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HALLUCINATION AND RELIGIOUS BELIEFS AMONG STUDENTS IN A NIGERIA UNIVERSITY

By

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ABSTRACT

This study investigated lifetime-prevalence of hallucination among a group of Nigerian students and the determinants of hallucination among them. Study involved 1095 students of a Nigeria university, screened for hallucination using Schedule for Clinical Assessment for Neuro-Psychiatry and psychological distress using General-Health Questionnaire-12. Data was analyzed with linear regression analysis ($p<0.05$). Auditory hallucination was present in 12.1%, visual in 10%, tactile in 12.1% and olfactory in 5.1%. Proportions of hallucination among religions were: 11.1% Christians, 9.8% Muslims, and 23.1% traditionalists. Point-prevalence of hallucination was 10% with 5.1% having multiple hallucinations. Hallucination interfered with daily-activity in 17.6%. About 44% had psychological distress while 13.4% required medical-intervention for it. Hallucination was more common among the Christian faithfuls. Females and the separated/widowed had significantly higher hallucinatory experience. It was concluded that hallucination cuts across religious groups. Age, religion, gender, ethnicity and marital status had significant influence on hallucinatory experience. Psychological distress is common in students even without hallucination.

Key words: Hallucination, Religious Beliefs, Nigeria University, Students

INTRODUCTION

Hallucinations especially auditory and visual are seen as part of religious experience (Azari et al, 2001). Sometimes people with mental disorders can manifest these with religious connotations. Hallucinations can be defined by the sense with which they are associated i.e. collective, command, visual, auditory, olfactory, somatic and gustatory hallucination (American Psychiatric Association [APA], 1995). A collective hallucination is a sensory perception induced by the power of suggestion to a group of people and generally occurs in heightened emotional situations, especially among the religiously devoted (Rawcliffe, 1999). Those witnessing to miracles agree because they have the same pre-conceptions and expectations (Rawcliffe, 1999). Those who see nothing extra-ordinary and admit it are dismissed as not having faith (Heffern, 2001). Some, no doubt, see nothing but rather than admit they failed, would imitate the lead given by those who did, and subsequently believe that they had in fact observed what they had originally only pretended to observe (Rawcliffe, 1999).

Not all collective hallucinations are religious (Rawcliffe, 1999). Where belief in miracles exists, evidence will always be forthcoming to confirm its existence. In the case of moving statues and paintings, the belief produces the hallucination and the hallucination confirms the belief (Rawcliffe, 1999). Religion, both indigenous and orthodox, whose method described as faith healing, is said to play an important role in many African sub-culture (Peltzer, 1999). Many reasons are given for hallucination religiously and these inform their steps taken to seek intervention. Majority of religious healers attributed supernatural phenomenon like witchcraft, sins and curses from gods as major causes of mental illness and are frequency consulted before psychiatrist (Adeyemi and Famuyiwa, 1994; Etuk, 2000; Agara, 2002).

Religious beliefs and practices have been conceptualized as pathological (America Psychiatry Association, 1995). Religious beliefs result from, and are indicative of, some kind of intellectual flaw or deficiency (Lantinga, 2000). Many studies have tried to find association between religious believe and psychiatric illnesses. World Health Organisation reported that religious hallucination and/or delusions occur in 3.2% of unselected schizophrenic patients (Saver and Rabin, 1997). They however noted that making diagnostic distinctions between culturally sanctioned religious beliefs and religious hallucination/delusions is both a clinical challenge

and a challenge to established psychiatric nosology. A previous study made a psychometric comparison between individuals reporting spiritual experiences and those reporting psychotic experiences and concluded that there was no clear distinction between them (Azari et al, 2001). However, it has been argued that any bizarrely implausible belief (i.e., a belief that violates logical, physical or biological principles that are widely known) that is formed and maintained in ways characteristic of (unambiguous) delusions should, for theoretical purposes, be classified as a delusion (Davies et al, 2001). Authors had maintained that hallucination delusions do not arise via defective reasoning, but rather constitute rational responses to unusual perceptual experiences, which are in turn caused by a spectrum of neuropsychological abnormalities (Maher et al, 1974, 1984, 1988, 1992, 1993, 1999; Young, 1990; Campbell, 2001). Hallucination/delusion arises when the affective component of face recognition is disrupted (Maher et al, 1999; Coltheart, 2000; Breen et al, 2001; Davies et al, 2001).

Many who have visions, voices and the other types of experiences do not easily seek psychiatric help. For many of these people, this phenomenon falls under spirituality. People who have religious-based hallucinations can spend many years under them without seeking medical intervention because they do not believe in the model of psychiatry.

Many questions have been raised about religion and hallucination. Some asked whether many mentally healthy and functional people hallucinate or whether their hallucination is the unnecessary by-product of their religious experience. This posses more confusions as answers are intended to be provided. There is need for studies that will illuminate the perception of people and religious experience so as to provide solution when psychiatry disorder is imminent. Such a study will also provide information on the pathway to seeking relieve when there is mental illness. Therefore, this study investigated the prevalence of hallucination among undergraduates in a Nigeria university. It also exploited the association between religious belief and hallucination among university students and to recommend solution to associated psychiatric disorder within religious rites.

METHODS

Ethical approval of the Federal Neuro-psychiatric Hospital, Yaba, Lagos, Nigeria Ethical Committee was obtained before the commencement of this study. Permission of the authority of the university where the students were recruited from and the informed consent of the participants were also obtained. This study involved undergraduates of a Nigeria university who were selected using multi-stage sampling technique. Six faculties and one school were randomly selected from the 9 faculties and 3 schools in the university. Two or 3 departments were randomly selected from each faculty and school. Seventy percent of each of the class population was selected using fish-bowl method from each level of study. All participants completed the questionnaires. The General Health Questionnaire-12 (GHQ12) was used to screen the participants for psychiatric morbidity. Their socio-demographic details were obtained using a structured interview system. They were all screen for hallucination using the Schedule for Clinical Assessment in Neuro-Psychiatry. The result of the screening was then coded and computed for data analysis. Statistical analysis was performed using the descriptive statistic (frequency, percentages, mean and standard deviation), Spearman's correlation coefficient, Analysis of variance and linear regression. The level of significance was set at less than 0.05 ($p<0.05$).

RESULTS

Nine hundred and seven-three (534-male and 439-female) data were valid (89% return-rate). Majority (86.9%) were Christians, 11.8 Muslims, 1.2% belonged to other religions. About 50% of the participants were between age of 21 and 25 years and in their second year of study (Figure 1 and 2). Auditory hallucination was present in 12.1%, visual in 10%, tactile in 12.1% and olfactory in 5.1% (Table 1). Proportions of hallucination among religions were: 11.1% Christians, 9.8% Muslims, and 23.1% traditionalist and 12.1% others. Point-prevalence of hallucination was 10% with 5.1% having multiple hallucinations. Hallucination interfered with daily-activity in 17.6% (Table 2). Four hundred and twenty-seven (43.9%) had psychiatry distress while 13.4% had medical-intervention for hallucination (Table 2). Religion had significant influence ($p<0.05$) on hallucinatory experience with difference lying between the Christians and other religion, Muslims and traditionalist. Females and the separated/widowed had significantly higher ($p<0.05$) hallucinatory experience. The younger age group had more hallucinatory experiences than others ($p<0.05$). Individuals from Igbo ethnic extractions had significantly higher hallucination ($p<0.05$) than the other ethnic groups.

DISCUSSION

The fact that there is high rate of hallucination among the participants in this study shows that hallucination is part of religious experience, but not all are pathological. This corroborates previous opinions that hallucination is part of religion and is often not perceived as ill-health (Rawcliffe, 1999). Nevertheless, many who have visions, voices and the other types of experiences do not easily seek psychiatric help. For many of these people, this phenomenon falls under intense spirituality (Peltzer, 1999; Rawcliffe, 1999). People who have religious-based hallucinations can spend many years under them. Some never try to get help for their hallucinatory experiences, for they either do not believe in the model of psychiatry (Lantinga, 2000), or associate it with deity interference in human affairs and therefore require only spiritual solution (Adeyemi and Famuyiwa, 1994;; Etuk, 2000; Agara, 2002). Often visions and voices can become confusing. Once they find out there is a modern

scientific explanation for some of these experiences, written by someone who even shares their belief that sometimes such experiences are divinely originated, they indulge.

The results of this study show that hallucination cuts across religious groups. This suggests that such experience is not limited to certain religion or a set within a religion. The fact that the younger aged experience more hallucination than the older ones may be due to expectation and curiosity on the path of young age people. Anecdotally, younger people tend to be more meticulous about an activity they are being introduced because they are having their first exposure to it. Therefore, they tend to be more emotionally inclined and devoted. It is not however surprising that the female gender hallucinate more than their males counterparts as females have been said to be more emotional than males (Young, 1990; Saver and Rabin, 1997; Azari, 2001; Campbell, 2001). Therefore, it may be inferred that association exists between emotional state and expression of hallucinatory experiences.
Religion and hallucination may look inseparable. The more the religious activity and expectation, the more the outburst of emotional expression. This may have informed while Christians may have experience of hallucinations more than the others. The expectancy and hope of bearing witness to a miracle, combined with long hour's religious activities makes certain religious persons susceptible to seeing such things that other people do not see. This has also be previously documented among authors (Saver and Robin, 1997; Rawcliffe, 1999). Those witnessing to miracles have been said to agree in their hallucinatory accounts because they have the same preconceptions and expectations (Rawcliffe, 1999). Those who see nothing extraordinary and admit it are dismissed as not having faith. A previous study have noted that some, no doubt, may see nothing but rather than admit they failed, would imitate the lead given by those who did, and subsequently believe that they had in fact observed what they had originally only pretended to observe (Rawcliffe, 1999).

Various ethnic groups have different culture and belief system. They are influenced by their environment as well as what history has impacted on them. This may explain the reasons for more hallucination in one ethnic group than the others. However, this has not made any ethnic group superior to the other. The widows and the separated or divorced may have emotional modulation as they often experience loneliness and also having the reminiscence of their previous marital experiences. In this situation, they may see what others do not see or hear what is not audible to a nearby person. This may result into hallucination and may require medical intervention. However, it should be noted that some religion hallucinations are pathological and require intervention. Therefore, there is need to provide solution when psychiatry disorder is imminent. This informs the need for mental health workers to engage in public health programme including awareness to religious leaders in order for them to be able to differentiate between true religious activity and religious activity superimposed with psychiatry morbidity.

The fact that psychological distress is common in students even without hallucination may be due to the fact that academic activities require both physical and emotional commitment. This may induce some psychological distress. However, it is pertinent to take health education to the students in order to reduce psychological problem and consequential psychiatry conditions in them.

CONCLUSION

This study has provided more information that may help in reducing the incidence of psychiatric disorder among the religiously inclined people. It may also inform the larger society on the appropriate steps to take when there is suspected mental illness. It may also assist the mental health-care provider in making accurate diagnosis, distinguishing between religious beliefs and those that reflect underlying pathology.

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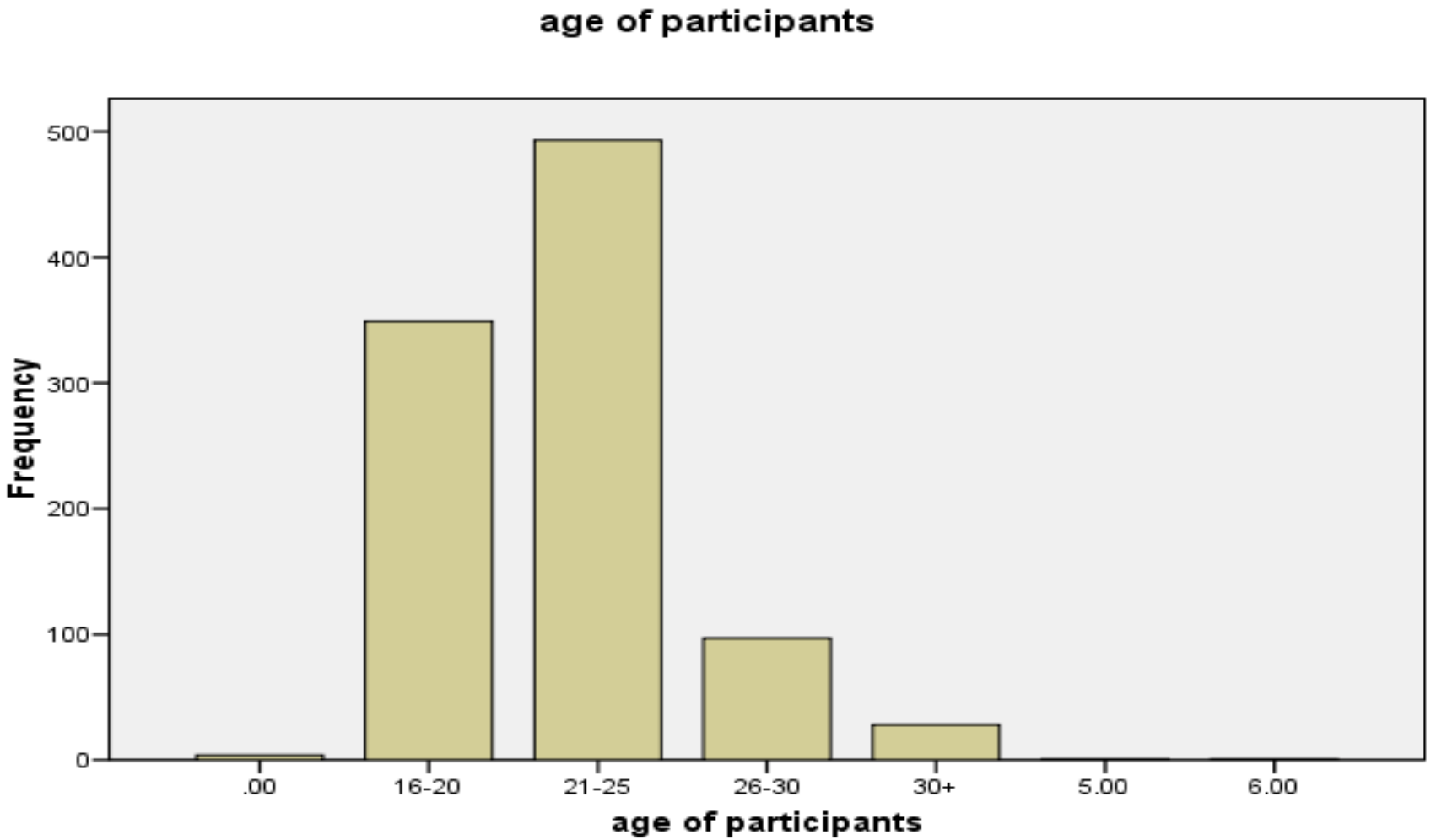

Figure1: Age group of the Participants

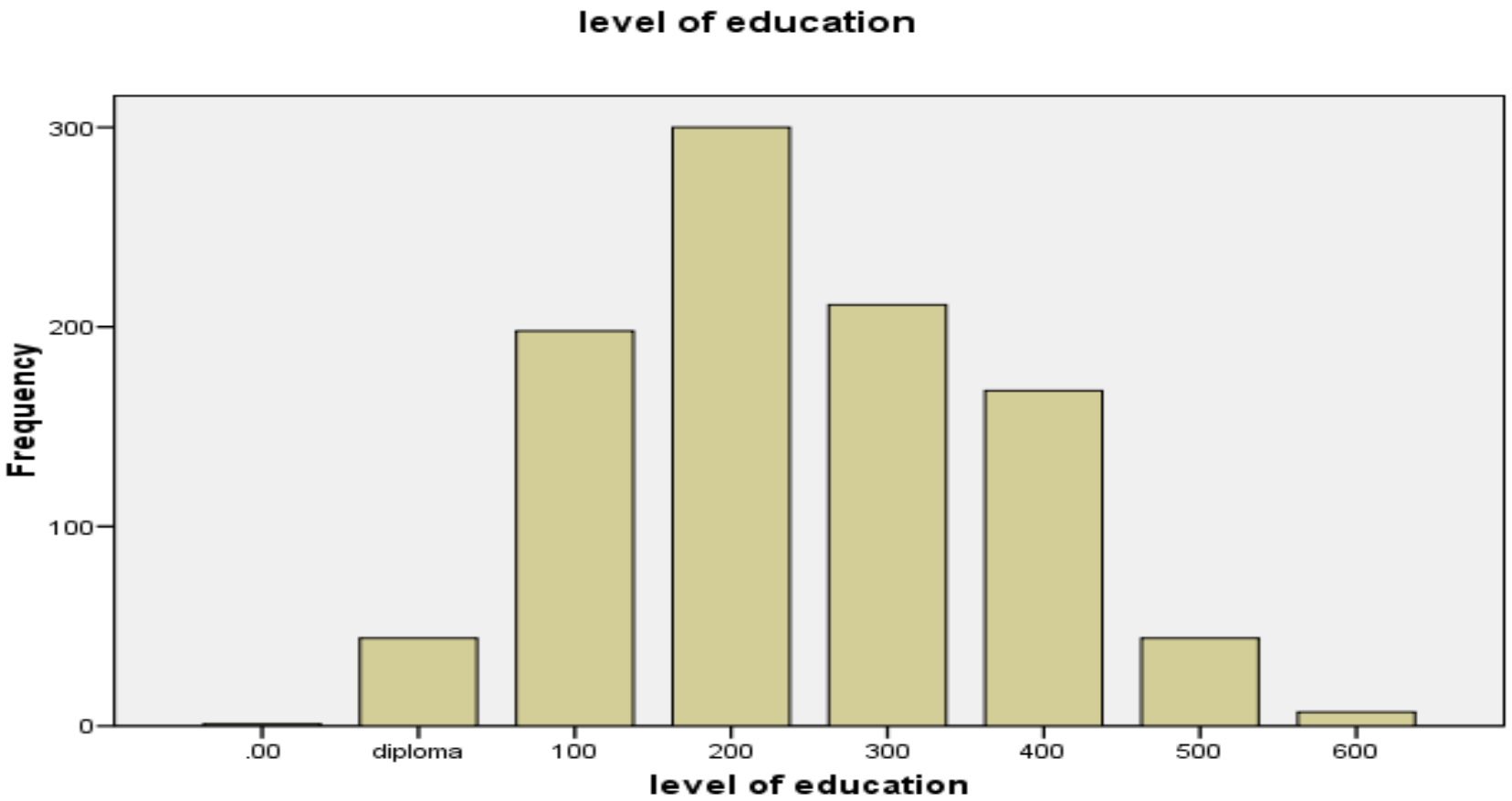

Figure 2: Level of Education of the Participants

Table1: Hallucinatory Characteristics of the Participants

Variable	Frequency	%	Cumulative	%
VISUAL				
Present	99	10.2	10.2	
Absent	874	89.8	100.0	
AUDITORY				
Present	118	12.1	12.1	
Absent	855	87.9	100.0	
OLFACTORY				
Present	52	5.3	5.3	
Absent	921	94.7	100.0	
TACTILE				
Present	118	12.1	12.1	
Absent	855	87.9	100.0	

Table 2: Clinical Effect of Hallucinatory Experience

Variables	Frequency	%	Cumulative	%
Require Medical Intervention				
Yes	130	13.4	13.4	
No	843	86.6	100.0	
Interfere with daily activity				
No	801	82.3	82.3	
A little	149	15.3	97.5	
Moderate	15	1.5	99.1	
Severe	8	0.8	100.0	

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