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PREVALENCE OF PSYCHIATRIC DISORDERS AMONG NURSES OF A NIGERIAN UNIVERSITY TEACHING HOSPITAL

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ABSTRACT
By means of a two-stage research design using the 30- item General Health Questionnaire (GHQ-30) and the Structured Clinical Interview for the DSM (SCID), 57% of the 100 study sample of female nurses of the University of Benin Teaching Hospital, Nigeria met definitive diagnoses for Anxiety Disorder, Dysthymia, Major Depressive Disorder, and Major Depression with probable Panic Disorder.

INTRODUCTION

Nurses form a vital link within the health team especially because they maintain a more continuous and persistent contact with the patients than the other health personnel[1]. The expectation therefore is that the nurse has to be a well adjusted and emotionally stable person for her to adequately fulfill her responsibilities to the patient and the health team.

Unfortunately, nursing as a profession has long been recognized to be very stressful[2, 3]. Efforts at comparing the level of stress experienced by nurses within the different nursing specialties[4, 5] yield results that suggest that because of the apparent pervasiveness of certain stressors, factors inherent in the nursing role are important determinants of the experience of stress. Yet the 'work' versus "personality" debate still rages on as some researchers attribute the observed high stress level amongst nurses to what has sometimes been tagged "the nurses' personal characteristics"[6]. The proponents of the personality factor however fail to proffer reasons why nurses as an occupational group should have personal characteristics that make them susceptible to stress.

There are few studies that have attempted to tease out of the general stress matrix the particular nature of the psycho-syndromes experienced by nurses. Some researchers had noted that the general nurses have a significantly higher proportion of psycho-neurotic disorders than their psychiatric nurse counterparts[7]. A study of psycho-pathology amongst shift workers the majority of whom were nurses, found that those who work two or more rotational shift duties were significantly more psychopathological and neurotic than their colleagues who work single straight shift duty; and that intellectual, sleep, mood, and general somatic complaints were the prominent disorders suffered mostly by the shift workers[8].

This study is therefore aimed at determining the prevalence and types of specific psycho-syndromes that afflict nurses, and the socio-demographic characteristics of the identified cases.

KEYWORDS: *Epidemiology; psychiatric disorders; GHQ-30; DSM diagnosis; nurses; university teaching hospital; Nigeria.*

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METHODOLOGY:

The subjects were drawn from amongst the nurses attending the weekly Continuing Education Program organized by the Nursing Service Department, University of Benin Teaching Hospital (UBTH) Benin City, Nigeria.

The author was invited to deliver mental health lectures once a week for four consecutive weeks to the Principal and Senior Nursing Officers in small groups of twenty five nurses in April 1990. The technique of incidental sampling was therefore employed in recruiting all one hundred subjects that make up the study sample.

SCREENING INSTRUMENTS

The General Health Questionnaire (GHQ) developed by David Goldberg originally designed for use in the London area, was used for the first stage screening. This is a self administered screening test that focuses on breaks in normal functioning rather than upon life-long traits. No diagnosis is made with this instrument. It has been used in diverse cultures and widely varied settings including psychiatric and non-psychiatric clinical settings and community surveys[9]. Although the 60-item version of the questionnaire has been validated for use in this culture[10], the 30-item version which has been most widely used globally was chosen for this study because of time constraint despite its relatively low sensitivity. The GHQ scoring system was also adopted and the threshold score of 4 chosen as the cutoff point.

STRUCTURED CLINICAL INTERVIEW FOR DSM (SCID)

This is an instrument designed to enable a clinically-trained interviewer to make DSM-III diagnoses. This version of the SCID was developed for use in the Upjohn Panic disorders program. It focuses on the current episode of illness which is assumed to have persisted into (or have started within) the last three months. It also covers past episodes for affective disorders[11].

PROCEDURE:

At the end of each lecture period and the subsequent question and answer session, the purpose of the study was explained to the group and their voluntary verbal consent obtained. Copies of the GHQ-30 to which was also attached a separate personal data sheet that elicited such socio-demographic information as age, sex, marital status, number and ages of children, present rank, date of last promotion, degree of job satisfaction, and regrets over choice of nursing profession were distributed. The questionnaires were collected after 20 minutes and scored immediately. All nurses with a GHQ score of 4 and above were invited for subsequent clinical interview within a period of two weeks using the SCID. Each interview session lasted on the average 40 minutes in the office of the researcher.

RESULTS:

The one hundred all female study group consisted of twenty principal and eighty senior Nursing Officers representing 21.8% of all the 457 registered trained nurses in the hospital. Sixty-two (62%) of the subjects had a GHQ score of 4, while 57 (57%) were found at interview to have a definite psychiatric disorder: 52 with current episode of a disorder and five with a past episode.

DIAGNOSES

Affective Disorders

- Major depression (Current Episode)	28*
- Major depression (Past Episode)	5
- Major depression (Current Episode) with probable Panic Disorder	3
- Dysthymic Disorder (Current Episode)	14
Anxiety Disorders	
- Panic Disorder (uncomplicated)	5
- Panic Disorder with limited Phobic Avoidance	2

* Two of the subjects in this category had a past episode of Major Depressive Disorder.

Table 1: Socio-demographic characteristics of the study sample

TABLE 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS AND GHQ SCORES OF THE STUDY SAMPLE.

SOCIO-DEMOGRAPHIC VARIABLES	CASES N=57	% (57)	NON-CASES N=43	% (43)
1. AGE IN YEARS:				
RANGE	32 – 53		30 -54	
MEAN ± SD	39.5 ± 6.3		38.6 ± 7.3	
2. MARITAL STATUS:				
MARRIED	51	89.4	30	69.7
SINGLE	5	8.8	8	18.6
SEPARATED	1	1.8	3	6.97
DIVORCED	-	-	2	4.65
3. NUMBER OF CHILDREN BELOW 6YRS IN THE FAMILY:				
ONE CHILD	4	7.01	18	41.86
TWO CHILDREN	9	15.7	-	-
THREE OR MORE CHILDREN	9	15.7	-	-
4. RATING OF PERCIEVED QUALITY OF MARRIAGE:				
HAPPY	36	63.15	26	60.45
SAD	10	17.54	2	4.65
COULDN'T BE BOTHERED	7	12.28	2	4.65
5. RATING OF JOB SATISFACTION:				
VERY SATISFIED	-	-	-	-
JUST SATISFIED	2	3.50	8	18.6
DISSATISFIED	40	70.17	26	60.46
NO COMMENTS	15	26.31	9	20.93
6. REGRETS CHOICE OF NURSING AS A PROFESSION:				
YES	14	24.56	1	2.32
NO	43	75.44	42	97.68
7. GHQ – 30 SCORNS:				
RANGN OF SCORNS	4 – 24		0 – 3	
MNAN SCORN ± SD	11.6 ± 5.1		1.8 ± 1.2	

DISCUSSION:

There are very few reports that have used the combination of the GHQ and the DSM in a two stage study design of psychiatric disorders among workers in the health services, including nurses. This is not unexpected since such design aims at a marriage of instruments from across both sides of the aisles (America and the rest of the world) which have subtle conceptual differences and diagnostic approaches. A research report combining the GHQ-30 and the Research Diagnostic Criteria, RDC (an instrument from which the DSM originated) in the study of mental disorders in primary medical care in the USA, noted that the sensitivity of the GHQ-30 for RDC diagnoses was good for depression, anxiety and labile personalities[12]. In a community survey in Edmonton, Canada, the GHQ-30 was used against the DSM diagnoses and it was found that the specificity was good for all the

disorders; and that the sensitivity was good for schizophrenia, depression, panic and somatization disorders[13].

Very similar to the finding in this study is the report that 56% of nurses in a palliative care unit had high scores on the GHQ-30 [14]. This is in contra-distinction to the reported finding of 17.9%, using the same instrument to screen nurses for psychiatric morbidity at the University of Ilorin Teaching Hospital in Nigeria[15]. A study which screened for anxiety symptoms in female Chinese nurses reported a prevalence rate of 43.4% [16].

That 57% of this study sample met the diagnostic criteria for a definite psychiatric disorder of anxiety and depressive disorders is alarming and worrisome. This is especially so when it is realized that the group of nurses so identified bear the clinical responsibility for looking after the sick, teaching, as well as supervising younger members of the nursing profession. Perhaps more disturbing is that only 10.5% of the identified cases ever sought expert help despite full awareness of being in distress. The reason for this "concealed suffering" may not be unconnected with the well documented negative attitude of the different segments of our society, including the caring professions, towards the mentally ill[17, 18 &19]. Similar attitude which creates career prejudice in the minds of employers has been observed in the developed countries as well[20]. There is therefore an urgent need for the establishment of preventive psychiatric services in the work-place in order to minimize or eradicate if possible, bias/stigmatization of members of the health team who may need psychiatric treatment.

Other avenues that could be explored to the benefit of health care givers needing psychiatric treatment might be the inclusion of psychiatrists in the running of staff health service within the work place; inclusion of mental health courses in the Continuing Education Programs of the nurses and the doctors – especially the Family Practitioners; and the organization of an annual awareness week for Mental disorder in the work-place during which stress identification, management and reduction strategies for all cadres of staff within the health institution should be taught.

It is noteworthy that all the identified cases suffered from anxiety, depression, or both disorders; none was a case of mania, cyclothymia, or psychotic disorder.

The most compelling explanation for this finding is the unitarists view of psychopathology[21, 22] which regards states of anxiety as continuous with depressive illnesses within a larger family of general disorders of affect or mood.

The precarious position of the nurses within the health delivery structure which strips them of power and control[23] unduly exposes them to conflicts with the management on the one hand, and the medical consultants whose patients they look after on the other. This probably explains the finding that while 55 (96.3%) of the cases expressed dissatisfaction with the job only 14 (24.5%) of them regretted choosing nursing as a profession. Other extraneous factors that could have contributed to this finding include the fact that the identified all female cases were more often married but 28.8% overtly or covertly expressed being unhappy with their marriage; about a third of them (31.5%) have two or more children below the age of six years; and working two or more rotational shift duties. Unhappy marriage would imply the absence of a confidant in the dyadic relationship; thus, two of the three established vulnerability factors[24] for a depressive disorder (the other being the presence of young children) are met by the identified cases.

The choice of six years rather than fourteen as reported by Brown and Harris in their study as cutoff age for the "depressogenic" effect of young children in the home is informed by the obvious differences in the child rearing practices within the cultures where these studies were conducted. As a result of our cultural permissiveness and

communal living orientation, the Nigerian child at 6years of age is not exclusively under the biological parents' supervision and guidance, unlike his Caucasian counterpart, and is thus less dependent on, and demanding of attention from the biological parents.

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