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Content

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SOCIAL SUPPORT, SOCIAL MALADJUSTMENT, AND PSYCHOLOGICAL WELLBEING AS DETERMINANTS OF PSYCHOPATHIC DEVIANCE AMONG CIVIL SERVANTS IN AKURE, NIGERIA

By

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ABSTRACT

The influence of social support, social maladjustment and psychological wellbeing on psychopathic deviance (PD) among civil servants in Akure, Nigeria was investigated. The survey adopted a cross-sectional design including 194 male and 153 female participants with a mean age of 33.97 years, selected using multi-stage sampling. Data was collected using an 89-item structured-questionnaire. Four hypotheses were tested of which two were confirmed. Social maladjustment (F [1, 339]= 120.49; p= .001), and general health (F [1, 339] = 41.83; p= .001); as well as a combination of social support, social maladjustment, and general health (F [1, 3092] = 52.47; p= .001) significantly influenced PD. General health (GH) predicted PD (R^2=.51, F [3,343] = 90.21; P<.01). There were significant differences between participants high and low social maladjustment (t [345] = -9.52; P = 0.00), and GH (t [345] = -9.08; P = 0.00) on PD, but not between participants with high and low social support (t [345] = -0.23; P = 0.82). This shows that the psychological factors determine PD among civil servants. Prospective employers should investigate these variables among civil service applicants, while psychological interventions would be imperative for secondary PD prevention in having mentally-healthy civil servants.

Key words: Psychopathic deviance, psychological factors, civil servants, influence, Nigeria

Social support, social maladjustment, and psychological wellbeing as determinants of psychopathic deviance among civil servants in Akure, Nigeria

Introduction

The Merriam-Webster Online Dictionary (2011) describes psychopathy as an antisocial personality disorder characterized by abnormal lack of empathy combined with strongly amoral conduct but masked by an ability to appear outwardly normal. Features such as deceitfulness, manipulation of others, impulsivity, irresponsibility, and aggression are also common (Cleckley (1941).

Workplace psychopathic behaviour is fast becoming uncontrollable because of the interpersonal conflicts that exist among employees and the inability of management to pay adequate attention to abnormal behaviours among employees (Speedy, 2005). For instance, it has been widely reported that sexual harassment, bullying, emotional disturbances and so on are very common in many workplaces (Patrick 2001, 2007), yet management of many public and private institutions hardly give it its due attention. This might have contributed to poor interpersonal relation among employees, reduced workplace safety, and reduced team-efficiency in organisations.

The civil service, a section of public service serves as a lasting instrument through which governments drive, regulate and manage all aspects of the society. However, the magnitude of attitudinal decay and character in the public service of developing nations in contemporary times is worrisome. Unethical activities have become so pervasive and even institutionalized, manifesting as un-civilised conducts, and other counter-productive behaviours (**Ezeibe, & Iwuoha, 2011**).

The Nigerian civil service has undergone changes over the years such as the Udoji recommendations of the mid-1970s. However, successive reforms aimed at achieving efficiency have failed to make significant impact in assessing and assuring the character of civil servants (**Ezeibe, & Iwuoha, 2011**). On April 3, 2009, the number one public servant, the ex-governor of Ondo state was arrested by the Economic and Financial Crimes Commission for allegedly squandering 25 billion naira (over $156 million USD) voted for the State development (**Ezeibe, & Iwuoha, 2011**).

Often, researchers have paid scant attention to the existence of psychopathic deviance (PD) in the workplace because most people probably feel that individuals who suffer from such disorder are either incarcerated or found on the streets. However, Patrick and Lang (1993), and Patrick (2007) reported the existence of PD in non-clinically diagnosed samples. While these authors reported the features of psychopathic deviance; its etiology and antecedents, there has been insufficient effort to empirically examine workplace PD, and the role of psychological factors in predicting PD among workers in public service. Research efforts in this

become imperative not only for diagnosis, but to serve as evidence-based reason for primary and secondary prevention and management.

A number of factors have been implicated in the development of dysfunctional behaviours in different settings; these include social support, social maladjustment, and psychological well-being. In *The Mask of Sanity*, Cleckley (1941) presented a series of highly detailed case studies from his own practice, in which he highlighted several features which distinguished psychopathy from other psychiatric disorders. This has also been supported by another investigation conducted later (Phillips, 2004).

The relevance of social support in improving psychological well-being is recorded in literature (Hardee, Eggleston, Wong, Irwanto, and Hull 2007). In stress buffering, social support protects people from the bad effects of stressful life events (e.g., job loss) by meeting the emotional and physical needs of people facing either physical, mental, social, and spiritual challenges. It is akin to helping affected people to fill up a critical gap. Perceived social support also shows consistent main effects on mental health outcomes (Lakey & Cronin, 2008). It is however unclear whether an individual's level of social support would affect his tendency to suffer PD, especially in the workplace.

Social mal-adjustment is the inability to adjust to the demands of interpersonal and social relationships, and the stresses of daily living. This is in some ways related to psychopathy. Psychopathy has been shown not only to predict violent recidivism in male offenders (Harris, Rice, & Cormier, 1991), but also predicts antisocial behavior in college samples (Nathanson, Paulhus, & Williams, 2006). Brackett, Mayer, and Warner (2004), for example, reported an association between low emotional intelligence (EI) and illegal drug use and deviant conduct in college men but not women.

Over the last few years, academic debate has, from a scientific perspective gone back to two ancient philosophical orientations namely hedonism and eudemonia. The hedonic approach considers wellbeing as the presence of positive affect and lack of negative affect while the eudaimonic perspective regards wellbeing as the consequences of full psychological actualisation from which people develop their potential. Whether assessed from a hedonic or eudaimonic perspective; wellbeing seems to play a role in the prevention of and in the recovery of physical conditions and diseases; and so possibly contributes to general healthy functioning and life expectancy (Vazquez, Hervaz, Rahona, & Gomez, 2009).

The civil service in Ondo state, Nigeria is the focus of this study. For many of the civil servants in recent years, appointment into the public service has become an instrument of campaign and indeed a token in exchange for

electoral votes (**Adeyemo & Osunyikanmi, 2009**). Consequently, the size of the civil service has increased from 23,597 in July 2001 to 27,719 in May 2003 (**Adeyemo & Osunyikanmi, 2009**), without adequate assurance of the mental health of new appointees (Erero, 1988: 181).

The prolonged strike action over the quest for minimum wage in 2011 by civil servants in Ondo State could also be a reflection of the mental character of the civil servants. Additionally, as it stands now, 65.31% of revenue accruable to the State goes to the payment of the emolument of public servants who constitute just 1 % of the entire population. The consequences of this, according to Erero (1988: 181) is that poor policy articulation, and implementation would likely hold sway, eventually becoming a major obstacle to the achievement of efficiency in public administration (Adebayo, 1997: 93) thus denying the larger populace the real dividends of democracy; and possibly eroding the confidence of the public in the service.

Objectives
This study is to determine whether:
i. **levels of the psychological factors** (social support, social maladjustment, and general health) **have influence on psychopathic deviance**
ii. the four dimensions of general health will significantly independently and jointly predict psychopathic deviance among participants
iii. participants with high levels of social support, those with high scores in social maladjustment and also those with high scores in general health will score significantly lower in **psychopathic deviance** than those with low scores in social support, those with low scores in social maladjustment, and those with low scores in general health

Hypotheses
1. Psychological factors will have significant main and joint effects on psychopathic deviance.
2. The four dimensions of general health (somatic symptoms, anxiety/insomnia, social dysfunction, and depression) will significantly independently and jointly predict psychopathic deviance among participants
3. Participants with high levels of dimensions of general health will report lower scores in psychopathic deviance than those with lower scores on dimensions of general health

general health will score significantly lower in **psychopathic deviance** than those with low scores in social support, those with low scores in social maladjustment, and those with low scores in general health.

Method

Design: This cross sectional survey examined the influence of social support, social maladjustment and psychological wellbeing on psychopathic deviance.

Setting: The study took place in Akure, the capital city of Ondo State, Nigeria, with a population of about 3.4 million people in 2006 (National Population Commission, Nigeria, 2011).

Participants and sampling: Participants were civil servants (N,347) from 7 of the government ministries. The inclusion criteria included: currently in the employment of the Ondo State government, English literate, and willingness to participate. To calculate the sample size, a 95% confidence interval, 5% for possible attrition, and a population of 27,719 based on officially published staff strength in 2003 (**Adeyemo, & Osunyikanmi, 2009**) were inputed into the MACORR Research Solutions online software (MACORR Research Solutions Online, 2011), yielding a sample size of 377. Participants were selected following multi-stage sampling. The list of the State ministries/clusters was obtained from where 7 (about 50%), were selected through balloting i.e. the Ministries of Health, Finance, Education, Establishment, Information, Natural Resources, and Works and Housing.

Procedure: The researcher obtained permission to conduct the study. In each of the selected ministries, potential participants were approached personally (accidentally) at work. The purpose of the study was explained, their informed consent obtained, followed by administration of the questionnaires to willing participants. Consenting participants were given a day to complete the questionnaire, which was collected the following day. Sixty questionnaires were accidentally administered in each of the 7 selected ministries, making 420 in all. Of these, only 347 were correctly filled and returned, representing 83% response rate. Of these, male participants were 194 (55.9%) while their female counterparts were 153 (44.1%). Two hundred and fifty-one (72.3%) were married, while 96 (27.7%) were single. Their ages ranged from 19 to 55 years with a mean age of 33.97 years and standard deviation of 7.65. Participants' work experience spanned between 1 to 28 years with a mean of 8.10 years and standard deviation of 5.16.

Instrument: An 89-item self-report structured questionnaire divided into 5

Instrument: An 89-item self-report structured questionnaire divided into 5 sections was used for data collection. The 9-item **Section A was designed to obtain the socio-demographic information about the participants** such as age, sex, work experience, marital status, etc. Section B contained the 12 –item Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet and Farley, 1988). Coefficient alphas for the scale ranged from .85 to .91. Also, test-retest values ranged from .72 to .85 with the same sample. The scoring of this scale is in such manner that high scores represent high level of social support, while low scores are indicative of low social Support. The norm established during the re-validation for the present study was (N 347, x=62.63). This is broken down in the subscales as; somatic symptoms (x=15.05), anxiety/insomnia (x_12.78), social dysfunction (_20.50), and social dysfunction (x_14.31) respectively.

The analysis of the data was done with the aid of the SPSS software for windows version 15.0. The socio-demographic information was analyzed using descriptive statistics such as mean, standard deviation etc, while inferential statistics were employed to test the hypotheses. All the hypotheses were tested at 0.05 level of significance, while Scheffe test was considered appropriate for post hoc analysis.

Results

In order to discover facts from the data obtained toward providing answers to meeting the research objectives, a combination of both descriptive and inferential statistics were conducted. The results are presented in this section. To determine which level of each of the psychological variables that will lead to the highest level of psychopathic deviance, a descriptive statistic was conducted with the result presented in Table 1 below.

Table 1: Descriptive statistics Table showing the influence of levels of psychological variables on psychopathic deviance

Psychological variables		N	$\overline{X}$	SD	Rank
Social Support					
	Low	145	33.88	8.51	8th
	High	202	34.15	12.90	5th
	Somatic symptoms				
	Low	185	28.69	8.48	11th
	High	162	40.15	10.96	2nd
	Anxiety/insomnia				
	Low	176	29.35	7.86	9th
General Health	High	171	38.86	12.19	4th
	Social dysfunction				
	Low	161	34.03	9.04	7th
	High	186	34.04	12.91	6th
	Depression				
	Low	185	28.09	8.68	12th
	High	162	40.83	9.97	1st
Social	Low	179	28.84	7.93	10th
Maladjustment	High	168	39.57	11.67	3rd

Table 1 shows that participants with high level of depression have the highest mean score ($x = 40.83$), i.e. they reported the highest level of psychopathic deviance (PD), while participants with low depression reported the lowest level of PD ($x=28.09$), ranking 12th.

Hypothesis one, which stated that social support, social maladjustment and general health will have significant main and joint effects on PD was tested using 2x2x2 Analysis of Variance (ANOVA). The result is presented in Table 2.

Table 2: 2 x 2 x 2 ANOVA showing the main and interaction effect of social support, social Mal-adjustment and general health on PD

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Social support (A)	.303	1	.303	.005	.943
Social maladjustment (B)	7132.202	1	7132.202	120.488	.000
General health (C)	2476.322	1	2476.322	41.834	.000
A * B	3723.904	1	3723.904	62.910	.000
A * C	72.464	1	72.464	1.224	.269
B * C	3819.436	1	3819.436	64.524	.000
A * B * C	3092.753	1	3092.753	52.247	.000
Error	20066.884	339	59.194		
Corrected Total	43912.513	346			

Table 2 reveals significant main effects of social maladjustment (F [1, 339] = 120.49; p= .001); general health (F [1, 339] = 41.83; p= .001); significant joint effects of social support and social maladjustment (F [1,339] = 62.91; p= .001); as well as social maladjustment and general health (F [1,339] = 64.52; p= .001). There was no significant main effect of social support (F [1,339] = 0.005; p = .94); nor significant interaction effect of social support and general health (F [1,339] = 1.224; p = .27).

In order to further determine the level of variables responsible for the significant interactive effect of the above combination of variables, the psychological factors were cross-tabulated and the influence on PD determined.

Table 3: Scheffe test showing cross-tabulation of the influence of social support, social maladjustment and general health on PD among Civil Servants

	Soc. Sup	Soc. Mal	Gen Health	N	$\overline{X}$	SD	1	2	3	4	5	6	7	8
1	Low	Low	Poor	32	28.25	8.36	-							
2			Good	32	34.63	4.68	-6.38							
3		High	Poor	25	30.36	9.93	-2.11	4.27	-					
4			Good	56	38.25	7.15	-10.0*	-3.63	7.89*	-				
5	High	Low	Poor	99	28.70	7.72	-0.45	5.93	1.66	9.55*	-			
6			Good	16	19.38	0.81	8.88	15.25*	10.99*	18.88*	9.32*	-		
7		High	Poor	38	32.13	8.84	-3.88	2.48	-1.77	6.12*	-3.44	-12.76*	-	
8			Good	49	51.55	8.30	-23.3*	16.93*	21.19*	13.30	22.85*	-32.18*	19.42*	-

*$P < .05$

Table 3 shows that there is significant difference in the means reported in the interaction among participants with high social support, high social maladjustment, and good general health compared to participants with high social support, high social maladjustment, and poor general health (n=49, x 19.42, $P < .05$). Similarly, the means reported by participants with high social support, low social maladjustment and good general health was significantly different from that of participants with low social support, high social maladjustment, and good general health (n=16, x 18.88, $P < .05$). Based on Tables 2 and 3, hypothesis one was confirmed.

Hypothesis Two, which states that the four dimensions of general health (somatic symptoms, anxiety/insomnia, social dysfunction, and depression) will significantly independently and jointly predict PD was tested with the use of multiple regression analysis.

Table 4: Showing multiple regression analysis of influence of dimensions of general health on PD

Variable	SEB	Beta	t-value	P	F	R	R^2	P
Somatic symptoms	1.00	0.404	6.695	<.001				
Anxiety/Insomnia	0.25	0.120	1.965	<.05				
Social dysfunction	-0.47	-0.172	-4.374	<.001				
Depression	0.54	0.255	4.402	<.001	90.21	0.717	0.513	<.001

Table 4 shows that General health (somatic symptoms, anxiety/insomnia, social dysfunction, and depression jointly predicted PD (R^2=.51, F [3,343] = 90.21; P<.01) accounting for 51% variance. Somatic symptoms (β=0.404, t=6.695, p<.001); anxiety/Insomnia (β=0.120, t=1.965, p<.05); social dysfunction (β=-0.172, t=-4.374, p<.001); and depression (β=0.255, t=4.402, p<.001) also significantly independently influenced PD. The hypothesis was therefore confirmed.

Hypothesis three which states that participants with high level of dimensions of general health will report lower scores in PD than those with lower scores on dimensions of general health was tested with the use of t-test.

Table 5: t-test analysis showing differences between high and low dimensions of general health on PD

General Health	Levels	N	$\overline{X}$	SD	DF	T	P
Somatic symptoms	Low	185	28.69	8.48	345	-10.78	0.001
	High	162	40.15	10.96			
Anxiety/Insomnia	Low	176	29.35	7.86	345	-8.61	0.001
	High	171	38.86	12.19			
Social dysfunction	Low	161	34.04	9.04	345	-0.01	0.992
	High	186	34.04	12.91			
Depression	Low	185	28.09	8.68	345	-12.61	0.001
	High	162	40.83	9.97			

The result in Table 5 shows that there were significant differences between the high and low dimensions of general health factors as follows: somatic symptoms (t[345] = -10.78; P = 0.001); anxiety/insomnia (t[345] = -8.61; P = 0.001); and depression (t[345] = -12.61; P = 0.001) with no significant differences among participants with high and low social dysfunction (t [345] = -12.61; P = 0.992). Therefore, hypothesis three was not fully supported.

The hypotheses which states that participants with high level of social support, those with high level of social maladjustment and also those with high level in general health will score significantly higher in PD than

maladjustment, as well as those with low scores in general health was tested with the use of t-test.

Table 6: T-test analysis showing the significant differences between high and low levels of social support, social maladjustment, and general health on PD

Variables	Levels	N	$\overline{X}$	SD	DF	T	P
Social support	Low	145	33.88	8.51			
	High	202	34.15	12.90	345	-0.231	0.82
Social Maladjustment	Low	179	28.84	7.93			
	High	168	39.57	11.67	345	-9.52	0.00
General health	Low	194	29.51	8.41			
	High	153	39.78	11.82	345	-9.08	0.00

The result in Table 6 shows that there were significant differences between high and low levels of social maladjustment (t [345] = -9.52; P = 0.00), and general health (t [345] = -9.08; P = 0.00), while no significant difference was noticed between those with high and low social support (t [345] = -0.23; P = 0.82). Therefore, hypothesis four was not fully supported.

Discussion

Of the four hypotheses stated, two were fully confirmed, while the remaining two were partially supported. This study revealed that social maladjustment and general health had significant main effects on PD. Social support and social maladjustment, as well as social maladjustment and general health also had significant interactive influence on PD. There was no significant main effect of social support; nor significant interactive influence of social support and general health on PD. Participants with high level of depression reported the highest level of PD, while participants with low depression reported the lowest level of PD. The four dimensions of general health (somatic symptoms, anxiety/insomnia, social dysfunction, and depression) jointly predicted PD. Social dysfunction; and depression also significantly independently influenced PD. There were significant differences between the high and low levels of the dimensions of general health and scores in PD, except among participants with high and low social dysfunction. Participants with high and low levels of social maladjustment and general health were significantly different in their reported scores in PD; while no significant differences was noticed between those with high and low social support.

The finding that psychological factors have significant independent influence on PD is also supported by earlier case studies presented by

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Cleckley (1941), and later confirmed through investigations conducted by Phillips, (2004). However, the revelation of the interactive influence of the psychological factors on PD is fairly new, and has not been commonly reported in psychology literature. Succinctly, this means that the psychological factors considered in this study (social support, social maladjustment, and general health) should be given attention when determining factors that could affect workplace PD.

The significant influence of social support on PD could be related to the possible protection that social support offers people from the bad effects of stressful life events. Challenges of employment, poor organisational support, and work-family conflicts among others could over-stretch an individual's coping ability, leading to stress, possibly manifesting in PD-related symptoms at work if not promptly controlled. These could be worsened in situations where the individual affected has genetic tendencies for PD, in which case unfavourable workplace challenges may serve as catalysts for epigenetic foundations for the manifestation of workplace PD. In this context, the role of social support is therefore to help affected people to fill up a critical gap by supplying required physical, mental, social, and spiritual needs as observed by Hardee, Eggleston, Wong, Irwanto, and Hull (2007) as well as Lakey & Cronin, (2008). This buffers the individual coping ability, and by extension, diffusing the impact of the underlying stressors, thereby providing the basis for restoring psychological wellness.

Social maladjustment was also discovered to have significant main effect on PD in agreement with the findings of Nathanson, Paulhus, & Williams, (2006) in a study among college students with antisocial behaviours. Social mal-adjustment is a reflection of an individual's inability to adjust to the demands of interpersonal and social relationships, and the stresses of daily living. As observed by **Adeyemo and Osunyikanmi, (2009),** these factors are preponderant in the Ondo State civil service. Possibilities thus exist that civil servants with difficulties in adjusting positively to environment-work conflicts may become gradually characterized by unethical and antisocial work-related behaviours; and where required socio-psychological interventions are lacking, affected individuals may further manifest PD-related symptoms in the workplace, as earlier reported by Erero, (1988).

Concerning the different dimensions of general health, it was discovered that civil servants with high and low levels of somatic symptoms, anxiety/insomnia, and depression were significantly different in the level of PD reported. Participants with high (or worse) levels of these

PD reported. Participants with high (or worse) levels of these indicators of general health also recorded higher levels of PD. This shows the relevance of the indicators in determining whether an individual will report high levels of PD. It also further confirms the discovery of the significant main effect of the psychological variables investigated in this study on PD.

Contrary to these, there was no significant difference in the means recorded in PD among participants with high or low levels of social dysfunction, especially when considering their potential influence or tendency to develop workplace PD. This implies that an individual's level of social dysfunction may not reveal differences in their tendencies to develop workplace PD. This finding is in agreement with that of Vazquez, Hervaz, Rahona, and Gomez, (2009). A further argument is that whether assessed from a hedonic or eudaimonic perspective, wellbeing seems to play a role in the prevention of and in the recovery of physical conditions and diseases; and so possibly contributes to general healthy functioning.

Further from above, the Table 6 containing t-test comparing the mean scores reported by participants with high and low levels of social support, social maladjustment and general health on PD shows that there were significant differences between high and low levels of social maladjustment, and general health; while no significant differences was noticed between those with high and low levels of social support. This shows that an individual's level (of either scoring high or low) on social maladjustment and general health could lead to significant differences in the individual's score in PD, with low scorers reporting lesser scores in PD. This suggests that provision of required social, physical, and psychological environment at the workplace is necessary for reducing workplace PD among civil servants.

Conclusion

From the above findings, it could be summarized that even though general health appeared to have a very significant influence on PD, the factor of high levels of depression and somatic symptoms underlie the strength of the variable to affect PD scores. The next critical variable that affects workplace PD score is high level of social maladjustment. These imply that civil servants should be screened for general health, and more specifically depression, as well as social maladjustment at the point of pre-employment screening; and also periodically during their careers in the civil service to avoid tendencies for workplace PD. The corollary of this is that civil servants with low levels of depression, somatic symptoms, social maladjustment (in that descending order) are less likely to develop PD in their civil service career; and should therefore be considered for civil service appointments,

especially if they met other required criteria.

The need for assuring the mental health of civil servants cannot be over-emphasised. It is the fulcrum on which good governance revolves. Failure to assess civil servants for PD, coupled with appropriate psychological intervention could be potentially risk-laden. A civil service filled with people with PD will lead to poor policy articulation, and implementation; eventually becoming a major obstacle to the achievement of efficiency in public administration (Adebayo, 1997). This will deny the larger populace the real dividends of democracy; and possibly eroding the confidence of the public in the service.

It is further suggested that the establishment arm of government ministries, community members, and all stakeholders should be more conscious of the psychological health of civil servants, with a greater focus on the variables investigated in this study. Doing these through the application of primary, secondary, and tertiary prevention schemes will reduce the manifestation of workplace PD, considering the quandaries of the contemporary political, economic and social challenges especially in many parts of Nigeria

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