Case Report

Caregiver Perspective in a Mental Diagnosis of Hyperreligiosity

Aminat Akintobi

ABSTRACT

Until the 20th century, religion was often seen from a negative perspective in the psychiatric treatment of mental illnesses. However, this has changed within the last fifty years to a more positive perspective, with psychiatrists overlapping religious beliefs of patients in psychiatry treatments. Family members are usually the primary caregivers of persons with mental health disorders. Caregiving for the mentally ill takes a physical as well as mental toll on the carer. Activities carried out by the caregiver include monitoring the administration of drugs; commuting the patient to and from hospital visits; the financial burden and many others. In a mental illness scenario, the caregiver bears the brunt of the behavioral pattern of the mentally ill patient, this includes giving emotional support to the ill family member. This study joins a body of research that documents the perspective of caregivers in the observation, diagnosis and treatment plan of mania hyperreligiosity. This study presents the case of a 55-year old middle aged female, who presented with a diagnosis of mania hyperreligiosity. Having carried out caregiving activities for the family member, the author concludes that the role of a caregiver include administration of medicines, observing and reporting improvement of the patient; observing and reporting side effect; and since this a behavioral defect illness, conversing with the patient to determine their mental status; and motivating the patient to undergo treatment. Following the importance of the caregiver role, the author document that it is important for psychiatrists to view caregivers as a resource rather than a medical care seeker. Psychiatry physicians will do well to involve the perspective and advice of the caregiver in care plans.

Key Words: Hyperreligiosity, Caregiver, Psychiatry, Spirituality

Received: 23-July-2023, Manuscript No. ijocs-23-107781; **Editor assigned:** 25-July-2023, PreQC No. ijocs-23-107781 (PQ); **Reviewed:** 30-July-2023, QC No. ijocs-23-107781 (Q); **Revised:** 2-August-2023, Manuscript No. ijocs-23-107781 (R); **Published:** 8-August-2023, DOI: 10.37532/1753-0431.2023.17(8).321

Introduction

Until the 20th century, religion was often seen from a negative perspective in the psychiatric treatment of mental illnesses. In the 1950s, the religious concern of patients were often approached with hostility. Psychiatrists often believed that religion was bad for one's health. On the flip side, religious institutions also distrusted physicians, they believed that psychiatry led people astray from a belief in God to seeing mental health as a purely medical phenomenon. However, in the 1970s, things began to change. There was a positive progression in the '80s when a small group of psychiatrists began marking out the territory for the overlap between religious faith and psychiatry symptoms. In the last fifty years, there have been significant improvements. Currently, it is known that religious involvement in psychiatry is a positive factor [1].

Practicing religion has been found to reduce tension, diminish anxiety and stabilize emotional variability. Religion generally helps individuals tolerate stress, generate peace, purpose and forgiveness. However, despite the importance of religion and spirituality in daily life, there is an optimum beyond which it is considered too much and can invariably affect mental health. At this point, it borders on hyperreligiosity which is a mental illness. "In this article, mental illness refers to any psychiatric condition or disorder that causes significant distress and impairment in social, work or family activities; these conditions include, and are not limited to, schizophrenia, bipolar mood disorder, anxiety disorder and depression. Specifically, hyperreligiosity is a mental disturbance in which a person experiences intense religious beliefs or episodes that interferes with normal functioning [2-4].

Although patients develop comorbid hyperreligiosity in an attempt to help them cope with terminal illnesses such as cancer, in this case, it is a stand-alone symptomatic case of hyperreligiosity [5, 6].

Caregiving in mental illness

24.4% of adults aged 45 to 64 are involved in caregiving activities (Centers for Disease Control

Department of Ayunran Medical Writing Services, Nigeria
*Author for correspondence: Aminat Akintobi, Department of Ayunran Medical Writing Services, Nigeria E-mail: aminatakintobi@gmail.com

and Prevention, 2023). One in three caregivers have provided more than 20 hours of care per week. On a mental health scale, in the US, as many as 8.4 million Americans are providing care to an adult with an emotional or mental health issue (Centers for Disease Control and Prevention, 2023). These mental illnesses include bipolar disorder, schizophrenia, major depression and/or emotional stresses. Caregiving for the mentally ill takes a physical as well as mental toll on the career. Activities carried out by a mental health caregiver include, but are not limited to, helping a loved one in dressing, toileting, conducting household tasks, buying groceries and chores.

Family members are usually the primary caregivers of persons with mental health disorders. The family caregiver plays multiple roles in the care of persons with mental illness. They also monitor the administration of drugs and commuting of the patient to and from hospital visits, amongst the financial needs and many others. In a mental illness scenario, the caregiver bears the brunt of the behavioral pattern of the mentally ill patient, they experience considerable stress. Several researches have highlighted the stress accrued by mentally ill patient caregivers and their underlying coping strategies and despite the importance of their activities in the care for more mentally ill patients, "the caregiver has remained a neglected lot," often ignored by mental healthcare policies. While the stress and burden undertaken by the caregiver has been documented severally, only a handful of research include the actual caregiver perspective; and particularly, little to none on the caregiver of a mentally ill patient [7-9].

Although patients develop comorbid hyperreligiosity in an attempt to help them cope with terminal illnesses such as cancer, in this case, it is a stand-alone symptomatic case of hyperreligiosity. This study joins a body of research that documents the perspective of caregivers in an observation, diagnosis and treatment plan. This case study on the perspective of a caregiver follows the case of a 55-year old middle aged female, who presented with a diagnosis of mania hyperreligiosity. This body also joins a body of research that addresses the diagnosis of hyperreligiosity as is it less often assessed from a caregiver perspective.

Case Presentation

The patient in this case study is a 55-year old middle aged female who presents with worsening moods, vocal hallucinations, intrusive thoughts and hyperreligiosity. The specific symptoms that led to her diagnosis include: change in eating habits, change in mood, excessive worry, anxiety or fear; feelings of distress, inability to concentrate, irritability or anger, low energy, sleep disruption, and most prominent of all, uttering religious words incessantly.

The patient arrived at the hospital care unit in a rather unstable state. She was quite expressive and was heard voicing thoughts that were really unclear. Most of all, her speeches were full of Islamic pronunciations.

To suppress her over-expressive mental state, she was first administered Olanzapine 10mg. This put her in a relatively calm state and suppressed her mood to a rather depressive episode. This depressive mood meant that her aggressiveness subsided, she talked less, had low energy, and had less interest in her surroundings even though she was fully aware. This was maintained the next morning. However, she kept expressing Islamic words.

Her treatment regimen continued with:

- Tigerton : 400mg in the morning; and 400mg at night
- Haloperidol 5mg is also included for sleep maintenance.

The patient spent a total of 11 days in the general ward, at the end of which she looked better, and was taking better care of herself. She stopped muttering religious words, she only prayed when she needed to and was taking better care of herself.

Discussion

Specific caregiver perspective on mental health care

Upon remission, because of the level of trust, the caregiver's conversation with the patient revealed why she had been so stressed as to be diagnosed with hyperreligiosity. Although formerly an out-patient at the Behavioral Mental Health unit, her condition had worsened upon the passing of her father whom she was really rather close with. Plus, having recently been facing some stress at work, all these were factors that led to her relapse. Thankfully, her doctors were involved physicians in the care plan and they made adequate plans to talk to her and involve

her concerns in the diagnosis and care plan. This brought about considerable improvement on an outpatient basis.

As a caregiver, being a relative of the patient, in an interview with the patient, she was able to confide in me, and in many instances, I was able to liaise with the doctors on treatment plans and coping mechanism for the patient, document and converse on patient improvement to manage and adjust her dosage changes until remission.

On one such occasion of the hospital visit on an outpatient basis, upon arrival at home, the patient's substantially changed. She was getting much too involved in activities around the house, while it was rather clear that she still needed adequate rest, she was agitated. I was able to report such. Thereafter, she was stabilized on mood stabilizers. The following week however, this mood became rather depressive that she began to lose interest in her normal daily activities and became rather depressive. Hence, her care plan was changed, the dosage of mood stabilizer was adjusted to ensure that she could cope without being agitated or depressive. These were the real instances where the functions of a caregiver came into play aside from daily care of the patient. Attention to medication and liaising with doctors to improve treatment plans is relevant. All these are stated with a view to guide mental healthcare professionals to develop treatment plans that take into consideration the presence of caregivers as a resource rather than a medical care seeker.

In my observation, the role of the caregiver on a medical aspect ultimately includes:

- Administration of medicines, and reminding the patient to take medicine if not available to administer it;
- Observing and reporting improvement of the patient;
- Observing and reporting side effect;
- Since this a behavioral defect illness, conversing with the patient to determine their mental status, and various needs;
- Conversing with patient to determine what medical improvements they would like to be made;
- Motivating the patient to undergo treatment when the experience a desire for treatment withdrawal (it is estimated that about three quarters stop the drug use within 18 month [10,11]
- Financial burden;
- And if hospitalization is required, then being with the patient in the hospital and meeting his/her needs; and
- In a really severe case, the caregiver might have to come up with tricks to ensure drugs are administered to the patient.

Caregivers among family members are usually more than one. But once s/he is in remission, the amount of caregiving reduces since the patient realizes the importance of treatment and takes the responsibility of taking medicines and attending the hospital visits on their own. However, in certain chronic cases, the caregiving is seen to continue even when the patient is free of symptoms [12-15].

Amongst all these, the caregiver is required to treat the patient with love and affection, caressing the patient when he/she is restless, listening to the patient when s/he desires to converse, comport the patient when he/she is upset, allowing visitors who understands the need for kindness towards the patient to visit, engaging the patient in small tasks and activities, listening to the future plans of the patient once they are better, if they offer such information, and upon remission, allowing them to engage in household tasks, decision-making and communication. And in this case, encouraging the patient to resist the urge to continually mutter Islamic pronunciations, until they are considerably better and can limit themselves.

Caregivers take initiatives and create opportunities for patients to be involved in productive activities. They motivate patients to lead good quality lifestyles, and not to fall back into a relapse. In conclusion, the load of 'psychological care' in a symptomatic phase relaxes as the patient gets into a stabilized phase. However, there is the need for continued emotional care and support.

Conclusion

Conclusively, there exists a need for physicians and the general health public to see the caregiver as a resource rather than just a career or a recipient of mental health services. As patients who believe in religion and spirituality begin to get stressed, they begin to depend on religion even more. The patient in this case was ultimately discharged in stable condition with resolution of her vocal

hallucinations.

While religious beliefs and practices can represent powerful sources of comfort, hope, and meaning, they are intricately engaged with neurosis and psychotic disorders. The line between them breeds reliability and liability. Still, with clinical research, scientists have come to the conclusion that religious beliefs and practices may be important resources for coping with illnesses. Despite spectacular advances in technology and science, 90% of the world population is involved today in some form of religious or spiritual practices; hence, the need for this inclusion.

On the flip side, even religious bodies are advising against hyperreligiosity. Authors like R.S. Pearson who have had some traits of hyperreligiosity from his teen years right into his adulthood also admit that hyperreligiosity could be detrimental to mental health. Conclusively, while religious leaders advice adherence to reading and reciting the Holy Books, engagement in prayer, and maintenance of a strong and close knit family and community because they have proven to neutralize feelings of stress and distress, they strongly advise against over engagement to prevent symptomatic hyperreligiosity.

References

1. Az, M. S, Chua, W.-J. Early withdrawal from mental health treatment: Implications for psychotherapy practice. Psychother. Theory res. pract. train. 45(2), 247(2008).
2. Centers for Disease Control and Prevention. Caregiving for Family and Friends — A Public Health Issue . Retrieved Cent. Dis. Control Prev. Website. (2019).
3. Chadda, Rakesh K. Caring for the family caregivers of persons with mental illness. Indian j. psychiatry. 56.3 (2014): 221.
4. Chong Guan Ng, Dijkstra, E, Smeets, et al. Psychiatric comorbidity among terminally ill patients in general practice in the Netherlands: a comparison between patients with cancer and heart failure. Br. J. Gen. Pract. 63.606: e63-e68(2013).
5. Chong Guan Ng, Dijkstra, E., Smeets, H. M. et al. Psychiatric comorbidity among terminally ill patients in general practice in the Netherlands: a comparison between patients with cancer and heart failure. Br. J. Gen. Pract. 63(606), e63-e68(2013)
6. Kazemi, A., Azimian, J., Mafi, M., et al. Caregiver burden and coping strategies in caregivers of older patients with stroke. BMC psychol. 9(1),1-9 (2021).
7. Koenig, Harold G. Religion, spirituality, and health: The research and clinical implications. Int. Sch. Res. Not. (2012)
8. Koenig, Harold G. Religion, spirituality, and health: The research and clinical implications. Int. Sch. Res. Not. (2012).
9. Akintobi, Aminat. Caregiver Perspective in a Mental Diagnosis of Hyperreligiosity. (2023)
10. Lehmann, C. S, Whitney, W. B. Hospitality Towards People with Mental Illness in the Church: a Cross-cultural Qualitative Study. Pastor. psychol. 1-27(2022).
11. Ntsayagae, Esther I., Chris Myburgh, et al. Experiences of family caregivers of persons living with mental illness: A meta-synthesis. Curationis. 42(1), 1-9 (2019)
12. Pearson, R. S. Hyperreligiosity: Identifying and Overcoming Patterns of Religious Dysfunction. Wash.: Telical Books (2015).
13. Read, John. The experiences of 585 people when they tried to withdraw from antipsychotic drugs. Addict. Behav. Rep. 15,100421 (2022).
14. Sims, A. Mysterious ways: Spirituality and British psychiatry in the 20th century. (2003).
15. Vukeya, T., Temane, A., & Poggenpoel, M. Experiences of family members caring for a sibling with mental illness in Giyani, Limpopo. curationis 45(1), 1-10 (2022).