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Psychiatric Morbidity among Undergraduates: A Review Article

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Abstract:

Globally, education is a powerful apparatus for engineering and backing up of social change in human societies. It is also imperative for the performance of productive tasks and affecting national development. Tertiary education in the university is an era of transition and experimentation where students are accorded the opportunity to decide what to do without the undue influence of their parents. Higher education is the catalyst, the bedrock, the right house and the dynamic force for the strong socio-economic, political, cultural, healthier and industrial development of a nation. However, university students are susceptible to psychiatric morbidity due to the makeshift nature of university life. Several correlates have been associated with psychiatric morbidity among undergraduate students. Coping strategies refer to the specific efforts (both behavioral and psychological) that people use to master, reduce, tolerate or minimize stressful events and psychiatric morbidity. The mental wellbeing of undergraduates is paramount and disturbance in any form will have adverse impacts on their current and future accomplishments. All stakeholders including parents, government officials and relevant government agencies, school authorities and the students themselves should be concerned about this observation.

Keywords: Coping strategies, psychiatric morbidity, undergraduates

1. Introduction

Education is regarded globally as a potent instrument for introducing and supporting social change in human societies, as well as shaping its destiny. Apart from serving as a vehicle for enhancing upward social and economic mobility, education is regarded as a key to social reconstruction (Schiefelbein and McGinn, 2017). Education imparts knowledge, teaches skills, and instills attitudes to the recipients. Imparting knowledge means putting across facts, current thinking, theories, principles or laws; teaching skills, impart practical skills, comprehension and ability to see implications or solve problems; instilling attitudes include inculcating tolerance, open-mindedness, scientific detachment and healthy skepticism (Bamber, 2016).

According to Jose, et al., (2017), education is important for social integration, the performance of productive tasks, and for effecting national development. Education brings liberation from the shackles of fear, prejudice, ignorance, and superstition. It helps to develop a free, independent and responsible citizenry, changes knowledge, attitude, skills, and

aspiration. It constitutes block for human capacity building and a key in helping an individual to discover, develop and properly deploy the inner ability, potentials, and capability for successful living in the society. (Seetharamu, et al., 2017). The University Education.

Tertiary education in the university is a period of transition where students are accorded the chance to decide what to do without the undue influence of their parents. (Pizzolato, 2004). All over the world, higher education has been known as an innate instrument for constructing the economy and the development of human capitals (Miletzki and Broten, 2017). According to Peretomode and Chukwuma (2012), higher education is the catalyst, the bedrock, the right house and the dynamic force for the strong socio-economic, political, cultural, healthier and industrial development of a nation.

The time spent in the university is supposed to be a memorable and pleasurable one. It is a time to build up someone socially, mentally, morally and physically. It is also a period to get a hold of endurance skill and time to acquire freedom from excessive parental control. However, university life is not without its jagged patches and problems (Isah and Inuwa, 2015). For most students, university period is the moment of experimentation. This is the time when risk risk-taking behaviors are displayed. Alcoholism, substance abuse and risky sexual behaviors are rampant among them and these can have an adverse effect on their academic performance. In Nigeria, the university system is plagued by several factors which include infrastructural decay, incessant strikes and lack of necessary facilities. Other factors include unfriendly academic environment and students being taught by poorly remunerated teachers with low self-esteem and never-ending strike actions (Amaghionyeodiwe and Osinubi, 2006). Hence, students would be expected to develop coping strategies if they want to successfully navigate through and succeed since academic performance is significantly correlated with conducive study environment (Amaghionyeodiwe and Osinubi, 2006; Lawal, 2013).

University students are susceptible to stressors due to the makeshift nature of university life. Students' health, as well as their academic performance, is believed to be related to the level of stress (Hamaideh, 2011). Students are subjected to different kinds of stressors, such as the pressure of academics with an obligation to succeed, an uncertain future and difficulties of integrating into the system. The students also face social, emotional and physical and family problems which may affect their learning ability and academic performance (Stoliker and Lafreniere, 2015; Armstrong and Fukami, 2009). Too much stress can result in physical and mental health problems, reduce students' self-esteem and may affect students' academic achievement.

University students are particularly apt for epidemiological study for a number of reasons: they form a rather discrete age group, they are an important section of the population, both socially and medically and at university, they are readily accessible for study (Kumaranayake and Srimathi, 2017).

University students are to some degree positively selected for mental health, however, it seems probable that there are other factors working in the opposite direction, for some academic success may have been achieved at the cost of social restriction and consequent immaturity (Szabo, 2015).

Information concerning the incidence and prevalence of mental ill-health among students is accumulating at every university, but there is a special need for a better understanding of the factors involved and the relative importance of each in order to stem the menace.

2. Student Mental Health

The term Student Mental Health was introduced in the 1950s and the first international conference on student health was held at Princeton, United States. Student mental health involves the etiology, prevention, and treatment of mental illness among students (Fatoye, 1998). Morakinyo constructed a comprehensive classification of student mental health problems after a detailed review of the literature. His classification was based on association with study difficulty. Those associated with study difficulty were subdivided into primary or secondary. The primary type was those with mental health problems which have been present in the student before studying, these include deficient intellectual functioning, dyslexia, some form of personality disorder, some neurotic states, substance abuse, and developmental disorder. The secondary was those who develop mental health problem after entering schools or after study difficulty, these are organic/medical, substance abuse and dependence, functional neurotic and psychotic state (Morakinyo 1990).

1	No Study Difficulty Associated	
2	<p>Associated with study difficulty</p> <p>Primary: Has always existed in the person before education</p> <p>Secondary: Developed after entering educational system</p>	<ul style="list-style-type: none"> • Substance (drug) abuse • Some forms of personality disorder • difficult intellectual ability • dyslexia • developmental problems • some neurotic states • Biological/organic • Functional (Neurotic and Psychotic state) • Substance (drug) abuse or dependence

Table 1: Morakinyo's Classification of Student Mental Health Problems

Globally, student mental health is a field of interest because of the negative consequences of its neglect. In Nigeria, school health is been anchored by various community health sectors of health institutions, community health workers and mental health workers. In spite of this, the mental health problem has not received adequate attention (Fatoye, 1998).

Psychiatric morbidity among undergraduates represents a serious health concern. Exploring psychiatric morbidity and its correlates among university students is imperative because subsequent impairment of the student's capacity for studying may invariably lead to the termination of their studies (Osasona, et al., 2011). Studies both in Nigeria and other parts of the world have reported high rates of psychiatric morbidity among undergraduates (Densen, 2011; Lima, et al., 2006).

3. Prevalence of Psychiatric Morbidity among Undergraduates

Psychological well-being is important for medical students, for the patients they meet and for their future medical practice. There is evidence that psychiatric disorders among medical students predict later problems, which in addition to their personal suffering as doctors, might negatively affect patient care (Firth-Cozens, 2003). High level of different kinds of psychiatric morbidity has been reported among students during medical training and much-published data confirms the view that medical students are excessively prone to mental health challenges (Fatoye, 1998; Raupach, et al., 2013). It is therefore important to be aware of the symptoms of psychiatric morbidity among students of health-related disciplines in order to facilitate early detection and treatment of these problems (Abolmagd, et al., 2018).

In the developed countries, Becker and associates found that 37% of young adults between the ages of 15 to 24 years in the United States of America had a diagnosable mental disorder, and many of these individuals were college students (Becker, et al., 2002). According to Phippen's, survey on counseling services in Higher education revealed that 64% of the counseling units had an increase in the proportion of seriously disturbed students (Phippen, 1995). Among Medical student in the United Kingdom, the prevalence of depression ranged between 5.7% and 10.6% among all Basic Science students and between 2.7% and 8.2% among all Clinical Students (Quince, et al., 2012). Papazisis, et al., (2008), found that 35.2% of Greek nursing students have psychiatric morbidity.

In the United States, a study among students at the country's top ranking academic centers showed that 26% of medical students had reported scores on the depression scale that may well be indicative of depression as compared to 22% of pharmacy students (Stecker, 2004). Using the General Health Questionnaire (GHQ), 47.9% of year two medical students in Antalya, Turkey, were found to have emotional disturbances, higher than the percentage of students studying economics (29.2%) and physical education (29.2%). (Aktekin, et al., 2001). A study in Sweden demonstrated that the prevalence of depressive symptoms among medical students was 12.9%, significantly higher than in its general population (Dahlin, et al., 2005). In Malaysia, 41.9% of medical students were found to have emotional disorders as reported by a previous study conducted at a local public university in 2002, using the GHQ-12 questionnaire (MohdSidik, et al., 2003). Emotional problems can cause serious mental suffering, which in turn lead to work disability and economic loss. The related economic costs soared in 1999 to 120 billion dollars in North America and Europe with over 60 billion dollars assigned to stress-related disorders (Wilkerson, 2003).

A cross-sectional study was carried out at Nishtar Medical College, Multan in 2008. The questionnaire was administered to 815 medical students who had spent more than 6 months in college and had no self-reported physical illness. A high prevalence of anxiety and depression (43.89%) was found amongst medical students. Prevalence of anxiety and depression among students of first, second, third, fourth and final years was 45.86%, 52.58%, 47.14%, 28.75% and 45.10% respectively (Jadoon et al., 2010). Depression, anxiety and stress levels of moderate severity or above were found in 27.1%, 47.1%, and 27% respectively among undergraduates in turkey (Bayram and Bilgel, 2008).

Warbah, et al., (2007) in their study on psychological distress, personality and adjustment among nursing students attending the College of Nursing, Christian Medical College, Vellore, India reported thirty participants (20.7%) of the 145 students assessed reported high scores on the General Health Questionnaire.

In the developing countries, a study in Oman among university students by Al-Dubai, et al., (2011) revealed that 27.7% had depression. Al- Bayram, and Bilgel, (2008) found the prevalence of depression and anxiety to be 27.1% and 47.1% among undergraduates, Sreeramareddy, et al., (2007) found that the overall prevalence of psychiatric morbidity among medical students was 20.9% among medical students in Nepal and was higher among students of basic sciences. Deb Chatterjee and Walsh (2010) found that the prevalence of mental distress among medical students in India was 14.5%. Another study among medical student in Tehran revealed that 40.7% had psychiatric morbidity (Shariati et al., 2007).

In Africa, the prevalence of depression was found to be 13.7% by Ovuga et al. among students of Makerere University, Uganda (Ovuga, et al., 2006). Dachew, et al., (2015) found that prevalence of psychiatric morbidity among undergraduates in Ethiopia was 40.9%. A study by Ibrahim among medical students and Pharmacy students in Egypt found that among medical students, the prevalence of anxiety and depression were 43.9% and 57.9% respectively while the prevalence of anxiety and depression were found to be 29.3% and 51.1% respectively in the Pharmacy students (Ibrahim, et al., 2015).

In Nigeria, Osasona, et al., (2011) found that 33.5% of undergraduates in Benin, who were assessed with the General Health Questionnaire (GHQ) had scores suggesting underlying psychiatric morbidity (Osasona et al., 2011). Results from Ibadan indicated that 12% of pre-clinical students and 21% of clinical students had psychiatric morbidity (Omokhodion and Gureje, 2003), Oshodi, et al., (2012) reported 42.2% of medical students in Lagos to have psychiatric morbidity while Oku et al reported that 39.2% of medical student in Calabar had poor mental health (Oku, et al., 2015). Also, Babalola et al., (2014) reported a prevalence of 65% of psychoactive substance use among medical students in Olabisi Onabanjo University.

Abayomi, et al., (2013) also found that the prevalence of alcohol use was 40.6% while alcohol-related problems were found in 14.9% of the undergraduate in southwestern Nigeria using the AUDIT questionnaire with a cutoff score of 5. Heavy episodic alcohol use was reported by 31.1% while alcohol-related injury had occurred in 8.9% of the students.

5. Factors Associated with Psychiatric Morbidity among Undergraduates

Several correlates have been associated with psychiatric morbidity among undergraduate students. In the developed nations, Mouret found that the associated factors with psychiatric morbidity among students of health-related disciplines in Australia were dealing with patient disease and witnessing death, relationship with consultants and effects on personal life (Mouret, 2002).

In the developing nation, a study in Turkey revealed that academic achievement and presence of a negative event in the last year were associated with psychiatric morbidity (Üner., et al., 2008). Student debt, greater material expectations, greater pressure on academic institutions and staff, expansion of student numbers, leaving one's family and making a new start elsewhere, placing great value on social and familial support and a change in environment were correlates of psychiatric morbidity among medical students in Malaysia (MohdSidikRampal, and Kaneson, 2003) while Bostanci et al found that information input overload, lack of leisure time and academic evaluation (examinations and continuous assessments) were correlates of psychiatric morbidity among medical students especially in their first academic year (Bostanci, et al., 2005). Present place of residence, parent's occupation, attempt in MBBS entrance examination and poor socioeconomic status were found as risk factors of mental illness among medical students in India (Deb, et al., 2010).

A cross-sectional study was carried out at Nishtar Medical College, Multan in 2008. The questionnaire was administered to 815 medical students who had spent more than 6 months in college and had no self-reported physical illness. Female students were found to be more depressed than male students (Jadoon, et al., 2010.) In Turkey, Naim, et al., (2008) found that anxiety and stress scores were higher among female students. First- and second-year students had higher depression, anxiety and stress scores than the others. Students who were satisfied with their education had lower depression, anxiety and stress scores than those who were not satisfied.

In Africa, Dachew, et al., (2015) found among undergraduates in Ethiopia that female sex, lack of interest towards their field of study, not having close friends, never attending religious programs conflict with friends, having financial distress, family history of mental illness, use of khat (stimulant) lower grade than anticipated, lack of vacation or break and low social support were significantly associated with psychiatric morbidity. A study by et al among third-year undergraduate in Nigeria revealed that female sex, course of study, mother's character, significantly poor academic performance and relationship between parents were variables that predicted psychiatric morbidity (Osasona et al., 2011). Omigbodun et al., (2006) found that the prevalence of psychological distress was found to be higher among the male students. Other socio-demographic factors associated with psychological morbidity include being in a transition year of study, reporting financial distress and not being a 'Pentecostal Christian', excessive school work, congested classrooms, strikes by faculty, lack of laboratory equipment, family problems, insecurity, and financial and health problems. They also noticed that Medical and dental students had significantly higher GHQ scores than the physiotherapy and nursing students. Among undergraduate in Southwestern Nigeria Male gender, older age, and higher paternal education were associated with problem drinking. In addition, psychological distress was significantly associated with heavy episodic drinking and history of alcohol-related injury (Abayomi et al., 2013).

6. Possible Management of Psychiatric Morbidity among Undergraduate

Coping strategies refer to the specific efforts (both behavioral and psychological) that people use to master, reduce, tolerate or minimize stressful events (Monteiro, et al., 2018). It is a stabilizing factor that may assist an individual in psychosocial adaptation but when these adjustments are not made smoothly with regards to studying, study difficulty becomes one of the most commonly encountered symptoms (Fatoye, 2003).

Two main strategies have been identified for coping with such situations: problem-solving and emotion-focused (Bamuhair et al., 2015). Problem-focused distillates on recognizing the problem and endeavoring to generate an alternative solution, while the emotion-focused strategies help the individual to manage the emotion associated with the problem rather than removing it. Problem-solving involves seeking help, solving problem, confrontation and obtaining information. Emotion-reducing methods are positive appraisal and ventilation of emotion. Maladaptive coping mechanisms are the use of alcohol, unrestrained display of emotion, deliberate self-harm, aggression, and other similar strategies.

However, other authors have identified active and avoidant coping strategies (Krohne, 1993). Active coping strategies are either behavioral or psychological responses designed to change the nature of the stressor itself or how one thinks about it while avoidant coping strategies lead people into activities such as withdrawal that keep them from frankly addressing stressful events. Active coping strategies include active coping; which involves taking action or exerting efforts to remove or get around the stressor; planning; which is thinking about how to meet the stressor and planning one's coping efforts; acceptance; which is accepting the fact that the stressful event has occurred and is real; positive reframing which is making the best of the situation by growing from it or seeing it in a more positive light and humour which means making jokes about the stressor. Avoidant strategies include denial: defined as an attempt to reject the reality of the stressful event; behavioural disengagement: meaning giving up or withdrawing efforts from the attempt to attain the goal with which the stressor is interfering; venting: which means an increased awareness of one's emotional distress and a concomitant tendency to ventilate or discharge those feelings. (Krohne, 1993).

According to Meyer, adaptive coping strategies include use of emotional support, positive reframing, acceptance, religion, humor, active coping planning and use of instrumental support while maladaptive includes venting, denial, substance, self-distraction behavioral disengagement, and self-blame. Active coping strategies are adaptive while avoidant coping strategies are maladaptive (Meyer, 2001).

7. Coping Strategies among Students

Coping strategies among students are influenced by ethnic, cultural, and socioeconomic characteristics (Kariv and Heiman, 2005). In the developed countries, the use of alcohol, tobacco, and drugs were common coping strategies adopted by medical students in the United Kingdom (Guthrie, et al., 1995). The main coping strategies used by medical students in Netherland were self-distraction, active coping, positive reframing, planning, and acceptance (Shankar et al., 1995). Gibbons found that United Kingdom nursing students who used avoidance coping were predisposed to burn-out (Gibbons, 2010).

In the developing nations, study among undergraduates in Thailand, showed that 86% of the respondents agreed that Social Support Coping Strategy helped them to cope with academic performance, 84.5% agreed that Avoidance Coping strategy was useful, and while 83.5% gave positive responses to Approach Coping Strategy (Kuncharin and Mohamad, 2014). In a qualitative study among Malaysian students, the common coping strategies adopted were meditation, counseling services, doing meditation, sharing problems, getting adequate sleep and going out with friends (Aan., et al., 2009). Sreeramareddy et al., (2007) also observed that medical students using mindfulness-based stress reduction classes, informal support groups and mentoring program to cope with study difficulty and anxiety are less prone to psychiatric morbidity than others in Nepal among medical students in Malaysia, active coping strategies were more used than avoidant. Females used self-distraction, religious coping, emotional support, instrumental support; and planning, than males. However, males were involved in alcohol or substance use than females. Older students (aged more than 21 years) used active coping, (reframing, and planning,) more than younger students (Al-Dubai, et al., 2011). In a study in Pakistan, Shaikh et al reported that sports, music, hanging out with friends, sleeping, or going into isolation were coping strategies among medical students (Shaikh et al. 2004). A study in Saudi Arabia among medical student by Bamuhair et al noted that prominent coping strategies include blaming oneself and being self-critical, seeking advice and help from others, and finding comfort in religion (Bamuhair et al., 2015).

Coping strategies used by Iranian nursing students were smoking, drinking, getting professional counseling, playing video games, talking to counselors, protest and staying away from home (Seyedfatemi et al., 2007). Mahat found that 59 out of 107 degree-nursing students frequently used problem-solving and 53 sought social support on their own in Nepal (Mahat, 1996). Sheu, Lin, and Hwang (2002) in Taiwan reported that four commonly used coping strategies among nursing students were optimistic, transference, problem-solving and avoidance (Sheu et al., 2002). In Nigerian a study by Oku, et al., among medical students in Calabar, they found that the students' community adopted positive coping methods (Oku et al., 2015), while Yusuf et al in Ilorin, Nigeria found that medical students with psychiatric morbidity were significantly more likely to use religion and 4 times less likely to use positive reframing as coping strategies (Yussuf, et al., 2013).

8. Conclusion

The mental wellbeing of undergraduates is paramount and disturbance in any form will have adverse impacts on their current and future accomplishments. All stakeholders including parents, government officials and relevant government agencies, school authorities (academic and non- academic) and the students themselves should be concern about this observation. Several aspects of students live must be important to the policymakers on education like the government and the school management who are saddled with the responsibility of providing educational training.

9. Recommendations

- The prevalence of psychological challenges in tertiary institutions has been largely overlooked. It requires more than just a few guidance counselors in the Students' Affairs Section of the school. Professionals from relevant disciplines have to come together to formulate and implement a logical and all-inclusive strategy for mental health education.
- Mental health services must be an active part of student health care services. There should be proper identification and referrer of mental health issues when necessary.
- More researches are recommended to unravel the role of coping strategies on psychiatric morbidity. Thus, longitudinal studies will need to be conducted in order to achieve this key goal.

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