- People must make time to talk to someone at work or at home so that they can share and vent of their stress.
- Awareness campaigns so that the younger generations desist from dropping out from school and the use of drugs.
- Government must equip the young generation with entrepreneurial skills that improve their livelihoods so that they will not be affected by the stress of making ends meet.

Conclusion

In conclusion, there is indeed some positive relationship between socioeconomic status and mental illness. Lack of education and physical disorders are some of the socioeconomic factors leading to mental illness. The state must stand as watchdogs so ensure the wellbeing of every citizen thus dealing with the scourge of mental illness.

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