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Prevalence of Mental Illness and Associated Factors Among Holy Water Users at ANDASSA Saint George Monastery North-West Ethiopia in 2023

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Abstract

Introduction: *Mental disorder is a syndrome that manifests as a clinically significant disturbance in a person's thinking, controlling their emotions, or acting in way that are inconsistent with the psychological, biological, or developmental mechanisms that underlie mental functioning. Many people with mental disorder get religious help before or after getting modern treatment, despite this, there is lack of information which indicated the prevalence and associated factors of mental illness among holy water users.*

Objectives: *The Aims of this study was to determine the prevalence of mental Illness and Associated Factors among Holy Water Users at Andassa Saint George Monastery in Amhara Regional State, Bahir Dar Zurya Woreda, North -West Ethiopia in 2023.*

Method: *Institutional based cross-sectional study design was conducted from April 25 to May 25/2023.A Total of 655 eligible individuals was included and selected by using systematic random sampling technique in this study. Data were collected by face-to-face interviews using structured questionnaire for socio demographic factors, interview and observation by Brief Psychiatric Rating Scale (BPRS) for mental illness symptoms and illness was 68.9% with 95%CI (63.9-73.9). During the multiple logistic regression being divorced [AOR=0.28, 95% CI(0.08,0.96)] with low somatic symptom [AOR=3.69,95% CI(2.28,5.99)] and moderate form of somatic symptoms [AOR=2.12,95%-CI(1.19-3.81)] low social support [AOR=3.8,95%(1.6-6.71)] and sleep deprivation[AOR=2.21 95%CI(1.51,3.24)] those variables were significantly associated with mental illness.*

Result: *The prevalence of mental illness was 68.9% with 95%CI (63.9-73.9). During the multiple logistic regression being divorced [AOR=0.28, 95% CI(0.08,0.96)] with low somatic symptom [AOR=3.69,95% CI(2.28,5.99)] and moderate form of somatic symptoms [AOR=2.12,95%CI(1.19-3.81)] low social support [AOR=3.8,95%(1.6-6.71)] and sleep deprivation[AOR=2.21 95%CI(1.51,3.24)] those variables were significantly associated with mental illness.*

Conclusion: *The prevalence mental illness among holy water users was high. The reason for the figure reflects the insight of the community towards mental illness mainly depends on the religious' site. To minimize the magnitude mental illness; stakeholders should work together with the religious fathers to bring those patients to mental illness clinics. Different factors were identified which contributed for mental illness.*

Keywords: Mental Illness, Holly Water Users, Andassa Saint George Monastery, Prevalence, Associated Factor and North -West Ethiopia.

Introduction

Back ground

A Mental health is "a condition of well-being in which the individual realizes his or her own strengths, can cope with the usual demands of life, can work productively and fruitfully, and is able to make a contribution to his or her," as stated in WHO [1]. A mental disorder is a syndrome that manifests as a clinically significant disturbance in a person's thinking, controlling their emotions or acting in ways that are inconsistent with the psychological, biological or developmental mechanisms that underlie mental functioning [2]. No matter one's age, gender, location, money, social standing, race or ethnicity, religion or spirituality, background or other part of cultural identification, mental disorders are curable and can impact anyone [3]. One essential element of health is mental well-being. There is proof that physical and mental illnesses can coexist, come before or follow one another [4].

Holy water in Christianity is water that has been blessed by a clergyman and is used during baptism as well as to bless people, places of worship, homes and other objects of devotion. Water a universal symbol of purification has been employed by religious peoples to wash away ritual or moral impurity [5].There are at least 700 million persons with mental illness worldwide (Ritchie and Roster, 2019). The most severe mental illness is schizophrenia and other psychotic disorders, which affect at least 1% of global population. In order to improve the accuracy and specificity of the diagnosis, the word spectrum was introduced to the category of schizophrenia in the most recent edition of DSM-5 2018 [6]. According to the WHO, 40% to 60% of Africans seek out traditional healers for medical reasons, with more than 80% of them having mental illnesses of some form. However, nothing is known about the characteristics and results of this conventional therapy technique [7]. Everyone has the right to the best possible level of bodily and mental health, according to one definition of the right to health. The concept of "the greatest attainable standard" takes into consideration a person's biological and social background as well as the resources that a State has available [8].

In Ethiopia where, modern public health services are limited or not accessible 80% of the population relies on traditional medicine for primary health care. Traditional medical services are also sought in urban areas of Ethiopia, where allopathic services are more readily available and contribute considerably to the public health care system [9]. Traditional medicine has a long history. It is essential to have a thorough understanding of the knowledge, skill, and practices based on the theories, beliefs, and experiences that are specific to various cultures, whether or not they can be explained, in order to maintain health as well as to prevent, diagnose, improve or treat physical and mental illness [8].

The mhGAP of the WHO and other programs are attempting to incorporate mental health services into primary care. However, the stigma that primary healthcare professionals hold toward those with mental illness is a barrier to the success of these initiatives [10]. Ethiopia is implementing a groundbreaking plan to scale up mental health care integrated into primary care in order to address the high levels of unmet need for mental health treatment [11]. Usage of conventional medicine alone or in combination with traditional medicine was more common than either at 77.5% and 63.7% respectively. The majority of participants (86.3%) preferred conventional medicine over traditional medicine, with the most frequent justification being that it was more efficient (68.2%) [12].

"Reducing incidence, prevalence, recurrence of mental disorders, the time spent with symptoms or the risk condition for a mental illness, preventing or delaying recurrences and also decreasing the impact of illness on the affected person, their families and the society," is the goal of mental disorder prevention [13]. In the United States, almost 58 million people or about 26% of people over the age of 18, suffer from a mental disorder each year. In 2004, 6% of adults or nearly one in every four people, reported having a mental disorder [14]. A national survey in USA to Estimates for the lifetime prevalence of various disorders are as follows: any disorder, 46.4%; anxiety disorders, 28.8%; mood disorders, 20.8%; impulse-control disorders, 24.8%; and drug use disorders, 14.6% [15]. Another study conducted in Brazil reported that the prevalence of common mental illnesses was 29.3 % [16].

More than 23 million cases were included in the population-based cohort study and we were able to identify 151 650 schizophrenia patients and 227 967 people with FDRs from the NHIRD. In persons with FDRs with schizophrenia, we found dose-dependently elevated chances of schizophrenia and other serious mental conditions, such as bipolar disorder, major depressive disorder, ASD and ADHD. The largest odds of ASD, bipolar disorder, schizophrenia and major depressive disorder were seen in people who had a twin who had the disease. Our findings of the familial co-aggregation of schizophrenia with other major mental diseases in a large sample with good coverage revealed that schizophrenia is transmitted inter diagnostically within a family and that the familial transmission of psychiatric disorders is heterotypic [16].

Other studies done in Latino Americans estimate a lifetime prevalence of 28.1% for males and 30.2% for women, with gender and substance use in both studies being linked factors. Utilizing WHO CIDI, studies conducted in Turkey Anxiety, depression and PTSD symptoms were all estimated to be present in 19.6, 34.7 and 36.1% of people, respectively [17]. In all 249 respondents (15%) self-reported experiencing emotional/behavioral issues since moving to Sultanb-eyli and tested positively for PTSD, depression or anxiety in our survey. The percentage of these 249 individuals who did not seek therapy or the treatment gap was 89% for PTSD, 90% for anxiety and 88% for depression.

There are a number of structural and psychological reasons why people choose not to seek treatment, including the high expense of mental health services, the conviction that symptoms will go away with time, aversion to stigma and ignorance of resources. Respondents indicated some unfavorable sentiments toward those with mental health issues [18]. other study which was conducted in South Africa reveals that About 32% of people had ever had a DSM-IV condition; 62% of those individuals reported not receiving treatment in the previous 12 months, and characteristics substantially associated with this were education level and place of residence [19].

According to research done in China, roughly 34.4% of respondents suffered common mental illness [20]. In Africa another study was conducted in South Africa's underprivileged and rural regions, this time involving three different community groups: the general public, primary care facilities and locations of traditional healers. Shows that primary care facilities and traditional healers had higher rates of mental illness than the general population (34.9%, 72.5%, and 82.9%, respectively).The criteria were being a woman and being unemployed [21]. In Ghana, 5.9% of people with mental illness contact traditional healers, while 14% of those with mental illness consult pastors. The location of one's domicile, one's ethnicity, one's immigration status, and one's history of medical use all affect where one goes for help services [22].

In Uganda, traditional healers are frequently sought out first for assistance with mental illness, with contemporary care typically being reserved as a last choice. According to research, stigma, beliefs about the origins of mental illness, the way services are delivered, accessibility and cost are all factors that can affect how people seek assistance [23]. The majority of respondents, according to a quick analysis of mental disease in Burundi, the Democratic Republic of the Congo and South Sudan, believe that the causes of mental illness might be natural, psychological or supernatural. Non-psychotic mental problems are not considered "medical" disorders and as a result, they were not considered a condition for which assistance should be sought in medical facilities.

Instead, assistance is anticipated from family members, conventional healers, and community members to develop through social and emotional support [24]. In Tanzania the prevalence of common mental illness was estimated to be 24–28.8% [25, 26]. In Kenya and South Africa, the prevalence of mental illnesses was 10.3% and 27%, respectively [27-21]. According to our country Ethiopia Patients with co morbid disorders had a greater frequency of common mental illnesses (36.43%). The general Ethiopian population had a high frequency of common mental illnesses (21.58) [28].

The economic side of the population is significantly affected by mental illnesses. Actual costs associated with providing treatment for those with mental illnesses by public and private organizations mental illness also has indirect expenses depending on the annual production losses, annual revenues, and patient work years [29, 30]. Additionally, persons who encounter social suffering and poverty are more likely to develop mental illnesses, and on the other hand, those who do not experience social suffering and poverty are less likely to do so [31]. According to a study done in Ethiopia, the majority of people believe that spirits and evil forces are to blame for mental problems. For these reasons, they favor religious institutions over mental health services while engaging in regular holy water rituals for healing [32].

Objectives

To assess the prevalence of mental Illness and Associated Factors among Holy Water Users at Andassa Saint George Monastery in 2023.

Method

Study Design and Setting

Institutional based cross-sectional study design was conducted at holly water of Andassa Saint George Monastery which was established around 16 centuries. The most popular Monastery where people use holy water as a therapy for their problem is Andassa Saint George monastery. Bahir-Dar University is considered as a community services center to address the community's mental health issues. As a result, the estimated population that uses holly water in a month is 1960 to 3000.

Sample Size and Sampling Technique

Table 1: Sample size was determined by using second objective in order to increase the sample size for factors associated with mental illness among holy water users in Andassa Saint George Monastery in Amhara Regional State Bahir Dar Zurya Woreda by using epi-info version 7.2.5.

S no	Predictor variables	Assumptions						Calculated sample size
		OR	P	Ratio	Power	CI	N.R.R	
1	Previous history of mental illness	5.82	72.8%	1	80%	95%	10	126
2	Family history of mental illness	1.42	85.6%	1	80%	95%	10	238
3	Known medical ill-ness	2.46	71.2%	1	80%	95%	10	300
4	Marital status	1.71	18.8%	1:1	80%	95%	10	658

Key; CI=confidence interval OR=odds ratio, P=prevalence of unexposed with outcome and NRR=non-response rate.

Data Collection Tool and Procedure

Face-to-face interviews with structured socio demographic and clinical factor questionnaires were used to obtain personal data. To identify signs and symptoms of mental illness Brief Psychiatric Rating Scale (BPRS) was employed. AUDIT For Substance use status, for Problematic khat uses; PKUST- 17 items, for Smoking the FTND which has six items and GAD-7 scale and PHQ-9 scale for the symptoms of sadness, anxiety, and psychosomatic ailments, OSLO-3 for social support and also for somatic problems SSS-8 was implemented. The original BPRS was first published in 1962 as a 16-item tool by Drs. John Overall and Donald Gorham. It was initially devised as an instrument to assess the symptoms of schizophrenia on five subscales of thought disorder, withdrawal, anxiety/depression, hostility and activity [33-35].

Then it became expanded to 18 items and finally expanded as a 24-item having seven scale measurements ranging from “not

present" to "extremely severe. Even though it has seven scales; it can be compressed in to three-point severity scales: lack of symptom (scored 1); sub-clinical symptom – medium severity (scored 2); pathological symptom – high severity (scored 3) for identifying the presence or absence of psychopathology depending on the suggestion of the authors. Items 1 -14 was rated on the basis of individuals self-report. Items 7, 12 and 13 are also rated on the basis of observed behavior. Items 15-24 are rated on the basis of observed behavior and speech. It provides a standard basis for cross-cultural research in screening of psychiatric disorders.

The study was carried out after Ethical approval was obtained from Institutional review board of college of medicine and health sciences in Bahir- Dar University. Objective and purpose of the study was explained for the study participants and confirmation of the consent by the client was obtained by oral consent from each individual during data collection before administering the questionnaire after communicating with monastery leaders since it takes from holly water users by keeping their values and norms according to their culture based on Ethiopian context and no clinical trial was done. The privacy of the participants was kept during the interview. For confidentiality purposes, respondent's personal identifier details were not required and this was made known to them. Further, all information generated from the study were treated with confidentiality and only reported as a group data summary without disclosing any potentiality of identifying information for any research participant and had the right to withdrawal from the interview [36].

Data Entry, Processing and Analysis

First the collected data using the questionnaires and screening tools was cleaned and checked for completeness. The data was collected by Ghion Research Application which was the new locally created by Bahir Dar University BIT institute staffs and coded by using these locally available Applications. Then it was exported into SPSS version 25 for analysis. Basic descriptive and summary statistics was computed by using means, standard deviation, percentages, proportions and data frequencies and the findings was presented in form of tables, bar graphs and charts as appropriate [37]. Binary logistic regression was employed to determine statistical association between the independent and the dependent variables with the CI set at 95%. All variables associated with the dependent variable with p-value less than 0.25 in the bivariate analyses of the binary logistic regression was entered into multivariable models of the logistic regression in order to identify interaction between variables and to control for potential confounders. Variables with p-value <0.05 in the multivariable analyses were considered as significant predictors of mental illness.

Results and Discussion

Socio Demographic Characteristics

A total of 655 of participants were involved in the study with the response rate of 99.54% with the mean age of 43.5.Since the data was collected by highly motivated data collectors from representative samples and new apps and it was included under project which was led by BDU, CMHS department of psychiatry. The software application which was created by BDU, BIT staffs. It didn.t pass the incomplete data during data collections. Among the respondents 354 (54%) were females and about 240 of the respondents were in the age group of 26-40 and 643 (98.2 %) of the participants were orthodox in religion. Among the respondents 463 (70.7%) were coming to holly water for the first time, followed by 139(21.2%) of them visited holy water for the second time and 514(78.5%) of them were living with their family followed 102 (15.6%) of them live alone by the living circumstance. Among holy water users 206 (31.5%) were had family history of mental illness and 97(14.8%) were also had family history of suicidal behavior [38-40].

Table 2: Socio demographic characteristics of holly water users at Andassa Saint George Monastery in Amhara regional state Bahir Dar ZuryaWoreda in 2023N=655.

Variable	Category	Frequency	Percent (%)
Education	Note take formal education	218	33.3
	Primary school level	196	29.9
	Secondary education	173	26.4
	Diploma and above	68	10.4
Number of visit to holly wa-ter	For 1st time	463	70.7
	For the 2nd time	139	21.2
	Three and above	53	8.1
Sex	Male	301	46
	Female	354	54
Age	18-25	194	29.9
	26-40	240	36.6
	41-64	202	30.8
	65+	19	2.9
Marital status	Single	315	48.1
	Married	236	36.0
	Divorced	72	11.0
	Widowed	32	4.9

Religion	Orthodox	643	98.2
	Muslim	7	1.1
	Protestant	1	0.2
	Catholic	4	0.6
Living circumstance of holly water users	With family or children	514	78.5
	With socials	27	4.1
	With others	12	1.8
	Alone	102	15.6
Family history of mental ill-ness	Yes	206	31.5
	No	449	68.5
Family history of suicide	Yes	97	14.8
	No	558	85.2
Monthly income of the fami-ly	<8900	410	62.6
	>or=8900	245	37.4

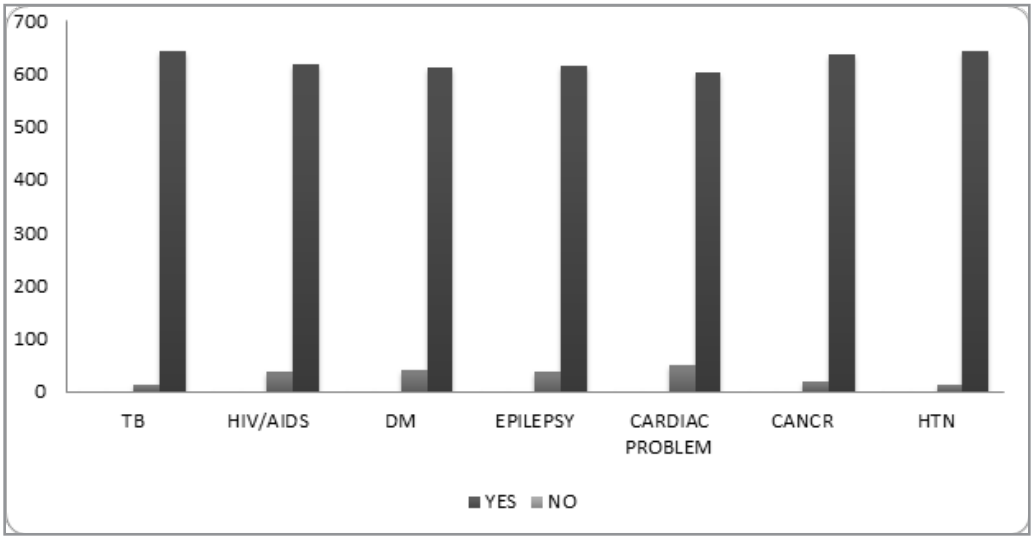

Figure 1: Prevalence of clinical factors in mental illness among holly water users at Andassa Saint George Monastery in Amhara Regional State Bahir Dar Zurya Woreda in 2023.

Psychosocial Factors and Somatic Symptom Problem

From the respondents 272(41.5%) of the respondents were had severe form of somatic symptoms, followed by 137(20.9%) of them were had moderate form somatic symptom and 86(13.1%) were also had mild,374(57.1%) of the respondents were had sleep deprivation, 429(65.5%) had low social support,166(25.3%) moderate social support and only 60(9.2%)were had high social support,140(21.4%) of the respondents were had mild form of anxiety,164(25%) moderate form of anxiety, 129(19.7%) were had severe anxiety disorder,122(18.6%) were had mild depression,126(19.2%) were had moderate depression and 112(17.1%) were had severe depression [41].

Behavioral Factors

Among the respondents 119(18.2%) of participants were low risk alcohol drinkers 8(1.2%) were higher risk dependency in alcohol, on nicotine dependency8 (1.2%) were moderate smoker and 12(1.8%) were had history of khat chewing's.

Table 3: Behavioral factor among holly water users. At Andassa Saint George Monastery in Amhara Regional State Bahir Dar ZuryaWoreda in 2023

Variable	Category	Frequency	Percent (%)
Alcohol usage	Never	503	76.8
	Low risk	119	18.2
	Medium risk	25	3.8
	Higher risk	8	1.2

Nicotine dependency	Never smoke	647	98.8
	Moderate smoker	8	1.2
Had problematic Khat use	Never use	643	98.2
	Have khat use history	12	1.8

Prevalence of Mental Illness Among Holly Water Users

The prevalence of mental illness was assessed by interviewing and observing the holly water users at Andassa Saint George Monastery by using Brief Psychiatric Rating scales (BPRS) from the total of participants 451(68.9%) of them had BPRS score of >or= 31.

The prevalence of mental illness in the holly water users was 68.9% with 95% CI (63.9-73.9). Among these 247(54.76%) were females. By their living circumstance 352(78.05%) were living with either with family or with their children, 21(4.66%) were live with their blood relations, 12(2.66%) were live with another person and 68(15.08%) were live alone. From mentally ill participants in age group 151(33.48%) were 18-25,152(33.70%) were 26-40,135(29.93%) were 41-64 and 13(2.88%) were 65 and above in age group. By how often they were visiting holy water 316(48.24%) were for the first time, 98(14.96%) were for the second time and 37(5.65%) for three and above times [42, 43].

By marital status 221(49.0%) were single, 153(33.92%) were married, 56(12.45%) were divorced and 21(4.66%) were widowed.138 (30.6%) were had family history of mental illness and 63(13.97%) were had family history of suicidal behavior on educational level 147(32.59%) were not take formal education ,139(30.82%) were in primary school level,122(27.05%) and 43(9.53%) were diploma and above. Among the respondents based on PHQ-9 122(18.6%) mild, 126(19.2%) moderate, 61(9.3%) moderately severe and 112(17.1%) of them were very severe form of depression. Among holly waters users based on GAD-7 140(17.1%) mild, 164(25.0%) moderate and 129(19.7%) Of them were had severe form of anxiety.

Factors Associated with Mental Illness

In Bi-varieties logistic regression analysis educational level, age, marital status, somatic symptom Problem, social support, alcohol history, history of tuberculosis, diabetes Miletus, human immune virus, Epilepsy and sleep deprivation of the participant's was showed p-value of <or=0.25 and then included to multiple logistic regressions analysis. During the multiple logistic regression the odds of being divorced [AOR=0.28, 95% CI(0.08,0.96)],with low somatic symptom [AOR=3.69,95% CI(2.28,5.99)] and the odds of moderate form of somatic symptoms[AOR=2.12,95%CI(1.19-3.81,)] and the odds of being having low social support [AOR=3.8,95%(1.6-6.71)].The odds of having sleep deprivation [AOR=2.21, 95%CI (1.51-3.24)] those variables were significantly associated with mental illness [44].

The odds of having mental illness people with low social support in holy water users were 3.8 times when compared with having high social supports in holy water users in social support level. The possible explanations for these may be mental illness may result from individual having low social support had the difficulty to cope in life when facing to the problem and easily vulnerable to mental illness and also this may be due to economical, psychological and environmental factors and they dependent on others. The odds of mental illness for being divorced in holly water users were 0.26 times when compared with widowed the possible explanation for these may be mental illness may result from being the death of wife/husbands it may cause emotional disturbance and creating mental illness symptoms relative with divorced.

The odds of mental illness for being having low somatic symptoms in holy water users were 3.69 times that of severe form of somatic symptom problems. The possible reason for this may be mental illness may result from low somatic symptom an individual compared with severe somatic symptom because they may have medical seeking and may improve taking medication rather than being mentally ill and also the same for mild form of somatic symptom problems which had odds 2.12 times on that of severe form of somatic symptom problems. Odds of having mental illness for sleep deprivation in holy water users were 2.21 times compared with that did not have sleep disturbances the possible explanation may be caused by due to emotional stress and due to mental illness and other physiological and psychological problems, economic, environmental and acute and post-traumatic stress problems [45-47].

Table 4: Bivariate and multivariate logistic regression of mental illness among holly water users at Andassa Saint George Monastery in Amhara Regional State Bahir Dar ZuryaWoreda in 2023

Variable	Category	Mental illness		COR(95%CI)	AOR(95%CI)	P-value
		Yes	No			
Education	Not formal learn-er	147	71	1.39(0.77-2.50)	0.71(0.37-1.37)	0.31
	Primary school	139	57	1.20(0.68-2.13)	0.56(0.29-1.09)	0.09
	Secondary	122	51	1.42(0.79-2.53)	0.64(0.33-1.25)	0.19
	Diploma &	43	25	1	1	1
Age	18-25	151	43	0.93(0.33-2.11)	0.87(0.2-3.79)	0.85
	26-40	152	88	1.62(0.58-4.52)	1.79(0.41-7.78)	0.44
	41+	141	80	1	1	

Marital status	Single	221	94	0.73(0.73-4.59)	0.48(0.16-1.46)	0.2
	Married	153	83	1.23(0.57-2.66)	0.41(0.13-1.28	0.12
	Divorced	56	16	0.97(0.44-2.11)	0.28(0.08-0.96)	0.043*
	Widowed	21	11	1	1	1
Somatic symptoms problem	Low	81	79	0.82(0.51-1.33)	3.69(2.28-5.99)	0.012*
	Mild	55	31	0.26(0.17-0.40)	2.12(1.19-3.81)	0.011*
	Moderate	103	34	0.48(0.28-0.82)	1.32(0.28-2.25)	0.3
	Severe	214	58	1	1	1
Social support	Low	317	112	1.4(0.77-2.54)	3.8(1.6-6.71)	0.003*
	Moderate	102	64	2.48(1.43-4.3)	0.72(0.37-1.4)	0.33
	High	32	28	1	1	1
Alcohol	Never	357	146	0.19(0.1-3.57)	1.17(0.21-6.47)	0.86
	Low risk	72	47	0.82(0.16-4.09)	1.86(0.32-10.77)	0.49
	Moderate/High risk	30	11	0.51(0.99-2.64)	2.2(0.32-14.93)	0.42
TB	Yes	10	6	5.55(0.72-42.97)	0.17(0.02-1.43)	0.10
	No	439	203	1	1	1
DM	Yes	34	8	2(0.91-4.4)	0.67(0.27-1.65)	0.38
	No	417	201	1	1	1
HIV	Yes	31	11	2.94(1.13-7.67)	0.34(0.11-1.03)	0.05
	No	420	194	1	1	1
Epilepsy	Yes	33	12	2.61(1.08-6.32)	0.49(0.19-1.28)	0.15
	No	418	186	1	1	1
Sleep	>or=5.5	291	83	0.37(0.27-0.53)	2.21 (1.51-3.24)	0.01*
	<5.5	160	121	1	1	1

Key: COR =crude odds ratio, AOR =adjusted odds ratio CI= confidence interval,* =p-value <0.05

The prevalence of mental illness among holly water users was 68.9% with 95% CI (63.9-73.9). The finding is higher than which was done across the world 50% and in England shows 63% In USA, in India, in China, in Japan, in Australia and in Brazil (25%, 52.2%, 17%42%, 17.7%, 22.6%) were this respectively which were lower than the result of the study. This difference might be mainly due to the study setting. Because the study setting were holy water sites the chance of getting large number of mental illnesses is high compared with community-based setting. This high magnitude of mental illness could be due to the reason that, mentally ill people prefer religious places than psychiatric institutions due to their thought, sprit, and possession that supernatural are the cause of mental illnesses [48].

The other reason is misunderstanding of population around the study area that might be mental illness is not treatable by psycho- medications rather they believed that the illness is due to punishment from God or their creatures.

In England the prevalence of mental illness ranges from 33.4-68.2 and research done in south Africa was (72.5%) which was in line of with the study(71).The study indicated that lower than the study done in South Africa and Ethiopia which was done at primary care facility (86.3%) and at traditional healers (82.9%) (62). This difference could be due to research done at selected area of care given for only mental illness and also it might be due to sample difference, population difference cultural difference could affect the study.

This study revealed that mental illness is more likely in low social support individuals as compared to those who had high social support. This study supported by which is done in Ethiopia. Revealed that having poor social supports were more risk for the occurrence of mental illness. This finding was in line with the studies done in Ethiopia. The possible explanations for this might be those individuals who had poor social support may exposed to certain harmful situations, stressors or substances like alcohol drinking and might be developed or susceptible for mental illness.

The odds of mental illness in holy water users who had sleep deprivation was 2.21 more than holy water users who hadn.t sleep deprivation. Sleep deprivation may result in mental illness due to poor sleep could make it much more difficult to cope with it, even relatively minor stressors and can even impact our ability to perceive the world accurately. Each sleep phase is characterized by specific chemical, cellular and anatomic events of vital importance for normal neural functioning. Different forms of sleep deprivation may lead to a decline of cognitive functions in individuals. Studies in this field make a distinction between total sleep deprivation, chronic sleep restriction, and the situation of sleep disruption. Investigations covering the acute ef-

fects of sleep deprivation on the brain show that the discovered behavioral deficits in most cases regenerate after two nights of complete sleep.

The odds of mental illness in holy water users who was divorced was 0.28 times less than compared with that of holy water users who was being widowed. The possible explanation for this might be widowed individuals may more vulnerable for economic, social, physical and environmental factors so it leads difficulty to cope grief and couldn't cope even relatively minor stressors and also these individuals may also develop acute stress problem, flash back the situations and might present isolated from social involvement's, sleep disturbance could also the major problem. Individuals may also develop symptoms of prolonged grief disorder often experience maladaptive cognitions about the self, guilt about the death, and diminished future life expectancy and life goals.

Somatic complaints commonly accompany the condition and may be related to comorbid depression and anxiety, social identity disruption, and increased health care visits; the somatic symptoms may be associated with those that were experienced by the deceased (e.g., changes in appetite). Harmful health behaviors related to decreased self-care and concern are also common in individuals with symptoms of prolonged grief disorder. Hallucinations about the deceased (e.g., hearing the deceased person's voice) may occur during normal grief but may be more common in individuals with symptoms of prolonged grief disorder; hallucinations experienced by individuals with prolonged grief disorder symptoms may be associated with disruptions of social identity and purpose related to the death (e.g., confusion about one's role in life, feeling of meaninglessness).

Other associated features of prolonged grief disorder include bitterness, anger, or restlessness; blaming others for the death; and decreased sleep quantity and quality. The odds of mental illness having low and moderate somatic symptom problem in holly water users were 3.69 and 2.12 respectively. Somatization is said to be present when psychological or emotional distress is manifested in the form of physical symptoms that are otherwise medically unexplained. Patients with multiple persistent physical symptoms that seem to have no apparent biologic basis are common in patients presenting to primary care.

Conclusion and Recommendation

The prevalence of mental illness among holy water user was high. So, it needs to give attention to develop reference link between psychiatric institutions and religious places, people's awareness about the cause, consequence and treatment options of mental illness must be enhanced. The reasons for this figure reflect that the insight of community towards mental illnesses mainly depends on religious sites. To minimize the magnitude of mental illness; stakeholders should work together with religious fathers or leaders to bring these patients to mental clinics.

Different factors were identified which contributed for mental illness. Giving special attention to decreasing poor social support, marital conflicts, sleep deprivation and somatic symptom problems these factors might help to decrease mental illness based on the study. To minimize the proportion of mental illness; I would like to recommend that Stakeholders like Bahir-Dar University College of medicine and health science specially department of psychiatry strengthen to work collaboratlly with religious leaders and community leaders to create awareness on holly water users about mental illness since the prevalence of mental illness was very high at holy water. Tibebe-Ghion Comprehensive Specialized Hospital and Felege-Hiwote Comprehensive Specialized Hospitals: to had reference link and giving awareness about the possibility of using medication with holly water.

Amhara public health institutes: giving chance to health workers to address mental health problems and make discussion with the community and religious fathers and budgeting to facilitate work. Amhara Regional Health Bureau: by giving man power especially psychiatric professionals for screening of mental illness. NGOs, Governmental and non-governmental organizations and other concerned body should work together with religious fathers or leaders to bring these patients to mental clinics. Because early management of mental illness helps to decrease mental illness. So, it needs to give attention to develop reference link between psychiatric institutions and religious places, communities' awareness about the cause and treatment options of mental illness must be enhanced.

The next researchers consider why the people more prefer holy water and when they come to holy water after, before or no clue for psychiatric treatment modality.

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