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Research Article

Psychiatric Morbidity Among Bankers in Southwest Nigeria

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Abstract

According to the PICI model, there are six personality disorders in the neurotic area (anxious, phobic, obsessive, somatic, avoidant, and manic), and the diagnosis of psychopathological disorder is determined based on the persistence of certain dysfunctional traits present in the personality framework. Based on clinical experience and through the application of the IPM/PICI, Deca, PDM, PHEM and PPP-DNA models, it was found that all disorders in the neurotic area had anxiety traits in common and that symptoms of the six different disorders were often present in comorbidity. This assumption led to the hypothesis of a different and better way to group them into one all-encompassing category: "Neurotic Personality Disorder" (NPD). Based on this construct, it is suggested to perform the same nosographic operations for the other personality disorders, grouping 7 personality disorders (bipolar, depressive, borderline, histrionic, narcissistic, antisocial, psychopathic) from the psychopathological area related to Cluster B of DSM-5-TR and PICI-3 into "Dramatic Personality Disorder" (DPD) and 4 other personality disorders (delusional, paranoid, dissociative, schizophrenic spectrum) from the psychopathological area related to Cluster A of DSM-5-TR and Cluster C of PICI-3 into "Psychotic Personality Disorder" (PPD). This paper aims to suggest their use to facilitate psychopathological framing.

Keywords: neurotic personality disorder; anxiety; Panic; mania; obsession; compulsion; avoidance; phobia; dramatic personality disorder; bipolar; depressive; borderline; histrionic; narcissistic; antisocial; psychopathic; psychotic personality disorder; delirium; hallucination; paranoia; dissociation; pici-3

Introduction

Morbidity is the departure from a state of physical or psychological well-being, resulting from disease, illness, injury, or sickness, especially where the affected individual is aware of his or her condition.[1] Psychiatric morbidity generally refers to the incidence of both physical and psychological deterioration as a result of a mental or psychological condition, usually those who are acutely aware of their condition, despite the mental deterioration.[2] In Nigeria and many parts of the world, one of the fields of practice where there is high demand for time, expectation and results is the banking sector and this potentially creates a great strain on the mental wellbeing of the workers.[3] Reasons that have been adduced for the poor mental wellbeing in the banking sector include: expectations of peak performance, long daily schedules and routines, stringent administrative policies and supervision, with goal-driven and result-oriented approaches to problem-solving.[4] Other sources of stress are incessant and rigorous capacity building, quests for astute interpersonal and communication skills with colleagues and customers. With the recent advancement in technology and recurrent down-sizing in the sector due to the global economic crisis, the workload on the existing staff may be outrightly overwhelming. All these, if not properly managed can serve as precipitating factors for various morbidity and decreased quality of life.[3] It is important to recognize that minimizing work-related stressors and

promoting good mental health through workplace policies can help prevent mental health problems from developing. This is because the risk factors for work-related stress are aspects of work that are associated with psychiatric, psychological and/or physical injury or illness.[3],[4] Also, work stress can precipitate or perpetuate psychiatric conditions among little number of workers that are expected to perform enormous tasks.[5] In Ilorin, the prevalence of psychiatric morbidity among bank workers was found to be 18%. Being married with smaller families (i.e. maximum of two children), being female, older age, acceptable workload, working overtime with adequate remuneration, and being a middle-ranking employee were associated with lowest risk of psychiatric morbidity among bank employees.[6] In a study done in Abeokuta among bank workers, the risk factors for Generalised Anxiety Disorders from work stress were found to be female gender, age < 30 years, single marital status, middle occupational posts, whereas having children and frequent participation in religious activities were protective.[7] Depression is an important contributor to the global burden of disease and affects people all over the world.[8] It results in significant decline in social, economic and occupational outcomes to employees, employers and the society at large.[9] It is associated with a high rate of presenteeism, that is an employee going to work despite reduced productivity.[10] In Nigeria,

perception of job as stressful and working longer hours were identified risk factors for depression among bank workers in Abeokuta.[7]

Aim Of the Study

The study aims to determine the prevalence of psychiatric disorders among bankers in Ado-Ekiti, southwest Nigeria.

Methods

Study Design and Setting

The study was conducted as a two-stage descriptive cross-sectional study and set among commercial bankers in Ado-Ekiti.

INCLUSION CRITERIA:

1. Must be a contract, core or management staff whose job description is within the banking hall
2. Must have a non-shift schedule

EXCLUSION CRITERIA:

1. Being on leave as at recruitment period: Whoever was on leave as at the time of the study was not recruited as such individuals were absent for the exercise.
2. Previous history of psychiatric disorder

Study Instruments

A semi-structured questionnaire was designed to obtain data on the socio-demographic characteristics of the respondents. It described the socio-demographic qualities, work and clinical histories of respondents. General Health Questionnaire (GHQ) – 12 was used to screen for Psychiatric morbidity. The General Health Questionnaire is a self-reported questionnaire designed by Goldberg and Hillier in 1979 for use as a screening instrument in primary care, general medical practice, or community surveys. It was designed as a shorter version of the original instrument containing 60 items. The full version can be completed within 10 minutes. Scores of at least 2/12 or 3/12 using the GHQ binary scoring system is considered GHQ-12 positive. For the purpose of this study, the 3/12 cut-off was used. This has been validated for research in this environment.

The Mini International Neuropsychiatric Interview (MINI), a semi-structured diagnostic instrument was used in the second stage to make the specific psychiatric diagnosis according to the ICD-10 criteria. This is a standardized diagnostic instrument.

Sample size, sampling technique and study procedure

A sample size of 312 was arrived at after making allowance for non-response rate.

The Leslie Fisher's formula was utilized to calculate the sample size (n) for a study population of less than 10000.[11]

n = nf /(1+nf/N)

 n = desired sample size when the study population is less than 10000.

nf = desired sample size when the study population is greater than 10000.

N = estimate of the population size. (This is the total population of bank workers in Ado-Ekiti.)

From the literature review, the prevalence of Psychiatric morbidity among bank workers is 18%.[18]

However, a total of 302 respondents were eventually recruited for the study as four of the questionnaires were incompletely filled, and six of the

questionnaires were not returned (i.e. 10 questionnaires) and these could not be used for the study. A cluster sampling technique was used in establishing the study sample. This was used because it is more practical than some other sampling methods for this research. All the branches of the commercial banks are in three main locations (clusters) in Ado-Ekiti and these are along Bank Road, Ekiti State University and along Afe Babalola University and the population of the bankers in all the clusters are heterogenous. There are six hundred and thirty bankers in Ado-Ekiti that are evenly distributed in branches in these three locations (clusters). This number was obtained by approaching all the Managers of each branch along Bank Road who volunteered the staff strengths of other branches in other locations, after the ethical approval of the research was presented to them. Since the number of the bankers (two hundred and ten) are evenly distributed in each location (cluster), fifty percent (50%) of the bankers from the branches in each cluster were recruited through a simple random process by balloting. So, one hundred and five respondents were recruited at the branch at Bank Road, one hundred and five respondents were recruited at the branch at Ekiti State University, while one hundred and two respondents were recruited along Afe Babalola University to make a total of three hundred and twelve respondents initially recruited for the study.[11] Two research assistants were employed, adequately trained strictly for the administration, collection and collation of the questionnaires in the first stage of this study.An ethical approval was obtained from the Health Research and Ethics Committee of the Federal Teaching Hospital, Ido-Ekiti to proceed with the study. The ethics committee reference number is: ERC/2019/03/12/195A and was approved on 3rd April, 2019. Permission was also obtained from the management of the various banks that participated in the study. Also, respondents were adequately informed about the study, the confidentiality involved and the voluntary nature of their participation. Informed written consent was sought and obtained from each participant. No harm was done on any subject for participating in the study. Data was collected between 6th November, 2019 and 24th January, 2020. The total distribution of the questionnaires was done in four days and it took an average of two days for the respondents to return them to the researchers. GHQ-12 score of each respondent was calculated by the research assistants to determine which participant goes to the 2nd stage of the study. This was to ensure the researcher conducting the second stage was blind to scores in stage 1 in order to reduce the risk of bias. Scores of 3 and above in GHQ-12 were regarded as cases for this study. Ten percent (10%) of non-cases (those scoring below 3 on GHQ-12) were added to those who were cases; this was to reduce type II error. This is because some bankers with psychiatric morbidity might have scored lesser than 3 (misclassification) and leaving them all out of the interview at the second stage would have increased the rate of false negative findings. The latter would affect the validity of the results.[12] The ten percent of the non-cases were selected through a process of simple random sampling by balloting and was done by the research assistants so as to forestall a selection bias from researcher. The overall process was used in determining the weighted prevalence. The weighted prevalence was done because it is more cost effective in terms of time and resources. Normally and according to standard protocols, after the use of a screening instrument, a diagnostic instrument should be applied to all the respondents to have a more objective view of the clinical variable being evaluated. However, applying the MINI on all the three hundred and two respondents would have been more resources-consuming, hence the idea for the weighted prevalence. And with the weighted prevalence, the most appropriate value is usually obtained. Arrangements based on convenience of the respondents during working hours (mostly early in the morning or late in the afternoon) were made with every case and 10% of non-cases selected for the administration of MINI.

Pilot Study

A pilot study was conducted in one of the banks outside the main study location. Thirthy - one respondents (10% of the sample size) were recruited for the pilot study. The pilot study enabled the researchers to evaluate the respondents' understanding of all questions in the tool, assess the time of completion and forestall any likely difficulty in the main study. It was also useful in determining the psychometric properties of the instruments in the study environment. The Cronbach alpha for the General Health Questionnaire (GHQ-12) was 0.8.

Data Analysis

Data was analyzed using the Statistical Package for Social Sciences software (SPSS) version 23. The data was presented using tables and charts. Continuous variables were summarized using mean and standard deviation while categorical variables were summarized as proportions and analyzed using Chi-square test. Fisher's exact test for Chi square was used where more than 20% of expected counts were less than 5. Probability (*p*) values less than 0.05 was accepted as statistically significant at confidence interval of 95% for all inferential statistics.

Results

Figure 1: Shows the probable psychiatric morbidity among the bankers.

Seventy-three (24.2%) of the respondents screened positive (scores ≥3) on GHQ-12 (i.e. probable psychiatric morbidity cases), while 229 (75.8%) had negative scores.

Figure 2: Shows the prevalence of psychiatric morbidity among the respondents.

Twenty-three respondents (10%) of the remaining 229 respondents who were GHQ-12 negative (non-cases) were added to the 73 respondents who had GHQ-12 scores of 3 and above making a total of 96 respondents who had the MINI interview at the stage 2. The 10% was added to reduce the misclassification rate of respondents with the screening instrument (GHQ-12).

Twenty-seven of the 73 respondents positive on the General Health Questionnaire (GHQ-12) had psychiatric diagnosis and three respondents from the 10% (23) added from those with GHQ-12 negative had psychiatric diagnosis. The sampling weight was calculated to get the prevalence of the psychiatric morbidity among the respondents. From the calculated sampling weight, one (1) diagnosed case from the added 10% represented ten respondents, so the total projected diagnosed cases from the 229 that were GHQ-12 negative was 30. Adding twenty-seven to thirty gives 57. Therefore, the overall prevalence of psychiatric morbidity found in this study was 57 out of 302 that is, 18.9%. The respondents with psychiatric morbidity were made up of 26 (8.6%) males and 31 (10.3%) females, while those without psychiatric morbidity were 177 (58.6%) males and 68 (22.5) females.

GHQ status: 1 = case   0 = non cases

Interview status: 1 = true cases   0 = false cases

Sampling weight:

$$\text{For Cases} = \frac{\text{Cases in stage 1(GHQ)}}{\text{Cases in stage 2(interview)}} = \frac{73}{73} = 1$$

$$\text{For Non} - \text{Cases} = \frac{\text{Cases in stage 1(GHQ)}}{\text{Cases in stage 2(interview)}} = \frac{229}{23}$$
$$= 9.9565$$

Prevalence of psychiatric morbidity =

$$\frac{\text{Sum of the product of sampling weight and interview status}}{\text{Sum of sampling weight}}$$

$$\frac{\sum w_i y_i}{\sum w_i} = \frac{27 + (3 \times 9.9565)}{302} = 18.9\%$$

Table 1: Shows the pattern of psychiatric diagnosis among the respondents.

Out of the fifty-seven respondents that had psychiatric disorders, a single diagnosis was made in the following respondents: Generalized anxiety disorder (GAD) in 12(4%); Alcohol dependence in 11(3.6%); Major depressive disorder (MDD) in 3(1.0%) and 3(1.0%) had Social phobia; 2(0.7%) had obsessive/compulsive disorder (OCD); 1(0.3%) each had Agoraphobia and PTSD. The remaining respondents had co-morbid disorders.

Diagnosis	Frequency (n= 57)	Percentage (18.9%)
GAD	12	4.0
Alcohol dependence	11	3.7
GAD and MDD	11	3.7
GAD and OCD	4	1.3
MDD	3	1.0
Social phobia	3	1.0
GAD and Social phobia	2	0.7
OCD	2	0.7
OCD and Panic disorder	2	0.7
Agoraphobia	1	0.3
GAD and Alcohol dependence	1	0.3
MDD, Social phobia and PTSD	1	0.3
OCD and Agoraphobia	1	0.3
Panic disorder and PTSD	1	0.3
PTSD	1	0.3
Social phobia and Panic disorder	1	0.3

GAD: Generalized anxiety disorder; MDD: Major depressive disorder; OCD: Obsessive compulsive disorder

Table 1: Pattern of Psychiatric Diagnosis among the Respondents (N=302)

The prevalence of social phobia in all respondents was found to be 3.3%, while that of generalized anxiety disorder was 9.9%, obsessive

compulsive disorder was 2.0%, panic disorder was 1.3%, and major depressive disorder was 5.0%. The prevalence of PTSD was 1.0%, alcohol dependence 4.0% and agoraphobia

Discussion

The prevalence of probable psychiatric morbidity using GHQ-12 in this study was 24.2%, which was different from reported findings from previous studies where similar screening instrument was used. A value of 28.9% was found among Bankers in Calabar,[13] 43% was reported among Bankers in Brazil,[9] while a value of 14.2% was found among managers and senior staff of private organizations in Sagamu, Ogun state.[14] The variation in values could be because of differences in locations, sociodemographic distribution of respondents and sample size.[15] More importantly, all categories of bankers were considered in this study and not just the managers or senior staff whose work may be supervisory in nature.[16] The prevalence of psychiatric morbidity was found to be 18.9% in this study. This was quite similar, although not identical to an earlier study where a prevalence of 18% was found in Ilorin.[6] The resemblance may be due to similarities in the screening and diagnostic instruments used as GHQ-30 and ICD-10 were used respectively in the Ilorin study, while GHQ-12 was used for screening and the Mini International Neuropsychiatric Interview (MINI), which was structured after ICD-10 diagnostic manual, was used for diagnosis in this study.[17] It may also be due to similarities in other methodological processes like sample size and proximity of study locations as Ado-Ekiti and Ilorin communicate with similar language which may indicate similar sociocultural settings.[18] However, the slight difference may be because of the recent and continuous restructuring policies in the Nigerian banking system, in which as a result of recent technological advancements, many bankers are being laid off leading to resultant emotional and psychological distresses on the available workers.[19],[20],[21] Consequent upon this, a feeling of uncertainty about their future and career may have ensued.[16] It may also be adduced to environmental factors like the rising trend of security challenges in the country, in which the banking industry has been seriously affected by the menace of incessant roberries.[15] A higher prevalence of 43% for minor psychiatric disorders among bankers was reported in Brazil, although a larger sample size was used and no diagnostic instrument was used after screening with GHQ-12.[9] The prevalence found in this study suggests that about 1 in 5 bankers have a psychiatric disorder. This is in line with a previous report that states that one out of every five Nigerians suffer from psychiatric disorders.[22] In this study, more females (54.4%) than males (45.6%) had psychiatric disorders. Epidemiologically, this may not be farfetched as most of the represented diagnosis like depression, anxiety disorders are commoner in females relative to the less represented ones like alcohol dependence, which is commoner in males.[10] It may also be because females are more likely to report emotional distress and as such are easily recognized.[9],[10] Females are also more involved in performing many tasks that could put them under pressure, thus resulting in increased risk of psychiatric morbidity.[23],[24] A similar finding was reported in Brazil,[9] while a study in Nigeria reported more males than females with psychiatric disorders.[6] The prevalence of generalized anxiety disorder (GAD) was found to be 9.9% in this study. A similar study done among bankers in Abeokuta found a prevalence of 5.6% for generalized anxiety disorder.[7] The difference in values may be in the instruments used, as the 20-item self reporting questionnaire (SRQ-20) was used for screening and diagnosis was made with the structured clinical interview for diagnosis (SCID), which is structured for making diagnosis as per the DSM in the Abeokuta study.[7] Making a diagnosis of GAD is more flexible with ICD-10 as the symptoms may be present for few months and do not have to be present for six months, which the DSM firmly upholds.[10] This means more diagnosis of GAD are more likely to be made with the ICD-10 manual.[10]

In this study, MINI which was structured to make ICD-10 diagnosis was used.[19],[25] Some researchers have reported generalized anxiety disorder as the commonest of all anxiety disorders and a prevalence of 9.2% has been reported, which is similar to that found in this study.[10],[26] Generalized anxiety disorder has been shown to reduce and undermine employees' efforts, concentration and productivity. The prevalence found in this study for other psychiatric disorders like anxiety disorders, obsessive compulsive disorder and posttraumatic stress disorder have been reported in other local and international studies.[10],[26] Although, their prevalence are generally lower than that of generalized anxiety disorder, when present, other types of anxiety disorders, obsessive compulsive disorder and posttraumatic stress disorder also contribute to significant distress among workers.[10],[22],[26] The prevalence of major depressive disorder in this study was 5.0%. A lower prevalence of 1.7% was however found in another study among bankers in Abeokuta.[7] This may be due to the earlier mentioned reason of differences in the screening and diagnostic instruments used as flexibility is more ensued in making diagnoses with ICD-10 manual than the DSM.[10] Besides, there were more respondents with children and with spousal complains about jobs in this study. Spousal complains may result in lack of confidant relationship, and the latter has been reported as a precipitant of major depression especially among working class women.[10] Also, after the Abeokuta study, some policies have been reviewed in the Nigerian banking industry which indirectly have led to the escalation of workload, longer working hours and more emotional distress among bank workers.[13],[22] Interestingly, the finding from this study falls within the 2-5% prevalence in the community from a larger study in the United Kingdom.[10] However, a higher value of 32% was reported in a larger study of 1,445 bankers in Brazil, and this may be due to differences in instruments employed as the screening tool used was the patient health questionnaire (PHQ-9) and no diagnostic instrument was used.[27] A prevalence of 20.6% for depression was also reported among bankers in South Korea, although no diagnostic tool was used after screening with the centre for epidemiologic studies-depression scale (CES-D).[28] Apart from the methodological differences between this study and the ones in Brazil and South Korea, the socio-cultural settings, which may determine vulnerability and resilience factors also differ and may explain the difference in the figures reported.[29] Besides, depression is a major contributor to the global burden of disease and a notable cause of absenteeism at work.[8],[10] It usually results in decline in personal and organizational performance and consumption of resources where treatments and policy restructuring have to be carried out.[9],[26] A prevalence of 4.0% for alcohol dependence was found in this study. A value of 1.1% for probable alcohol dependence was reported in a cross-sectional study of ninety-four bankers in Brazil after screening with the alcohol use disorder identification test (AUDIT).[30] Apart from the fact that a diagnostic instrument was used in this study, other reasons for a higher value in this study could be: a larger sample size, variations in the pattern of work-related stress, and national policy guiding the use of alcohol.[31] In a larger study of 1,080 bank workers in Brazil, the prevalence of alcohol-related disorders (including alcohol dependence) was reported as 13.5% after screening was done and diagnosis made with the alcohol use disorder identification test (AUDIT) and the composite international diagnostic interview (CIDI) respectively.[32] Apart from the methodological differences like variations in the instruments used and study location of the larger Brazilian study, there were also more male respondents in the study and as a way of dealing with their depressed states, males are more likely to take alcohol and some psychoactive substances and may end up meeting the criteria for alcohol and other substance use disorders, rather than other disorders like anxiety and major depressive disorders.[10],[31] Hazardous use of alcohol accounts for about 4% of the global burden of disease, and apart from the bidirectional

relationship between alcohol and work-related stress, chronic use of alcohol can result in physical conditions like liver cirrhosis, psychological distress and social problems like strained interpersonal relationships.[10] When some or all of these occur in an employee, work-related stress from low job control is almost inevitable. Also, excessive alcohol drinking may induce persistent depression or anxiety.[7],[10] People with a history of alcohol dependence have a fourfold increased risk of experiencing subsequent major depression, and the risk remains elevated even in those who no longer drink.[10]

Strength of the Study

The sample size was appropriate for the study and adequate instruments were used for the study. As it is a prevalence study, the cross-sectional study design was fitting as it made the findings reliable.

Limitation of Study

The effects of remuneration on psychiatric morbidity were not adequately explored in this study. This may reveal the effects of socio-economic status on psychiatric morbidity and vice versa. This study is localized to Ado-Ekiti and a multicentre study may be necessary to obtain findings that are more representative nationally.

Implication of Study

An adequate system of mental health promotion at the workplace that will facilitate the prevention, early identification, diagnosis and treatment of mental health conditions should be instituted through the enactment and enforcement of appropriate labour laws in Nigeria. Also, there is a need for more advocacies in the area of organizational psychiatry in Nigeria so that more enlightenment and researches can be done with a view to improve the mental health and wellbeing of Nigerian workers especially those in the banking industry.

Conclusion

In conclusion, this study shows that an important proportion of bankers have psychiatric disorders, most of which have never been presented for treatment. It also shows that the prevalence of psychiatric morbidity among them are in line with that of the general population.

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