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EC PSYCHOLOGY AND PSYCHIATRY
Research Article

Psychiatric Morbidity among a Marginally Housed Community with Psychological Difficulties in a Catholic Institution

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Received: January 20, 2019; **Published:** March 05, 2019

Abstract

Objectives: The study was designed to determine the psychiatric morbidity among a marginally housed community with psychological difficulties in a Catholic Institution – Madonna University Teaching Hospital Elele, Nigeria.

Materials and Methods: 200 consenting subjects recruited by random sampling procedure between March and July 2017 were enlisted in the study. The General Health Questionnaire and Positive And Negative Syndrome Scale questionnaires were administered to the subjects.

Results: The psychiatric morbidity found was 65.5%. The largest proportion of the subjects 43% presented with moderate psychopathology. A greater percentage of the subjects (39.50%) presented with negative bipolar index, were female (62.5%), aged between 20-39 years (37.0%), of the Roman Catholic denomination (93%), married (37.5%), had primary education (47.0%), denied having a family history of mental illness (56.5%) and don't believe that mental illness can be biologically treated (52.5%).

Conclusion: Despite the protective and possibly therapeutic benefits of religious adherence, the need to step up public education on the availability and efficacy of orthodox medical intervention for psychological problems especially among religious adherents is imperative.

Keywords: *Psychiatric; Religious; Psychopathology; Mental Illness; Psychological*

Introduction

It is common knowledge that disasters and several untoward events and circumstances of physical, psychological and social dimensions affect mental health and therefore increase the risk of psychiatric morbidity [1].

Rates of psychopathology are elevated in marginalized and unsuitably housed persons, underscoring the need for applicable clinical measures for these populations [2]. Many studies on psychiatric morbidity have been hospital based [3,4] and among special groups in other secular settings [1,5]. There is paucity of similar studies in religious settings. However, some studies have tried to examine the connection between religious devotion and mental illness [6-8]. These studies were carried out in the developed world and there is paucity of similar studies in the undeveloped world.

In view of the widely held view that the undeveloped world appear to be more religious than the developed world, with the attendant paucity of studies that have attempted to examine the psychiatric morbidity of people associated with such settings, the current study

becomes imperative. The aim of the study is to assess the psychiatric morbidity among a marginally housed community with psychological difficulties in a catholic institution - Madonna University Teaching Hospital, Elele which is domiciled in southern Nigeria. The result will help elucidate the importance of orthodox psychiatric intervention for many worshippers who may be ignorant about the available medical solution to their psychological difficulties.

Methodology

Study Location

The study was conducted at the Madonna University Teaching Hospital, Elele, Rivers state, Nigeria.

Study design

This is a prospective cross-sectional study. Two hundred randomly selected subjects from the Madonna university community living in the make-shift houses provided for them by the authorities were assessed. A General Health Questionnaire (GHQ), Positive and Negative Syndrome Scale (PANSS) questionnaire and a socio-demographic questionnaire were administered to each participant by some selected 500 level medical students selected who were trained to administer the instruments.

The General Health Questionnaire (GHQ-12) was developed by Goldberg for the screening of psychiatric morbidity in clinical studies [9]. It has been validated for use in our environment and a cutoff point of 3 is considered adequate [9].

The Positive and Negative Syndrome Scale (PANSS) published by Stanley Kay., *et al.* in 1987, is a medical scale used for measuring symptom severity of schizophrenic patients [10]. It has been widely used in other studies, not only on schizophrenic patients [2].

Of the 30 items included in the PANSS, 7 constitute a positive scale, 7, a negative scale and remaining 16, a General Psychopathology Scale. The scores for these scales are arrived by summation of ratings across components items. The bipolar index was derived by subtracting the negative score from the positive score. It is essentially a difference score reflecting the degree of predominance of one syndrome in relation to the other.

Ethical approval was obtained from the institution and informed consent from the subjects before the instruments were administered.

Data analysis

Data analysis was done using the SPSS (16^{th} version). Frequency distribution tables were used to display the various clinical and socio demographic variables. Chi-square test was used to assess association of the variables and the development of psychopathology.

Results

Out of two hundred subjects who took part in the study, one hundred and thirty one (131) had GHQ score of at least 3; thus translating to a psychiatric morbidity of 65.5%. Based on the PANSS scores, the largest chunk of the cohort 86 (43.0%) presented with moderate psychopathology, followed by 53 (26.5%) who presented with severe psychopathology. The Bipolar index analysis showed that a greater percentage of the subjects (39.5%) presented with negative symptoms more than positive symptoms (33.5%). A greater percentage of the subjects were female (62.5%), aged between 20 - 39 years (37.0%), Roman Catholics (93%), married (37.5%), unemployed (23.0%), had primary education (47.0%). Similarly, a large chunk of the cohort (56.5%) denied having a family history of mental illness and (52.5%) don't believe that mental illness can be biologically treated.

However, there is no significant association between most of the socio-demographic variables and developing psychopathology except for belonging to the Roman catholic denomination ($X^2 = 5.385$, df = 3 p = 0.046).

GHQ Score	Frequency	%
≥ 3	131	65.5
< 3	69	34.5
PANSS Score	**Frequency**	**%**
Nill Psychopathology	22	11.0
Mild (31 - 85)	39	19.5
Moderate (86 - 141)	86	43.0
Severe (142 - 196)	53	26.5
Bipolar Index	**Frequency**	**%**
Negative index	79	39.5
Positive index	67	33.5
Zero index	54	27.0
Gender	**Frequency**	**%**
Male	75	37.5
Female	125	62.5
$X^2 = 0.001$, df = 1, p = 0.961		
Age (years)	**Frequency**	**%**
0 - 19	49	24.5
20 - 39	74	37.0
40 - 59	53	26.5
60 and above	24	12.0
$X^2 = 9.281$, df = 6, p = 0.647		
Christian Denomination	**Frequency**	**%**
Roman Catholics	186	93
Orthodox Protestants	7	3.5
Others	7	3.5
$X^2 = 5.385$, df = 3, p = 0.046*		
Marital Status	**Frequency**	**%**
Single	67	33.5
Married	75	37.5
Divorced/Separated/ Widowed	58	29.0
$X^2 = 0.537$, df = 2, p = 0.764		
Employment	**Frequency**	**%**
None	87	43.5
Farmer	46	23.0
Semi-skilled	33	16.5
Skilled/Trader	24	12.0
Professional	10	5.0
$X^2 = 4.786$, df = 3 p = 0.188		
Education	**Frequency**	**%**
None	41	20.5
Primary	95	47.0
Secondary	61	30.5
Tertiary	3	1.5
$X^2 = 6.494$, df = 3, p = 0.091		
Family History of Mental Illness	**Frequency**	**%**
Yes	87	43.5
No	113	56.5
Belief in the Biological Treatment of Mental Illness	**Frequency**	**%**

Table: *Frequencies of the various clinical and socio-demographic variables N = 200.*
**= Significant.*

Discussion

In this study, the prevalence of psychiatric morbidity is 65.5%. It is higher than the reports of some earlier researchers in which prevalence rates of between 45 - 60% have been reported in studies carried out in non-hospital settings [11-14]. A study by Aghahowe., *et al.* among convicted inmates in a Nigerian community, a kind of institutionalized setting yielded a psychiatric morbidity of 80% [15]. Nevertheless, there is paucity of data on psychiatric morbidity in religious settings. Most of the studies on psychiatric morbidity have been carried out in hospital settings and varying rates in the range of 10 - 65% were reported [16-19].

The study showed that the greater percentage of the subjects (43%) presented with moderate psychopathology; followed by severe psychopathology (26.5%) and then mild psychopathology (19.5%). The subjects in this study were housed in make shift houses which are by all standards far from comfortable or ideal. Apart from being overpopulated, personal privacy, the quietness, serenity and ambiance that should characterize an adequate accommodation is lacking. The noxious physical and psychological sequale of institutionalization and living outside a family are well documented [20,21]. Therefore the high rate of psychiatric morbidity, most of which are moderate to severe is not surprising. Furthermore, most of these subjects are people who came to seek for a spiritual solution to the plethora of problems both physical and psychological plaguing them. This is further exemplified by the fact that the greatest proportion of the subjects presented with negative bipolar index (39.5%) compared to 33.5% that resented with positive bipolar index. This indicates a preponderance of negative symptoms of social withdrawal, apathy, anhedonia etc. in the subjects.

The largest percentage of the subjects were female (62.5%) and belonged to the age group 20-39 (37%). This is in consonance with studies done by Armiyau., *et al* [11,14]. Similarly, Roman Catholics (93%), the married (37.5%), the unemployed (43.5%) and those with primary education (47.0%) make up the largest proportions of the cohort.

The prevalence of mental illness in the young compared with the elderly in this study is similar to reports published elsewhere [13]. The young are energetic and are always on the move in search of how best to solve their problems, hence their predominance in the study population. The current harsh economic realities with associated high unemployment rates in the nation is mirrored by the elevated unemployment rate among the subjects. This is in keeping with reports by other researchers [22]. Furthermore, Bebbington., *et al.* reported a greater prevalence rate among women compared to men [23]. This is in keeping with our finding.

It is not surprising that the Roman Catholics constituted the largest percentage (93%) of the study cohort. The study was carried out in a Catholic institution. This explains the statistical association between psychiatric morbidity and being of the Roman Catholic faith.

A greater percentage of the subjects (47.0%) has only a primary education. This is similar to results reported in other studies which reported low educational achievement as being associated with the development of psychopathology [11]. Apart from denominational affiliations there was no other socio-demographic variable that was significantly associated with the development of psychopathology.

It is also worth nothing that only 43.5% of the subjects reported a family history of mental illness. It is possible that many more people may have denied their family history of mental illness because of stigma or because of their lack of understanding of all the range of abnormal behavior that is officially regarded as symptoms and signs of mental illness. However, it is most worrisome that 52.5% don't believe that mental disorders can be treated biologically and 19% are not sure if biological treatments of mental disorders are effective. This reflects the level of ignorance about mental illnesses and their remedies in our environment. The twin factors of ignorance and superstitious cultural beliefs that deny the biological causes of mental illness is further highlighted by this study and is a real challenge in our society. These factors represent the grand origin of stigma and discrimination against the mentally ill and contribute significantly to the reluctance by sufferers to seek medical solution to their mental health challenge [24-26]. The mentally ill face many challenges in adapting to life in a society that doesn't understand them and oftentimes, the effects of the stigma that they face are overwhelming [25].

Conclusion

Studies have shown that people who have no religious framework are vulnerable to developing mental disorders [27] and those at the risk of mental illness may experience protection from strong cultural or religions identity [28]. Conversely, morbidity is significantly more

likely to engender the use of religion as a remedy [29]. Nevertheless, "psychological mediation of a religion-mental health link is plausible and consistent with research on correlates and determinants of health and healing" [30]. This is because commitment to a religious belief system may be beneficial to health by promoting healthy behavior conducive to wellness, facilitates receipt of tangible and emotional support and may promote positive emotions of gratitude, humility and forgiveness which may be of preventive or therapeutic benefit [27].

Nevertheless, the need to step up advocacy towards religious adherents to encourage them to also explore the orthodox solutions to their medical and psychological problems is imperative. A move towards an eclectic approach for the management of psychological problems in our environment is advocated.

Limitation

The data was collected with the aid of some trained 500 level medical students. Therefore some error in collection of data is not unlikely.

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Volume 8 Issue 3 March 2019