To explore the role of Religious Institutions on Mental Health in Malawi. The case study of Blantyre CCAP Synod

Master of Arts (Theology and Religious Studies) Thesis

By

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Submitted to the Department of Theology and Religious Studies, School of Humanities and Social Sciences in Partial Fulfilment of the Requirement of the award of the Degree of Master of Arts (Theology).

UNIVERSITY OF MALAWI

FEBRUARY 2024

DECLARATION

I, the undersigned, hereby declare that this thesis is the product of my own original work and is not the result of anything done in collaboration. It has not been previously submitted to any other institution for similar purposes. Where other people's work has been used, acknowledgements have been made.

Full Legal Name

Signature

Date

CERTIFICATE OF APPROVAL

We, the undersigned certify that, this thesis represents the student's own work and effort has been submitted with our approval.

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DEDICATION

This thesis is dedicated to my parents Mr. & Mrs. Mtisau. Words cannot explain enough on how grateful I am to you. You have been very supportive to me financially, spiritually and psychologically. May the good Lord grant you your heart desires.

ACKNOWLEDGEMENTS

I greatly thank God almighty for being so good to me and for the endless blessings of good health, wisdom, knowledge, strength, Intelligence, protection and care.

A Special thanks should go to my father Mr. D. Mtisau for the financial assistance. May the good Lord remember you. To my mother Mrs F. Mtisau, thank you very much ,your endless prayers kept me going, stay blessed.

I would like to acknowledge and give my warmth thanks to my supervisor Dr. Mawerenga. His advice and guidance carried me through all the stages of writing my thesis. I would like to thank all staff members at Theology and Religious department for the encouragement rendered to me during the entire course.

A heartfelt gratitude to people who stood by me through thick and thin to the success of my research study, Olley Mtisau, Tiya Mtisau, Suave Chunga and Kondwani Chunga.

Finally, thanks be extended to my best friend Johannes Chikufenji, for the support you have shown to me through out my study.

ABSTRACT

The study aimed at Exploring the role of Religious institutions in Mental Health in Malawi. The study used qualitative methodology where in depth interviews, focus group discussions and standardised open ended interviews were involved. The study established the following twelve findings: Mental health issues are neglected in Malawi, mental health challenges are increasing in Malawi,depression is the main mental health problem in Malawi, there are various misconceptions on mental health in Malawi that makes it hard to effectively address the situation, religion influences mental health, Religious Institutions are at the best position to deal with mental health issues that requires Cognitive Behavioural Therapy and some Religious Institutions are imposing mental health problems in Malawi. The study established the following implications: The government of Malawi should develop a mental health policy that will will address the challenges faced by mental health institutions, guided by a set of goals the government must aim at changing the negative perception of mental disorders by the public, reduce the incidences attributed by mental disorders and the prevalence of mental disorders, mental health should be incorporated mental in the school's curriculum,The Religious Institutions should provide counselling, prayer and support to people experiencing adverse life situations, the Religious Institutions should work hand in hand with mental health care providers and Mental health awareness campaigns should be provided and reach all stakeholders thus, community religions, community leaders, community members. The study serves as an informant to the Government, communities, religious institutions, non-governmental organisations and every reader about Mental Health in Malawi.

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LIST OF ABBREVIATIONS AND ACRONYMS

AD Affective Disorder

AIDS Acquired Immonodeficiency Syndrome

ASD Autism Spectrum Disorder

CBT Cognitive Behavioural Therapy

CCAP Church of Central African Presbytery

DID Dissociative Identity Disorder

GBV Gender Based Violence

HIV Human Immune Virus

LGBTQIA+ Lesbian, Gay, Bisexual, Trans gender, Queer, Intersex, Asexual & All other identities

MBBS Bachelor of Medicine & Surgery

MOEST Ministry of Education, Science and Technology

NGOs Non Governmental Organisations

OCD Obsessive Identity Disorder

PTSD Post Traumatic Stress Disorder

RIs Religious Institutions

SSPSS Statistical Package for Social Sciences

TV Television

UNICEF United Nations Children's Fund

WHO World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter presents an introductory section of the research. The section constitutes of the background of the study, the problem statement, aim of study, research objectives, research hypothesis, justification of study, significance of study, limitations of the study, delimitations of the study, and assumptions of the study.

Studies show that the burden of mental health problems is increasing rapidly in Malawi. For example, 72% of adolescents being screened for mental health issues were diagnosed with depression in Lilongwe.[1] Not only that, a recent study estimates that around 30 percent of deaths in Malawi are attributed to mental health problems with some lives lost to suicide and drugs and alcohol abuse. For example, 208 people committed suicide between January and August of 2022.[2] According to the World Health Organization (WHO), mental health problems are "when a person's emotional suffering leads to problems in thinking and behaviour, and a decline in daily functioning." The distress may be shown through physical, emotional and behaviour symptoms, and in worst cases

[1] Ian Matandika et al., "Prevalence of Common Mental Disorders among Children and Adolescents in Blantyre- Urban, Malawi, *Malawi Med Journal* 34, 2 (2022):105-110., accessed April 15, 2023. doi:10.4314/mmj.v34i2.5.

[2] Chikondi Mphande, " Special Report: The Dilemma of Suicide in Malawi," *Zodiak*, September 27, 2022, accessed, April 21,2023. https:www.zodiakmalawi.com.

the situation may turn into psycho pathologies or mental illness, for example bipolar disorder and depression. In other words, mental health problems are the opposite of mental health which is the normal of a human functioning. By definition, mental health is "a state of well-being in which the individual realizes his or her own abilities can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." The definition also connotes positive feeling and positive functioning of a human being and an individual's ability to live joyful and create psychological resilience. It also implies an absence of mental health problems. [3]

As there has been growing cases of mental health problems in Malawi, religious institutions have been seen actively aiding the government and Non-Governmental Organizations (NGOs) in addressing the same. Hence, this paper explores the role of religious institutions in mental health. The study uses Blantyre Synod of Church of Central Africa Presbyterian (CCAP) as a case study.

1.2 Problem Statement

Much as religion is identified with being concerned with people's spiritual and moral life, religious institutions have proved to go beyond the spiritual realm in their work of domain and operation since time immemorial. Religious institutions have played, and are playing, roles in education provision, politics, economic empowerment and poverty eradication, environmental conservation, apartheid and racism elimination, and promotion of equalities, among others. As the government and NGOs are lobbying for mental health and fighting a rapid increase of mental health problems in Malawi, religious institutions have also been seen partaking in the same. Nevertheless, the existing literature on the aforesaid has not exhausted

[3] Spotlight Initiative, *Mental Health and Psychosocial Support Professional Development Needs and Gaps Assessmen*t (UNICEF, 2020), 8-9

everything regarding the role of religious institutions in addressing mental health issues in Malawi and worldwide. Hence, questions come regarding to what extent religious institutions do this, the theological basis for their involvement and tools used in the course, among others.

1.3 Aim and Objectives

The overall aim of the study is to explore the role of religious institutions in mental health in Malawi basing on a case study of Blantyre Synod CCAP.

1.3.1 Objectives

In line with the aim of the study, there are six specific objectives to be achieved. These are:

1. To understand the situation of mental health in Malawi.
2. To discuss the state of mental health challenges in Malawi.
3. To assess the state of mental health in Africa.
4. To identify religious institution's theological position on mental health in Malawi.
5. To determine the impact of religious institutions in addressing mental health problems in Malawi.
6. To assesses opportunities and challenges encountered by religious institutions in addressing mental health problems.

1.4 Significance of the study

The research has a threefold significance: academic, practical and policy significance.

1.4.1 Academic significance

The research advances the body of knowledge on the topic: "the role of religious institutions in mental health in Malawi basing on a case study of Blantyre Synod CCAP." Thus, it fills some gaps in academic literature regarding the role of religious institutions in mental health in Malawi. Also, present and future researchers will use this study as a reference in constructing their respective works.

1.4.2 Practical significance

The study provides practical references on how to address mental health issues from the religious perspective in Malawi, as Blantyre Synod is used as a case study. The data from the study shows strategies used in addressing mental health problems, and opportunities and challenges encountered in the course. Besides, the paper provides recommendations on how future works on mental health should operate. Hence, while referring to the research, other institutions intending to venture into mental health will have a basis for starting their respective work. Not only that, they will also have a picture of what to expect and how to address some of challenges that may encounter in the process of discharging their various mental health initiatives.

1.4.3 Policy contribution

The findings of the study and its recommendations provide ideas that may be used by policy makers to make and implement new policies on mental health in Malawi. Since the findings come from a practical encounter, policy makers will be able to see what works and does not work as far as dealing with mental health is concerned. By focusing on what works, policies may be revised in the context of the study to see if changes or additions can be made.

1.5 Hypothesis

The hypothesis for this study is that the level of participation in mental health by religious institutions directly influences awareness in mental health, the promotion of mental health and addressing mental health problems in Malawi. This could be done by advocating for positive living amidst life adversities and by providing counselling to those going through depression and other mental health problems.

1.6 Theoretical framework

The study uses the Cognitive Behaviour Therapy (CBT) as a guiding framework. CBT traces its origins to Aaron Beck, an American psychologist, and it was further developed by other psychologists that followed. The theory is a synthesis of cognitive psychology and behavioural psychology. In its being, CBT is a psychotherapeutic approach that concentrates on changing how people think, feel and behave. The process involves considering a person's history, biological and environmental factors, and setting them into a context of a problem being addressed.

CBT hinges on the assumption that psychological problems are partly grounded in faulty ways of thinking and a learned pattern of non-constructive behaviour, and that people can learn ways of coping up with their psychological suffering. The approach constitutes talk therapies and has proved to be effective for addressing depression, anxiety, bipolar disorder and many other psycho-pathologies.

As mental health problems can be addressed by CBT, this paper uses CBT as a guiding framework to set context for analysing the role of RIs in mental health. The study reveals whether religious involvement in mental health could be a CBT.

1.7 Delimitations of the Study

The study will only focus on the role of the Blantyre CCAP synod in engaging with mental health issues in Malawi, therefore the extent to which the study findings can be generalised is relatively unknown. Furthermore, limited time and financial resources to cover the initial plan of the research delimits the study. Initially, I wanted to include both Nkhoma Synod and Livingstonia Synod as cases of analysis. The approach could have given a more comprehensive picture of the role of CCAP in mental health in Malawi as voices from all the three synods of CCAP could have been in this paper than the way it is with just Blantyre Synod as the subject of analysis.

1.8 Assumptions of the study

The research assumes that the Bible is an inspired world of God with ultimate truths regarding how the Church should operate in various dimensions of life. Aside from spiritual and moral stipulations, it has references to postulate role the Church can play in politics, women empowerment, poverty eradication, environmental conservation, and also in mental health.

1.9 My position as a Researcher

I am conducting this research as a concerned theologian who has witnessed various mental health related challenges. For instance, there has been a series of suicide cases in Malawi in the past decade. This demonstrate the gravity of the mental health situation in Malawi. Therefore, this research will act as call for the religious institutions to arise and fight this battle. Religious institutions are at the very best position to curb this mental health related challenge as most people finds solace in them.

1.10 Motivation for the study

I have opted to research on the role of religious institutions in mental health in Malawi as there are questions and doubts regarding religious institutions' involvement on the same. With little literature available on mental health in Malawi, I have found it necessary to use this opportunity to extend the body of knowledge by providing a comprehensive discussion on the topic.

1.11 Conclusion

In, conclusion, I give chapter intimations for the study and it has presented on; statement of problem, aim and objectives of the study, research hypothesis, motivation for the study, significance of the study, my stand as a researcher, delimitations of the study and assumptions of the study. Chapter two will present Literature Review, chapter three will present on Research methods and methodologies and chapter four contains the discussion of research findings.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature pertaining to the role of the Church in addressing mental health problems in Malawi.

2.1.1 Background of Mental Health Problem

This subsection gives a general background of mental health problem. The section includes definition of mental health problem, theories of mental health problem, and a historical background of mental health problem.

2.1.1.1 Definition of Mental Health Problem

World Health Organization (WHO) describes mental health problem or mental illness as a condition whereby a person's emotional suffering leads to problems in thinking, behaviour, and a decline in daily functioning in social work and family activities.[4] The definition is the opposite of the mental health which is the normal status of a human being. To be precise, mental health is "a state of well-being in which the individual realizes his or her own abilities can cope with the normal stresses of life, can work productively and fruitfully, and is able

[4] Spotlight Initiative, *Mental Health and Psychosocial Support Professional Development Needs and*

*Gaps Assessmen*t (UNICEF, 2020), 8-9. Watipaso Mzungu,

to make a contribution to his or her community." The definition connotes positive feeling and functioning of a human being and an individual's ability to live joyful and create psychological resilience. It also implies an absence of mental health problem.

2.1.1.2 Theories in Mental Health Problems

There have been three main general theories regarding etiological analysis of mental illness. These are supernatural, somatogenic (biological) and psychogenic.

A. Supernatural Theory

A supernatural theory attributes mental illness to a force beyond scientific understanding. Those going through mental disorders are believed to be possessed by demons or to be practitioners of black magic. For example, in the 16th and 17th centuries they were cases whereby people who showed signs such as failing into a state of frenzy accompanied with foam at the mouth, screaming and experiencing convulsions were believed to either be possessed by demons or have carnal relations with demons or Christ. The supernatural view was the prominent perspective in the middle ages with the Church being the main proponent of it.

B. Somatogenic Theory

The somatogenic or biological theory considers mental disorders as to be linked with genetic factors such as chemical imbalances and brain abnormalities. Proponents of this view include Hippocrates. Hippocrates suggested that there are four main fluids or humors responsible for the normal personality and functioning of a human being. These fluids are blood, black bile, yellow bile and phlegm. Imbalances in such fluids lead to mental disorders. For examples, an excess of yellow bile causes mania and too much black bile causes melancholia. Unlike the supernatural perspective, the somatogenic perspective is supported by evidence. For example, genetic factors have proved to be the leading cause of schizophrenia. Besides, sophisticated neural imaging

technologies in recent years have proved that abnormalities in brain structure and function lead to the development of some mental disorders.[5]

C. The Psychogenic Theory

The psychogenic theory, also known as stress-diathesis model, considers mental disorders as being caused by a combination of biological and psychological processes. Evidence suggests that many mental disorders develop not as a result of a single cause, but rather from fusion between partly biological and partly psychosocial factors.

The diathesis-stress model contends that a genetic vulnerability (diathesis) can result in mental illness when combined with a stressing environment or situation. Therefore, mental disorder is a combination of nature and nurture. For example, a family member with history of bipolar disorder, but has not experienced signs of it, may have a genetic diathesis of experiencing it, and when faced with stress, for example coming from losing a loved one, the event may work hand in hand with bipolar genetic diathesis to cause the person develop the same. The genetic diathesis is a nature phenomenon while a stressful environment and event is a nurture diathesis.

Due to high research involved in the diathesis-stress model, the approach is able to predict the likelihood of a person experiencing a specified disorder. Not only that, the model offers a more credible explanation for behavior change than looking at genetic and environmental factors separately.

2.1.1.3 Historical Background of Mental Health Problem

Mental health problem has existed in history since human existence. However, the discipline of mental health has been viewed from varying perspectives in different historical periods. Such varying views have existed from the Pre-

[5] Patricia O'regan "*Theories of mental health and illness: Psychodynamic, social, cognitive, behavioural, humanistic and biological influences*". 101.189

Greco Roman period, the Greco-Roman period, the Middle Ages, the renaissance period, the Reformation err to the post-reformation period. [6]

A. Pre-Greco-Roman Period

History shows that mental health problems have been there since human existence. For example, trephination has been used to treat mental illness since 6500Bc. The treatment involved using a stone instrument to create an opening believed to be a way of releasing an evil spirit from a person as it was assumed that mental illness was caused by demonic possessions. In the same period, exorcism was used as an alternative treatment for mental illness. It was common in early Greek, Hebrew, Egyptian and Chinese cultures. Likewise, in exorcism the assumption was that mental health problems were caused by demonic possession hence prayer, magic, flogging, starvation, noise-making and horrible tasting drinks were used to exorcise evil spirits from a person to heal him or her from mental illnesses.

B. The Greco-Roman Period

The Greco-Roman (332 BC -395AD) world rejected the view that mental health problems were caused by demonic possession. Greek physicians like Hippocrates claimed that mental disorders were akin to physical disorders and hard natural causes, just like physical disorders. Hippocrates suggested that mental disorders are either heredity, caused by brain pathology, or caused by head trauma and disease. He also noted that mental health problems could be classified into three categories namely; melancholia, mania and phrenitis (brain fever). He further claimed that there are four main fluids or humors that makes the normal functioning and personality of a human being namely; blood, black bile, yellow bile and phlegm. To him, mental disorders occur when there is

[6] Patricia O'regan "*Theories of mental health and illness: Psychodynamic, social, cognitive, behavioural, humanistic and biological influences*". 190.

imbalance in the aforementioned fluids. For examples, an excess of yellow bile causes mania and too much black bile causes melancholia.

Plato opposed the tendency of putting people suffering from mental disorders in caves and away from the public in isolation. He stated that people going through mental problems were not responsible for their own actions and so had to not be punished through isolation, starving or flogging as was the case with the pre-Greco-Roman thought. He believed that the community and families had the responsibility to care for the mentally sick in a humane manner just as physical illness.

Galen, a Greek physician, agreed with Hippocrates that imbalances of body fluids could cause mental problems. He further observed that mental disorders had either mental or physical causes. He listed these causes as fear, shock, alcoholism, head injuries, adolescence, and changes in menstruation.

Roman physicians, for example Asclepiades, and Roman philosophers, for example Cicero, rejected Hippocrates claim that mental disorders are caused by imbalances of four fluids. They argued that melancholy is caused by grief, fear and rage and not excess black bile as suggested by Hippocrates.

Roman physicians used massage and warm baths as a way to treat mental disorders. They also used "contrariis contraries" (opposite by opposite) as a treatment approach. The approach involved introducing contrasting stimuli to balance the physical and mental domains. For example, a warm drink could be consumed while in a cold bath[7].

C. The Middle-Ages (500 AD-1500AD)

The Middle-Ages saw the fall of the Roman Empire and the increase in power of the Church. The Church worked hand in hand with the state thereby influencing decisions and beliefs. Scientific and medical explanations proposed

[7] Edward Shorter, *A history of psychiatry: From the era of the asylum to the age of Prozac*.

London: Wiley, 1997

by Hippocrates and others were strongly opposed. Like in the pre-Greco-Roman period, mental illness was again seen as a sign of demonic possession. Consequently, methods like exorcism, flogging, prayer, touching of relics pilgrimages to holy places, and holy water were used as treatment. In some cases, the sick were confined, beat and even executed.

The Middle-Ages also registered cases of hysteria (mass madness). Large numbers of people could display similar false beliefs and symptoms of mental disorders. This included the belief that one was possessed by wolves or other animals and imitated their behavior, called lycanthropy, and a mania in which large numbers of people had an uncontrollable desire to dance and jump, called tarantism. [8]

D. The Renaissance (14th to 16th century)

The renaissance period saw the rise of humanism supported by a gradual decline of the Church's power. Humanism emphasized human welfare and the uniqueness of an individual above all. This resulted in decline of superstitions and related views. Johann Weyer, a German physician, published a book in 1500 that opposed the Church's witch hunting activities. The author argued that many accused of being witches and being tortured for the same were not actually witches, let alone be possessed by demons. They were actually patients suffering from mental illnesses. Like the body, the mind too was susceptible to illness.

In the 16th century, states started building places were mentally ill persons could be treated as cases became rampant. Patients were fed, clothed and housed. However, the intention of such act was to protect the public from the mentally ill, and the mentally ill were treated as less human. Patients were put in such places against their will, and they were chained and placed on public display for entertainments in some cases. Worse still, asylums were turned into tourist sites as people were paying some monies to see the mentally ill for entertainment purpose. One of such places was opened in Bethlem in London in 1547, and it

[8] Ibid 12

was known as Bedla, and another place was opened in France and it was known as “Hopital General of Paris”.

E. The Reformation Era (18th -19th century)

The 18th century saw the rise of moral movements in Europe and America. The movements considered definitions regarding what is right and wrong, and there was an emphasis on doing what was right. The moral movement triggered a humanitarian view of mental illness which led to protests over the conditions under which the mentally ill were going through in asylums. Vincezo Chiraughi, an Italian physician, removed the chains of patients at his St. Boniface hospital in Florence, and encouraged good hygiene and recreational and occupational training. Philippe Pinel, a French physician, developed a moral for dealing with mentally ill persons at a hospital. The guidelines included unshackling patients, moving patients to well aired and lit rooms, and giving patients freedom to move around the hospital. Pinel stressed on the importance of dealing with the mentally ill with respect, moral guidance and human treatment while putting into consideration their individual, social and occupational needs. The approach led to great improvement for many patients so much so that many were discharged

Likewise, William Tuke established a moral guideline for dealing with the mentally ill in their treatment places in England. At the retreat, patients could work, rest, talk out their problems and pray. Dorothea Dix raised millions of dollars to build over 30 mental hospitals in England which were more improved and hygienic as she was an advocate of mental hygiene movement. Her influence extended to US and beyond Canada and Scotland[9].

A great milestone was made around 1908. Clifford Beers published a book in which he narrated his personal struggle with bipolar disorder and the cruel treatment he and others going through similar cases went through in asylums (places of treatment). He experienced and witnessed abuse at the hands of caretakers. At certain moment during his days in asylum, he was put in a

[9] Shorter, *History of Psychiatry*, 15.

straight jacket for 21 consecutive nights. His book led to public sympathy and led him to found a National Committee for Mental Health in America. The committee is still in existence till today, and it has over 200 affiliates. [10]

2.2 Examples of Mental Disorders

Mental health problems include depression, schizophrenia, Post-Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder, Dissociative Identity Disorder (DID), affective order, mass hysteria, and paranoia.

2.2.1 Depression

Andreason describes depression as a feeling of low mood that affects an individual for a long period of time. Depression makes an individual feel hopeless, worthlessness, unmotivated and exhausted. It may reduce self-esteem, lead to insomnia and reduce sex drive. Depression makes an individual see doing his or her daily activities harder and worthless. Depression is a common mental health problem in Malawi and worldwide. For examples, Maclean shows that 98 out of 200 female sex workers screened for depression in 2018 in Lilongwe tested positive, and Mphande reveals that 72% of adolescents being screened for mental health issues in Lilongwe in 2022 were diagnosed with depression.[11]

2.2.2 Schizophrenia

Anderson describes the schizophrenia as a mental disorder that utters one's cognition, behaviour, emotions and interpretation of reality. Signs and symptoms of schizophrenia include delusions, hallucinations or disorganized speech, and reflect an impaired ability to function. Delusions are false beliefs

[10] Ibid17.

[11] Sarah Maclean, "*Prevalence and correlates of probable depression and PTSD* (2018).

not based on reality. For instance, a false belief that someone is trying to poison you. Hallucinations involve seeing or hearing things that do not exist. Disorganized speech constitutes a person's problems to communicate effectively. These may be manifested through answering unrelated answers to questions or saying things that do not make sense.[12]

2.2.3 Post-Traumatic Stress Disorder

Anderson discusses Post-Traumatic Stress Disorder (PTSD) as a mental health problem caused by experiencing or witnessing a terrifying event, for example rape, war or an accident. Its symptoms include flashbacks, nightmares and severe anxiety. PTSD experiences may occur and be experienced for months or years.

2.2.4 Obsessive Compulsive Disorder

Obsessive Compulsive Disorder is a mental disorder whereby a person has uncontrollable obsessions and recurring thoughts of repeating a certain behavior or action. People with obsessive compulsive disorder have symptoms of obsession, compulsions, or both. Obsessions are repeated thoughts, urges or mental images that cause anxiety. Examples of these are being a perfectionist and having fear of germs. Compulsions are repetitive behaviour that come as a result of obsessions. In context of OCD, these may be cases of uncontrollable excessive cleaning and uncontrollable repeatedly checking and verifying of things. Some individuals with OCD tend to have tic disorder, characterized by repetitive uncontrollable movements, for example, shoulder shrugging and eye blinking.[13]

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[12] Ibid, 68.

[13]Anderson, *Mental illnes*s ,45.

2.2.5 Dissociative Identity Disorder

Dissociative Identity Disorder is a mental condition whereby a person shows two or more separate personalities. The personalities control a person's identity and behaviour without a person's knowledge that he or she has more than one separate identity. Childhood abuse is the common cause of this. The victim unconsciously creates other personalities who do have a memory of the traumatic event that was experienced at the stead of him or her. This is a way for the victim to distance himself or herself from the trauma.

2.2.6 Affective Disorder

Anderson describes affective disorder as a condition as a psychiatric illness whose symptoms are limited primarily to the patient's mood and emotional state. It affects how a person thinks, feels and goes about daily life. The disorder occurs in the form of episodes of mania and depression, and sometimes these occur in alternation as manic-depressive or as bipolar. Approximately, two individuals out of a hundred have severe symptoms of effective disorder at some point in their lives

2.2.7 Mass Hysteria (Mass Madness)

Mass hysteria refers to a mental health [problem whereby a group of exhibit same abnormal psychological and physical symptoms. Mass madness was first observed in Middle Ages when groups of people in Europe succumbed to wild dancing into exhaustion or death. Another instance of mass madness was recorded in 1962 in a Tanzanian village whereby there was an outbreak of uncontrolled laughter for two years. The source was thought to be a girl at boarding school who couldn't stop laughing and eventually affected others.

2.2.8 Paranoia

Paranoia is an irrational and persistent thought that one is about to be attacked by others. Its symptoms include: difficulties in trusting others, be easily offended, being always defensive, , being overly suspicious of others, and believe in unfounded conspiracy theories. Paranoia is classified into paranoid personality disorder, delusional disorder and paranoid schizophrenia. Paranoid personality disorder constitutes a mildest type of mistrust of others. Delusional paranoid disorder is characterized by dominance of a false belief of others wanting to harm or persecute him or her or a belief of having a certain illness despite evidence suggesting otherwise. Paranoid schizophrenia is identified with strange delusions, for example believing that one's thoughts are being broadcasted on TV. Other signs include hallucinations.

2.2.9 Melancholia

The term melancholia, meaning black bile, is a form of major depression with severe signs. Its symptoms include: depressed mood characterized by strong despondency, despair or emptiness, depression that is intense I the morning, psychomotor disturbances, weight loss, excessive guilt and loss of interest in everyday activities. Its causes include genetics, family history, past trauma, brain chemistry, and hormone abnormalities. Cases and discussions regarding melancholia goes back to as early as the ancient medieval period. Hippocrates described melancholia as a disease with both mental and physical symptoms including persistent fear, insomnia, irritability and poor appetite.[14]

[14] Ibid, 57.

2.3 Causes of Mental Health Problems

According to Bastos, mental health problems are caused by various generic, psychological and environmental factors. These include: abuse, genetic make-up, drug and substance abuse, stigma and discrimination, and trauma.

2.3.1 Abuse

Abuse is when a person purposefully hurt another. It can be in form of physical, sexual, emotional, or verbal, and can involve bullying or neglect. Abuse can occur in childhood or adulthood and can happen regardless of sex. For example, estimates show that one in five women, one in six children and one in twenty men will be victims of sexual abuse at some point in their lives. Abuses experienced in childhood have a lasting effect on the victim's mental health. Abused children are likely to develop anxiety, depression, PTSD and other mental health problems. Likewise, in adulthood victims of abuse likely suffer from depression, anxiety and PTSD.

2.3.2 Genetic Make-up

Bastos states that some mental health problems are hereditary. Genetics plays a significant role in mental disorders such as bipolar, Obsessive Compulsive Disorder and Autism Spectrum Disorder. According to the National Institute of Mental Health, about 50% of mental illnesses are inherited. This means that a person who has a blood relative with a mental disorder is likely to develop the same in future. However, environmental factors play a part for one to develop a hereditary mental disorder, as suggested by the diathesis-stress model discussed in this chapter. One can have a predisposition to a mental illness but still not experience it if in a good environment. While some environmental factors can actually protect a person against a genetic disorder, others, for example a stressing place, can increase the risk of acquiring it.

2.3.3 Stigma and Discrimination

Stigma is when someone views another in a negative way because he or she has distinguishing characteristic or personal traits thought to be negative while discrimination is the unfair or prejudicial treatment of people and groups on basis of race, gender, age, or sexual orientation. Both stigma and discrimination can be stressful, lead to feelings of shame and worthlessness, and may lead to depression to the subjects. Just the anticipation of stigma and discrimination creates stress. People might even avoid situations and places where they expect could be treated poorly there by missing opportunities. Cases of stigma and discrimination are prevalent among people of color, the LGBTQIA community and people with disabilities.[15]

2.3.4 Trauma

Trauma is an emotional response to a deeply disturbing event that overwhelms an individual's ability to cope. A person may experience trauma as a response to any event they find physically or emotionally threatening. A traumatized person can feel a range of emotions both immediately after the event and in the long term after the event. They may feel helpless, shocked or have difficulties processing their experiences. Events that may cause trauma include loss of a loved one. The death of a loved is one of most traumatizing situations people can experience. When the grief and sadness intensify people may experience nightmares, flashbacks, anxiety, depression, Post Traumatic Stress Disorder (PSTD) and others may turn into drug addicts as a coping mechanism. Other events that may cause trauma include natural disasters, sexual assault and physical assault.[16]

[15] Baastos, *Leading causes of Mental Health issues* (2007)

[16] Ibid.

2.3.5 Drug and Substance Abuse

People who use drugs and substance excessively are likely to suffer from depression, anxiety and other mental disorders. Use of drugs, such as cocaine, amphetamines and marijuana, can lead to changes in brain areas that are disrupted on mental disorders such as schizophrenia, anxiety, mood and impulse-control disorders. In common cases, substance abuse leads to substance dependency or addiction, a situation where by one cannot perform without taking the substance. In Malawian setting, research shows that most mental disorders are caused by drug and substance abuse. For example, between 1995 and 2003, annual admissions at Zomba mental hospital of clients with mental disorders caused by cannabis and alcohol abuse ranged between 143 and 326.

2.4 Effects of Mental Health Problem

Mental disorders have negative effects on an individual and those around the patient. Untreated mental disorders can cause disability, and emotional and physical health problems. Complications linked to mental health disorders include: insomnia, loss of appetite, aggressiveness, social isolation, self-harm (to the extent of suicide sometimes) and harm to others, deceased productivity, heart disease and other medical complications, and drug and substance abuse. For example, a study by Richard Van Dorn found that in a national representative community sample of 34,653 people 2.9% of people with mental disorders had committed violent acts between 2 and 4 years compared with 0.8% of people without mental problems.

Adding to the above, mental disorders have negative impacts on the family and society at large. Mental health issues can affect a family's financial and emotional wellbeing. Taking care of a family member with a mental illness can be a burden to family members. Guardians may experience somatic problems (for example insomnia and loss of appetite), cognitive and emotional problems

(for example guilty, fear and depression) and behavioral changes. For example, a Swedish survey reveals that one half of family members claimed had developed either a psychological or a social problem while looking after a relative with a mental disorder. Not only that, the cost and time of looking after the mentally ill may cause families experience a financial crisis and disturb their daily routine.

2.5 Treatment of Mental Disorders

According to Andreasen, mental health problems are treated by both drugs and therapies.

2.5.1 Drugs

Drugs used to treat mental disorders are classified into two main categories namely; sedatives and antidepressants.

2.5.1.1 Sedatives

Sedatives are used to slow brain activity thereby being effective for treating anxiety. A common example of sedative is chloropromazine. The medicine is used to treat mood disorders such as schizophrenia, bipolar, mania and organic brain syndromes. The drug is suitable for hostile or combative patients. It helps a person to think clearly, feel less nervous and concentrate on his or her daily activities. The drug reduces aggressive behavior and the desire to hurt oneself or others. Besides, it reduces hallucinations. However, the drug causes dizziness, nausea, constipation, insomnia and blurred vision as temporary side effects. Other sedatives include diazepam, estazolam, flunitrazepam, primidom and mephobarbital[17]

[17] Wyngarden . F. *Theories Governing Mental Health studies*. (2018). Humanity and Inclusion Operation Divisions..p'12

2.5.1.2 Antidepressants

Antidepressants are used to slow depression. Depending on the particular medication and severity of the depression, the drugs may take from one to three weeks to take effect. A common example of antidepressants is citalopram. The drug helps to restore the balance of serotonin in the brain as low levels of serotonin leads to depression. Its side effects include headaches and nausea. Other antidepressants are duloxetine, vilazodone and fluoxetine. Apart from depression, antidepressants are also effective for treating Obsessive Compulsive Disorder (OCD), PTSD and generalized anxiety[18].

2.5.2 Therapies

Therapies for treating mental disorders include psychotherapy, behavior therapy, Cognitive Behavior Therapy (CBT) and hypnotherapy.

2.5.2.1 Psychotherapy

Psychotherapy refers to various techniques aiming at changing behavior and attitude through talking, achieving insight, becoming introspective, understanding interactions with other people and relieving traumatic moments from the past. Its examples include: classical psychoanalysis, group and family therapy, An example of psychotherapy is classical psychoanalysis. It is a talk therapy involving a patient airing out his or her mind in the presence of a psychiatrist. Another example of psychotherapy is group therapy and family therapy. Group therapy involves gathering a group of five to 10 people with similar problem and let them talk to each other about their experiences while under the guidance of a counsellor while family therapy brings a family together to address mental issues arising out of a family, for example drug abuse by children due to existing problems with their parents.[19]

[18] Wyngarden. F. (2018) p. 12

[19] Andreason, Mental illness, 67.

2.5.2.2 Behaviour Therapy

Behaviour therapy focuses on changing one's negative behaviour through negative conditioning and reciprocal inhibition. Negative conditioning implies putting a patient in situation which he or she learns to dislike a particular behaviour. For example, an alcoholic is given liquor to drink with unpleasant stimulus, a drug, making him to vomit. On the other hand, reciprocal inhibition is used to train patients to defeat their phobias by training their minds to gain control and be relaxed.

2.5.2.3 Cognitive Behaviour Therapy

Cognitive Behaviour Therapy (CBT) is a synthesis of behavioural psychology and cognitive psychology. As a therapy, CBT aims at changing how people think and feel as it is assumed that some mental problems are a result of faulty thinking and interpretation of events. A change in such entities implies a subsequent change in their behaviour. The process involves considering person's history, biological and environmental factors, and setting them into a context of a mental problem being addressed. CBT has proved to be effective for treating bipolar and depression, among others.

2.5.2.4 Hypnotherapy

The term hypnotherapy denotes a heightened state of concentration and focused attention guided by a trained hypnotist. Hypnotherapy makes an individual make changes in perceptions, thoughts, emotions and sensations. During

hypnosis, a trained hypnotist guides a patient into a state of a deep focus and relaxation. The technique is effective for treating anxiety.[20]

2.6 Mental Health Problems in Malawi

This section looks at mental health problem in the Malawi. Issues that will be covered are: cases of mental health problem in Malawi, government response to mental health problem, and Church and society in mental health.

2.6.1 Cases of Mental Health Problem

Mental health problem has been in existence in Malawi from time immemorial, with care and treatment for the ill being noticed as early as 1910. Recently, mental health studies show that 22 to 30 percent of the patients accessing health services in Malawi have a mental health problem. Disorders diagnosed include depression, schizophrenia, Post-Stress Disorder (PTSD), Obsessive Compulsive Disorder, drug and alcohol abuse, Dissociative Identity Disorder (DID), and affective order. For example, Maclean shows that 98 out of 200 female sex workers screened for depression in 2018 in Lilongwe tested positive, and Mphande reveals that 72% of adolescents being screened for mental health issues in Lilongwe in 2022 were diagnosed with depression.[21] Likewise, Malimba observes that 305 out of 882 patients admitted at Zomba mental hospital in 2004 had schizophrenia.[22] Further, Maclean notes that the prevalence of PTSD in Malawi is around 8% among those being screened for the same.[23]

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[20] Ibid, 69-70.

[21] Sarah Maclean, "*Prevalence and correlates of probable depression and PTSD* (2018).

[22] Chikondi Malimba, " *Factors that contribute recurrence of schizophrenia among discharged clients*" (Lilongwe, 2005).

[23]Maclean, *Prevalence and correlates*

The severity of mental health problem in Malawi is evidenced by the fact that recent study estimates that around 30 percent of deaths in Malawi are attributed to mental health problems with some lives lost to suicide and drugs and alcohol abuse. For example, 208 people committed suicide between January and August of 2022.[24]

2.6.2 Government Response to Mental Health Problem

The government has been responding to mental health problem since the colonial period. The response has been in form of opening and supporting asylums for the mentally ill. Besides, the government has training institutions for psychiatrists. Not only that, the government is involved in advocacy campaigns for mental health. Further, the government has enacted mental health policies.

2.6.2.1 Opening and supporting of Asylums

The government opened Zomba Lunatic Asylum in 1910 to look after mentally ill prisoners. The prison warders were responsible for the care of the mentally abnormal prisoners as hospitals did not allow mentally ill persons even when they were physically ill. By 1920s, mentally ill patients in the asylum were involved in casual work and Christian worship as a form of therapy. However, those attending to the ill were not professional caretakers. By 1930, there was advocacy for trained health professionals to attend to the mentally ill. As cases of the mentally ill increased, the Zomba Lunatic Asylum was turned into Zomba mental hospital in 1953. The hospital admits individuals with various psychiatric illnesses such as schizophrenia, affective disorders and substance dependence. The hospital is the main public in-patient psychiatric referral hospital in Malawi with a bed capacity of 330. It is staffed with psychiatric nurses, occupation therapists and

[24]Chikondi Mphande, " Special Report: The Dilemma of Suicide in Malawi,"*Zodiak*, September 27, 2022, accessed, April 21,2023.https:www.zodiakmalawi.com.

psychiatrists, and it offers various drugs and therapies. Estimates show that Zomba Mental Hospital admits around 1500 patients per year.[25]

Apart from Zomba Mental Hospital, there is a psychiatric unit under Kamuzu Central Hospital, in Lilongwe, with about 30 beds that attends to mentally ill patients. The government also supports a missionary hospital, St John of God in Mzuzu, which has 50 psychiatric beds.

Mental health services found in the mentioned facilities fall under the office of the district health officer and the associated expenditure is included in the district's health budget. The budget includes salaries for psychiatrists and associated staff.

2.6.2.2 Enacting Policies for Mental Health

The government enacted the Mental Treatment Act in 1959 and amended it in 1968. The act makes provision for the care of persons suffering from mental defect, for the custody of the patients and time management of staff and the management and control of mental hospitals in general. The act also list patient rights. Further, the act has stipulations pertaining to: reception into a mental hospital, appointment of visiting committees, dealing with voluntary patients and discharge procedures, among others. For example, the act gives a person above 15 the right to be received at a treatment institution as a voluntary patient in case of a mental defect.

Besides, the government enacted another mental health policy act in 2000. The act stresses the integration of psychiatric services into the primary healthcare system. Besides, the policy demands the appointment of a national mental health coordinator at the ministry of health headquarters. The policy also calls for

[25] Chikondi Mphande, " Special Report: The Dilemma of Suicide in Malawi,"*Zodiak*, September 27, 2022, accessed, April 21,2023.https:www.zodiakmalawi.com.

coming up with a human resource development plan to attend to mental illnesses[26].

2.6.2.3 Provision of Training institutions

The government has training institutions for mental health professionals. For examples, the Malawi College of Health Sciences provides a certificate course in psychiatry for enrolled nurses, the Malawi College of Medicine offers postgraduate training in certain mental health specialities in conjunction with other universities in South Africa, and the Malawi College of Health Sciences offers training in clinical psychology and other related diploma programs. Besides, as part of MBBS course at Malawi College of Medicine, students have 2 weeks of psychiatry theory.

The training institutions mentioned above have also served as centers for researches in mental health. For example, Zomba Mental Hospital has made studies on community attitudes to and knowledge of mental illness, common cause of relapse and readmission in patients with schizophrenia, pathways to care for psychiatric patients, and neuro-psychological sequalae of cerebral malaria, among others[27].

2.6.2.4 Advocacy for Mental Health

There have been campaigns by the government advocating for mental health literacy. The approach aims at equipping people with the ability of recognizing mental disorders and having the skill and knowledge to support others going through them, and also to prevent mental disorders. For example, such campaigns are common during the World Mental Health Day. The celebrations occur on 10th

[26] ibid, 12.

[27] Felix Kaauye and Chistanzo Mafuta, "*Mental Health issues in Malawi*", 4(1), 200, 9-11

October every year in a selected district. Posters, T-shirts and leaflets explaining mental health issues are distributed to the public for free at a chosen venue[28].

2.7 Society and Mental Health

Since mental health problem happens among people, the society cannot be left out in discussions pertaining to the same. Issues that can be discussed are impacts of mental health defects on society, myths associated with mental illness, and society's response to mental health problems.

2.7.1 Impacts of Mental Health Problem on Society

Like many African societies, Malawi societies subscribe to ***"ubuntu"*** philosophy. The philosophy considers all members of a society as a single family, and it is believed that one is, because others are. Whatever happens to one person is everybody's concern and problem in the community. Hence, mental health illnesses have huge negative impacts on Malawian societies. For example, family members and societies are left without choice but rather to look after the mentally ill when there are such cases. Doing so costs some moneys and some end up being financially broke, and even loss their jobs as they need time to look for the mentally ill.

Adding to the above, the presence of a mentally ill person in societies has negative effects on the mental health status of other members in a society. Researchers have proved that people looking after a mentally ill person or who know one who is mentally ill likely go through stress, depression, and some feels guilty and pity, and experience insomnia. In some cases, the mental illness experienced by patient is somehow transferred to other members of the society. This is true with mass hysteria, as suggested in this paper in the previous paragraphs,

[28] Derek Wilson, "Ubunthu: A model of positive mental health", *Journal of mental health* (2019).

Furthermore, like with physical illness, those suffering from mental illnesses fail to function normally in a society. The situation slows development activities in a society, in cases where numbers of the mentally ill are huge or in cases where the patient is an important member of a society.

Likewise, the presence of mentally ill persons causes threats and fears in societies. Patients suffering from schizophrenia and affective disorders are usually violent and easily irritated. Apart from cause self-harm, they may also cause inflict harm on their caretakers and other members of society[29].

2.7.2 Myths on Mental Illness

The term myth refers to a widely held false belief concerning early history or explanation of some phenomena. Some Malawian societies have myths pertaining to mental illness. For example, some believe that mental health problem is caused by witchcraft or demonic possession. The belief has been influenced by African Traditional Religions, and it has always been there in many African societies long way before Christianity was introduced. However, the coming in of Christianity played a part in cementing such beliefs as they were normally also views of the Church on the same.

Some societies believe that the mentally ill have been bewitched by others. The reasons for the bewitchments include jealousy. Jealousy is the common reason for alleged bewitchment in cases whereby the mentally ill was doing something successful before suffering a mental illness (for example, a promotion at work place could be the reason others are believed to have bewitched the patient). In some cases, bewitchment is seen as an act of punishment. The mentally ill is believed to have been bewitched as an act of revenge for harm he or she had caused on another, for example theft, slander and adultery. Others believe that the mentally ill were bewitched by a relation as a sacrifice by a relative- to get rich. In

[29] Derek Wilson, "Ubuntu: A model of positive mental health", *Journal of mental health* (2019).

some cases, the mentally ill are believed to have acquired the illness for failing to follow instructions, for using charms, given by witch doctors.

The mentioned myths associated with causes of mental illness affect how societies look at the mentally ill and their response to their defect. For example, some families tend to take the mentally ill person to a witch doctor for treatment, and some tend to take them to pastors for prayers. A study, conducted by Nyando in 1995, on factors that influence rehabilitated schizophrenic patients preferring traditional medicine to western medicine revealed that 6I.7%(n=35) of the research participants believed that their illness was caused by witchcraft.

2.7.3 Society's Response to Mental Health Problem

Malawi societies' response to mental health problem is both positive and negative, as suggested by various observations

2.7.3.1 Positive Response

As noted before, the *ubuntu* philosophy in Malawian and other African societies plays a great part in terms of how societies look at the mentally ill. Since ubuntu philosophy considers a person's problem as a problem for all, some societies respond positively in as far as looking after the mentally ill is concerned. The dedication is shown in taking the mentally ill to places of treatment, and also in looking after them at their homes. The ethical obligation to do so is not just limited to the family of the sick, but rather to the whole society the patient is based. The support rendered is of importance as it helps the mentally ill to hill fast as there is also psychological or emotional support in such acts. Not only that, the society's support to the families of the ill helps families to cope up with their situation easily and reduce their cases of going through stress and depression as they are looking after their relation.[30]

[30] Derek Wilson, "Ubunthu: A model of positive mental health", *Journal of mental health* (2019).

2.7.3.2 Negative Response

Much African societies are known for **ubuntu** philosophy, there have been cases whereby some societies have failed to respond positively to mental health defects. For example, since some mental illnesses are caused by drug and substance abuse, and there is a belief that attributes mental illness to failing to follow up instructions from witch doctors, the mentally ill are judged wrongly by those who tend to believe that the ill deserve whatever they are going through as they are solely responsible for it. Hence cases of mockery against the mentally ill are common in some societies.

Adding to the above, there are cases whereby the mentally ill experience stigma and discrimination. Stigma is when someone views another in a negative way because he or she has distinguishing characteristic or personal traits thought to be negative while discrimination is the unfair or prejudicial treatment of people and groups on basis of race, gender, age, or sexual orientation. For example, some tend to avoid the mentally ill and discriminate them as it is assumed that the mentally ill persons are violent, abusive and smell bad.[31]

2.8 Challenges Faced in Promoting Mental Health

Attempts discussed by various stakeholders in addressing mental disorders and promoting mental health in Malawi have faced various challenges. These include: stigma, limited access, mental health illiteracy, inertia, wrong coping mechanisms and myths and misconceptions.

[31] Moses Banda." *Influence of protestant churches on public education in Malawi*" (international handbook,

2022). 361-370.

2.8.1 Stigma

As suggested in the previous paragraphs, mental illness is viewed with stigma in some societies. For example, some people tend mock the mentally ill and treat them as less humans. The stigma experienced makes people suffering from mental illness to fail to open up and seek treatment and support from friends and hospitals.

2.8.2 Limited Access to Resources

Many societies in Malawi do not have access to the resources needed to manage mental health. As noted already, there are few institutions that offer therapy and medication for the mentally ill. For example, its only the Zomba Mental Hospital, Kamuzu Central Hospital and the St John of God that have bed spaces for mentally ill patients.

2.8.3 Mental Health Illiteracy

Some people do not have knowledge regarding various mental defects, for example, signs and symptoms of mental defects, their causes and treatment. The lack of knowledge makes it hard for them to recognize when they are mentally ill or when someone else is going from mental problem. The lack of knowledge also extends to what certain mental health issues entail, leading to name calling (for example, calling the mentally ill crazy or insane).

The lack of knowledge also makes people have problems regarding who to see in cases of mental illness. For example, some individuals fail to differentiate a psychiatrist from a psychologist and a psychotherapist.

2.8.4 Inertia

Inertia is the tendency to do nothing or to remain unchanged. Some people suffering from mental illness tend to do nothing about their problem and delay

to seek treatment. The tendency to act in such manner arises as a result of various factors, for example stigma associated with treatment for mental illness, mental health illiteracy and lack of access to treatment facilities.

2.8.5 Wrong Coping Mechanisms

Some people suffering from mental disorders resort to some coping mechanisms that can be both physically and mentally harmful. For example, some people going through depression tend to use drug and alcohol or sleeping pills to easy their misery. In the long-term, these coping mechanisms can make it difficult for the patient to recover from mental issues he or she is suffering from.

2.8.6 Myths and Misconceptions

Misconceptions and myths regarding causes of mental disorders hinder patients from seeking right treatment. As suggested, some people believe that mental illness is caused by either witchcraft or demonic possessions. Hence, instead of going to a hospital for treatment, they opt to visit a traditional doctor for treatment which have never been proved to be effective for treating the same[32].

2.9 The Church and Mental Health

The church in Malawi claims to have a responsibility to operate in all aspects of human life beyond the spiritual life. The belief is grounded on the view that God is believed to be a Sovereign omnipotent ruler (Gen 18:14, Isa 55:11 Psa. 115). With this logic, aside from the spiritual role, the church has been actively involved in education, for example the CCAP, the Roman Catholic, the Anglican churches have various education institutions that offers primary, secondary and tertiary education. Not only that the church has been attending to

[32] Chalimba, *factors causing recurrence*, 17.

various social economic activities, for instance Nkhoma Synod CCAP established a program called Church and Society in 2004 which promotes democracy and advocate for women empowerment among others. Likewise, the church has been propagating for environmental conservation through its stewardship theological position, and it has been actively involved in advising politicians on governance while appealing to Theocracy and forth-telling element of prophecy. Hence, there is something the Church is supposed to say regarding mental health.

Church ddiscussions on Church and mental disorders have always been there since the institutionalization of the Church. As discussed, there were moments when the church considered that those who were experiencing mental disorders were possessed by demons. Despite medical specialists such as Hippocrates opposing the view, the Church still kept its view until the renaissance period whereby science and reason were considered to be compatible with faith. The changes brought a change in how the Church considers mental illness.

Today, the Church sees mental illness as any illness equal to physical illness (though some members still believe in the demonic possession theory. Not only that, the Church is seen actively involved in prompting mental health and addressing mental defects. Nevertheless, the literature available fails to show the extent the Church in Malawi does this, challenges and opportunities encountered in the course, and the theological basis for the Church's involvement[33].

2.10 Conclusion

This chapter has reviewed literature pertaining to the role of Church in mental health. The authors whose writings have been reviewed include Filipe Bastos, Donncha Mulin and Robert Stewart, Nancy Andreasen and Watison Mzungu. The review has given a historical background of mental health problem, examples and

[33] Ibid, 43.

causes of mental defects, effects of mental problems, treatment of mental problems, and mental health in Malawi, among others. As the discussion narrowed down to mental health in Malawi, the review looked at: cases of mental health problems, government response to mental health problem, society and mental health, civil society institutions and mental health, challenges encountered in promoting mental health, and Church and mental health.

However, the literature reviewed shows little or no knowledge on the role the Church plays in mental health. Questions rise regarding the extent to which the Church participates in mental health, its theological basis, and challenges and opportunities faced in the course, among others. Hence, this research study is necessary as it seeks to fill such gaps in academic literature. The study uses Blantyre Synod of CCAP as a case study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents a research methodology that was employed in the study entitled 'Exploring the role of Religious Institutions on mental Health in Malawi'. The main purpose of this chapter is to give a detailed description and explanation of the research design and method, target population, research instrument, data collection procedures and ethical considerations applicable in this study.

3.2 Methodology

This study used qualitative methodology tools for collecting data. Qualitative study or research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that transform and make the world visible.[34] With qualitative approach, data is collected in the field at the site where participants experience the issue or problem under study. The researcher does face-to-face interaction over time.[35] This is the reason this approach was chosen for the researcher to observe on her own what is being done on the ground. The researcher focused on exploration of roles of religious institutions on mental health in Malawi. This was done by evaluating the situation of mental health in Malawi, the state of mental health challenges in Malawi, assessing the state of

[34] Creswel, J.W, Qualitative Inquiry and Research Design: Choosing Among Five Approaches, London: Sage Publication, 2007. P 36

[35] Ibid. P 37

mental health in Africa, identifying the religious institution's Theological position on mental health in Malawi and finally, determining the impact of religious institution in addressing mental health problems in Malawi.

Qualitative research is conducted in order to have a complex and detailed understanding of the issue. This detail can only be established by talking directly with people, going to their refreshing spots and their work places, and allowing them to tell the stories unencumbered by what is expected to find or what have been discovered in the literature. Qualitative research is also conducted to empower individuals to share their stories, hear their voices, and minimize the power relationships that often exist between a researcher and the participants in a study [36]. This is what the researcher did by bringing to light the detailed understanding of the roles of religious institutions on mental health through direct conversation with the church ministers, church elders and church members randomly. This helped to provide a general picture of the results and the required recommendations.

3.3 Research Design

A research design is a strategic plan that is adopted by the researcher to answer questions validly, objectively, accurately and economically.[37] Through a research design, the researcher decides what to use and how to collect information from the respondents and communicates to others. This study uses phenomenology research design. Phenomenology is a design of inquiry coming from philosophy and psychology in which the researcher describes the lived experiences of

[36] Creswel , J.W, Qualitative Inquiry and Research Design: Choosing Among Five Approaches, London: Sage Publication, 2007, P 41

[37] Kumar, R. Research Methodology, A Step- by- Step Guide for Beginners, London: Sage Publications, 2011. P 96

individuals about a phenomenon as described by participants.[38] This design was chosen because it fits the study as it deals with the psycho-social well-being of people. The design typically involves conducting interviews and this is why the design was chosen. Interviews were carried out in Zomba CCAP, St. Michael's and All Angels Church, Zomba Mental Hospital and Matawale Health Facility This was essential as it helped to come up with the most relevant data to base for analysis and making the right conclusions.

3.4 Population and Sample

The population for a study is the group of elements from which one will actually draw the sample(s) about whom one wants to draw conclusions. Participants were identified and recruited in accord with the research purpose and research questions.[39] Therefore, purposeful sampling was used where the researcher was interested on the focus and phenomenon of the study. The goal of purposive sampling was to sample cases or participants in a strategic way, so that those sampled are relevant to the research questions that were being posed. The group of sampled people were of caliber to give the right information that best address the research purpose and questions so as to come up with the best results. The researcher then used snowball and quota sampling strategies. Snowball sampling is a process whereby each participant leads to the selection of another participant.[40] This was used when doing interviews so that the church members could suggest their fellow members who could make good interviewees. Quota sampling is a strategy whereby one identifies the relevant characteristics of the

[38] Creswel, J.W, Qualitative Inquiry and Research Design: Choosing Among Five Approaches, London: Sage Publications, 2007. P 57

[39] Leavy, P. Research Design: Quantitative, Qualitative, Mixed Methods, Art Based and Community- Based Participatory Research Approaches, New York: The Guilford Press, 2017. P 148

[40] Ibid. P149

population that is interested in and their overall presence in the population.[41] This strategy was used when sampling participants in focus group discussions. The sample size of the study was thirty -two in total. There were two groups, the first was carried out at St. Michael,s and All Angels church comprised of ten church members and the second was conducted at Zomba CCAP where ten church members participated. Six church ministers and elders from the two congregations were interviewed and six health care providers at Zomba Mental hospital and Matawale health facility were also interviewed. This population helped in the exploration of the roles of the Religious institutions in Mental health in Malawi.

3.5 Data Collection Instruments and Their Techniques

There are various instruments and techniques used in collecting data. Data collection is the process of gathering and measuring information on targeted variables in an established systematic fashion, which then enables the researcher to answer relevant questions and evaluate the outcomes. Data collection instruments and techniques are the tools used to collect data. A qualitative researcher engages in a series of activities and instruments in the process of collecting data.[42] According to the nature of this study, the researcher chose interviews to be used in collecting data that is needed in this study. What the researcher looked for was the information of mental health services rendered by Blantyre synod through thorough investigation of the two Blantyre synod congregations. The researcher evaluated the state of mental health challenges in Malawi and the possible psychosocial services rendered by the church to support people with mental health problems. In the process of finding the information, the researcher used standardized open-ended interviews, in depth interviews and focus group discussions as data collection tools and techniques.

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[41] Leavy, P. Research Design: Quantitative, Qualitative, Mixed Methods, Art. Based and Community-Based Participatory Research Approaches, New York: The Guilford Press. 2017 P149

[42] Creswel, J. W, Qualitative Inquiry and Research Design: Choosing Among Five Approaches, London: Sage Publication, 2007.

3.5.1 Interview

This is one of the instruments to be used in collecting data. An interview is an interchange of views between two or more people on a topic of mutual interest. Interviews enable participants, be interviewers or interviewees to discuss their interpretations of the world in which they live, and to express how they regard situations from their own point of view.[43] The researcher chose this as a tool in her research because of its flexibility. It is flexible in data collection, enabling multi-sensory channels to be used thus verbal, non-verbal, spoken and heard.[44] With its flexibility, the researcher was able to gather more information from the interviewees. The interview is not simply concerned with collecting data about life but it is part of life itself, its human embeddedness is inescapable. The interviewer experiences the real life situation experienced by the interviewee. This is why among different types of interviews, the researcher chose standardized open ended, in depth interview and focus group to be used in the study.

3.5.1.1 Standardized open-ended interviews

This is a type of interview where all interviewees are asked the same basic questions in the same order. The researcher chose this type of interview for easy comparability of responses as respondents answer the same questions. This was used among the church ministers and church elders. The advantage of this, is that it reduces interviewer effects and bias when several interviewers are used. It also permits decision-makers to see and review the instrumentation used in the evaluation. This helped to evaluate the stand of the church in dealing with mental heath related problems[45].

[43] Ibid.

[44] Ibid

[45] Bryman, A. (4 th ed), Social Research Methods, New York: OXFORD University, 2012. P468

3.5.1.2 In-depth interviews

An in-depth interview is basically an interaction, where questions are posed or a discussion which involves two or more people with specific purpose in mind[46]. This method will invariably involve contact with the respondents. The interviews were unstructured for flexibility purposes as it impinges on respecting respondents and this made it convenient in accessing data. According to Cohen, this technique increases the salience and relevance of questions, interviews are built on and emerge from observations, the interview can be matched to individuals and circumstances[47] . The interviews were carried out at St Michael and all angels CCAP church, Zomba Mental Hospital, Matawale Urban Health facility and Zomba CCAP Congregation. The participants were available to render support to get direct and easily accessed information instantly.

3.5.1.3 Focus Group Discussion

A Focus Group Discussion is a form of qualitative research in which a group of people are asked about their perceptions, opinions, beliefs and attitudes towards a particular phenomenon[48].This method produces rich data and insights that would be less accessible without interaction found in group settings where participants listen to others' verbalised experiences which stimulate memories, ideas and thoughts[49]. These open discussions will be conducted as one of the ways to collect data as the participants will be organised and be able to express their views on mental health.

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[46] Ibid

[47] Louis Cohen, Lawrence Manion et el. *Research Methods in Education* (2007). p.353

[48] R. Edwards, J. Holland. What is qualitative interviewing? London: Bloomsbury Academic, 2003.p28

[49] Ibid p.28

3.6 Data Processing, Analysis and Interpretation

Data processing is the collecting and manipulating of data into usable and appropriate form. The manipulation of data is the automatic processing of data in a predetermined sequence of operations. The collected data for this research underwent all the processes of analysing data thus editing, coding and analysis.

3.6.1. Editing

Editing is a quality control process applied mostly to paper and pencil surveys. This is the stage where the collected data is cleansed by checking and eliminating errors. The purpose of this step-in data processing is to make sure that the data is clean and free from inconsistencies and incompleteness. The data is ready to be transferred to the computer when it is complete and free from errors.[50] Some of the errors might be missing of classification of responses, incomplete written responses, spelling errors and forgetting to write a response. If data can be entered without editing, it might lead to wrong analysis of the results. The editing of data can be done in two stages namely field and post-field editing. The field editing is a review of reporting by the investigator for completing what has been written in an abbreviated form during interviewing the respondent. The post-field editing on the other hand is carried out when field survey is completed and all the forms of schedule have been collected together. This type of editing requires review of all forms thoroughly. There are different ways of editing raw data, firstly, by examining all the answers to one question or variable at a time. Secondly, by examining all the responses given to a questionnaire by one respondent at a time. This provides a total picture of the responses, which also

[50] Singleton, A R and Straits C B, 2005, Approaches to Social Research (4th ed), New York: Oxford University Press.

helps to assess the internal consistency.[51] The collected data for this research used the second method.

3.6.2 Coding

This is the second step in processing the collected data. Coding is the process of transforming raw data into a standardized form.[52] The coding process is based on the way how variables have been measured in the research instrument and the way how one wants to communicate the findings about a variable to the readers of the paper. When coding qualitative research especially a descriptive information, one needs to go through a process called content analysis. Content analysis means analysing the contents of interviews or observational field notes in order to identify the main themes that emerge from the responses given by the respondents or the observation notes made by the interview.[53] This process involves the following steps:

- Identify the main themes. This is done by going carefully through descriptive responses given by the respondents to each question in order to understand the meaning they communicate.
- Assign codes to the main themes. After identifying the themes, one assigns a code to a main theme depending upon whether or not one wants to count the number of times a theme has occurred in an interview.
- Classify responses under the main themes. This is done by going through the transcripts of all the interviews or notes and classify the responses or contents of the notes under the different themes. This can also be done by using a computer program such as Ethnography.

[51] Ranjit Kumar, 2011, Research Methodology, A step by step Guide for begginners, London: Sage Publication, P 255

[52] Babbie, E. 2010, The Practice of Social Research, USA: Wadsworth Cengage Learning. P338

[53] Ibid. P 278

- Integrate themes and responses into the text of the report. Having identified responses that fall within different themes, the researcher is there to integrate them into the text of the report.

3.6.3 Analysis

Data analysis is the process of inspecting, cleansing, transforming and modelling data with the goal of discovering useful information, informing conclusions and supporting decision making.[54] The collected data of this research will be analysed by using thematic method. A theme provides the researcher with the basis for a theoretical understanding of his or her data that can make a theoretical contribution to the literature relating to the research focus.[55] With thematic method of analysis, one uses framework approach which provides a strategy for analysing data. Framework is a 'matrix-based method for ordering and synthesising data' (Ritchie et al. 2003: 219).[56] Themes are then constructed and represented in a matrix that closely resembles an SPSS spreadsheet with its display of cases and variables.

One of the ways of searching for themes, according to Ryan and Bernard (2003) is through identification of repetitions in the transcriptions. Repetition is one of the most common criteria for establishing that a pattern within the data warrants being considered a theme. Repetition may refer to recurrence within a data source. However, the most important thing is that repetitions should be relevant to the investigation's research questions. The researcher requires to reflect on the initial codes that have been generated and to gain a sense of the continuities and linkages between them.[57] All these can be done through rereading of the transcripts.

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[54] Mourton, J. *How to succeed in your Masters and Doctoral Studies*, Pretoria: J.L Schalk. 2001

[55] Babbie, E. 2010. *The Practice of Social Research*, USA: Wadsworth Cengage Learning. P 579

[56] Ibid. P 580

[57] Ibid. P 581

The other means for searching themes according to Ryan and Benard (2003) include observations of local expressions that are either unfamiliar or are used in an unfamiliar way, the ways in which participants represent their thoughts in terms of metaphors or analogies, the ways in which topics shift in transcripts and other materials, exploring how interviewees might discuss a topic in different ways or differ from each other in certain ways or exploring whole texts like transcripts and asking how they differ, examining the use of words like 'because' or 'since', because such terms point to causal connections in the minds of participants and reflecting on what is not in the data by asking questions about what interviewees omit in their answers to questions.[58]

3.6.4 Interpretation

Interpretation is the last step in data processing. It is an art of expressing a given data or information in a written or oral form to provide a logical explanation or meaning for the given facts. The researcher couches in the understanding that the inquirer brings to the study from her or his own culture, history, and experiences.[59] The researcher interprets the findings in the light of the hypothesis set forth in the beginning. The interpretation addresses whether the hypothesis is supported or refuted. The researcher also considers whether the treatment that was implemented actually made a difference for the participants who experienced them. The researcher then suggests the reasons why or why not the results are important. Finally, the researcher indicates the implications of the results for the population studied for future research.[60] While interpreting the information, the researcher is mindful of the:

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[58] Ibid. P 581

[59] Creswell, J. W, *Research Design: Qualitative,* Quantitative and Mixed Methods Approaches, London: Sage Publications, 2009 P 182.

[60] Creswel, J. W, *Research Design: Qualitative*, Quantitative and Mixed Methods Approaches, London: Sage Publication, 2009. P 167

- Clarity and explicitness of the interpretation
- Segregation of common and special features
- Presentation of the focus to be right in the beginning
- Organisation of the facts to be step by step
- Accuracy of facts need to be thoroughly checked.

This is exactly what the researcher in this study did after collecting data from the field.

3.7 Study Setting

This is the physical, social or experimental context within which research is conducted. Qualitative researchers collect data in the field at the site where participants experience the problem under study.[61] When gathering information, there must be a face to face interaction directly to people and seeing them behave and act within their context. Face to face interaction helped the researcher to explore the problem by herself. The study is based in the southern region of Malawi, specifically in Blantyre and Zomba districts. Two congregations from the presbytery of Blantyre Synod were chosen as sites for the study. These include St. Michael's and All Angels Church in Blantyre district and Zomba CCAP in Zomba district. The congregations were chosen as they comprised of people from all walks of life as they are located in urban areas.

3.8 Ethical Considerations

Ethical consideration is a collection of principles and values that should be followed while doing human affairs. The ethical considerations make sure that no one acts in such a way that is harmful to society or an individual. A qualitative researcher faces many ethical issues that surface during data collection in the field

[61] Creswel, J.W, *Qualitative Inquiry and Research Design:* Choosing Among Five Approaches, London: Sage Publication, 2007. P 37

and in analysis and dissemination of qualitative reports.[62] A good researcher is responsible for the protection of the dignity of the informants during data collection as well as analysis. In this study, the following ethical principles were followed to protect the dignity of the informants.

3.8.1 Protection from Harm

The issue of harm is not simple and straight forward as it may appear. Harm is sometimes difficult to define and predict. The study informed the subjects of any reasonable risks before the study begun and gave sufficient opportunity to consider whether to participate or not. This is in line with the recommendation by Kelvin Garry Smith , that a professional research should ensure that neither emotional nor physical harm is induced on the participating individuals[63]. In this study the researcher minimised the participants' harm by informing them on what was to be done and how the activities would be done. All documents did not bear any name but figures and names of places. During face to face interviews names of informants were not used.

Secondly, the research study screened out research participants' who might be harmed by the research procedures. In addition to this, where potential harm was possible, measures were taken to assess the harm after the study and research participants were informed of the procedures.

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[62] Creswel, J.W, *Qualitative Inquiry and Research Design*: Choosing Among Five Approaches, London: Sage Publication. 2007 P 142

[63] Kelvin Garry Smith, "*Academic writing and Theological Research*". A Guide for students. Johannesburg:South African Theological seminary press, 2008 p.62

3.8.2 Informed consent

Informed consent is the permission granted in full knowledge of the possible consequences that one may pass through.[64] Increasingly, researchers prefer to obtain the informed consent of research participants by getting them to sign informed consent forms. The advantage of such forms is that they give respondents the opportunity to be fully informed of the nature of the research and the implications of their participation at the outset.[65] Further, the researcher had a signed record of consent capturing any concerns subsequently raised by participants or others. The participants were requested to sign a consent form as proof of voluntary participation. The researcher asked for permission from the participants to use a tape recorder, while also taking notes, as a way of gathering additional data. This was reflected on the consent form to indicate that the participants were informed and have agreed to be recorded.

3.8.3 Right to privacy

Levin defines 'privacy' as the freedom an individual has in determining the time, extent and general circumstances under which private information will be shared with or withheld from others[66].The right to privacy is a tenet that many people hold dear, and transgressions of that right in the name of research are not regarded as acceptable. It is very much linked to the notion of informed consent, because, to the degree that informed consent is given on the basis of a detailed understanding of what the research participant's involvement is likely to entail. He or she in a sense acknowledges that the right to privacy has been surrendered for

[64]Ranjit Kumar, 2011, *Research Methodology*, A step by step Guide for begginners, London: Sage Publication, P 220

[65] Ibid. P220

[66] H. Levin. *Primary papers prepared for the commissio*n, The Belmond Report. Washinton DC :DHEW Publication. 1976. p 9

that limited domain.[67] The researcher made sure that all participants understood and agreed willingly on the privacy that was involved through the informed consent.

3.8.4. Privacy and confidentiality

The researcher pledged that no information that is directly linked to individual participants and their private lives would be divulged without their consent.[68] The researcher standardised the questions in the interview guide so no participants responded to questions regarding their private and confidential information. The researcher eliminated all those questions which the participants in the pilot study felt uncomfortable with, as they feared that it would infringe on their privacy or threatened confidentiality.

3.9 Honesty with professional colleagues

This is to do with the protection of other people work which is called plagiarism. Plagiarism means using or copying someone's work and presenting it as your own. Plagiarism leads to lack of originality of the document and ends into penalties. This study ensures that all forms of plagiarism have been avoided especially by acknowledging the sources of all information gotten from anywhere else. Lastly the research was carried out in a way which made the decisions to constitute ethical judgements.

3.10 Conclusion

In summing up, this chapter focused on the methodology that was used to generate data for the study. Among others, the chapter presented research design, sampling, data collection, data processing and analysis techniques that were employed and

[67]Creswell, J. W, 2014, *Research Design:* Qualitative, Quantitative and Mixed Methods, USA: SAGE Publications, P 99

[68] Ibid. P 100

all the reasons for the choice of the methodological framework. Furthermore, other aspects of research such as study setting and ethical consideration have also been presented. The next chapter will cover research findings from the collected data.

CHAPTER FOUR

STUDY FINDINGS AND DISCUSSION

4.1. Introduction

This chapter presents findings from the field work which was conducted from 14th September 2023 to 12 January 2024 where two focus group discussions were conducted among the church members from the two congregations and in-depth interviews from Church ministers, church elders and health care service providers. The collected data was analysed and discussed.

4.2 Findings

The research study has established the following twelve major findings:

1. Mental health issues are neglected in Malawi.
2. Mental health challenges are increasing in Malawi.
3. Depression is the main mental health problem in Malawi
4. There are various misconceptions on mental health in Malawi that makes it hard to effectively address the situation.
5. There are barriers to mental health care in Africa
6. Religion influences mental health.
7. Medical mental health care should consider patient's religion prior to treatment as medical care is never enough to promote mental health.
8. RIs are at the best position to deal with mental health issues that requires CBT
9. Fellowship is one of the effective CBT the church renders.
10. Sacred religious texts are tools for behavioural change.

11. There are challenges and opportunities encountered by the RIs in addressing mental health problems
12. Some RIs are imposing mental health problems in Malawi

4.3. Discussion of Findings

4.3.1. Mental Health is neglected in Malawi

Mental health is been overlooked in Malawi just like some of the non-communicable diseases but most people are affected, others even lose their lives. The following are some of the evidences that portrays negligence in Mental health in Malawi:

Firstly, Resources for mental health are scarce, and they are also inequitably distributed in low- and middle-income countries[69]. Malawi, like most LMICs, has limited resources allocated to mental health including health facilities. Mental health services are mainly found in urban areas despite the fact that the majority of people in sub-Saharan Africa live in rural areas. Currently, according to the Ministry of Health (MoH)'s strategic plan, Malawi has 0.3% mental health facilities. Furthermore, the available mental health facilities in Malawi are found in urban areas and services are centralized. This limited availability of mental health facilities affects accessibility of services for the people suffering from mental health problems/illness in the country[70]. As evidenced by the minister of Health Hon. Khumbize Kandodo Chiponda during the commemoration of World Mental Health day in Zomba, October 11th2023. she uttered that:

[69] Saxena . S et al, *Resources for mental health: scarcity, inequity and inn-efficiency*. The Lancet 2007. 37(9590) p. 878- 889.

[70] Kauye . F. et al. *Increasing the capacity of Health Surveillance Assistants in community mental health care in developing country*,Malawi. Malawi Medical Journal 2011. 23(3) P. 85-88

> "*we have not invested much on mental health and going around the country, one will see that we don't have enough mental facilities in all the regions"*.[71]

In addition, basing on recent studies done in primary health care (PHC) settings in Malawi by Kauye and Udedi, respectively, indicate that prevalence for probable common mental disorders among primary health care patients range between 20-28.8%. Despite this high prevalence of mental health problems, mental health services are centralised and not effectively integrated into primary healthcare. Stigma and cultural beliefs coupled with lack of knowledge has a negative impact on the access to mental health care services[72].One mental health expert at Zomba Central Mental Hospital explained that:

> "for *Malawi to properly deal with mental health related problems, firstly we ought to provide primary health care services in the rural communities, primary health care involves raising awareness and preventive knowledge on mental health, since most of the mental health care facilities are urban based, people in rural settings have nil or little information on the problem"* [73]

Secondly, Human resources for mental health are inadequate in most low- and middle-income countries and Malawi shares the same problem, Malawi has few psychiatricc personnel (both nurses and doctors)[74].Most of the general healthcare workers are not confident in dealing with psychiatric patients[75]. One respondent a

[71] Minister of Health (Hon. Khumbize Kandodo Chiponda)

[72] Kauye. F. Jenkins & A. Rahman. *Training primary health care workers in mental health and its impact on diagnoses of common mental disorders in primary care of developing country*. Malawi: A cluster -randomised controlled trial. Psychological medicine.2014. 44(03) p. 657-666

[73] Respondent. Zomba Central Mental Hospital, 8th November, 2023

[74] Kauye F.et . Ibid

[75] Kauye F. et. Ibid

medical doctor at ZCMH in line with the idea that Malawi has few psychiatric personnel said that:

> "Zomba *Central Hospital's mental health facility has only 68 nurses, this is a complete drawback in service delivery as they are very few to handle mental health patients. Apart from that there are also few staff houses here at Zomba mental hospital. ZMH, regardless of lacking medical equipment, our institution is doing well in producing practices of passion, professionalism and transparency, however, the ratio of health care providers to that of the patients admitted does not tally. Of cause, Malawi may be poor but isn't that poor, certainly not with the millions it gets as a development aid in healthcare …."*[76]

Furthermore, Mental health services are underdeveloped in the country and that the rural community, where the majority of the population lives, lacks access to mental health services. As such, there is a huge unmet need for mental health services in the country[77]. Dr. Felix Kauye in his remarks on the underdevelopment of mental health in rural areas stressed on the provision of primary health care (PHC) in rural communities. PHC mainly focuses on the awareness and prevention, He calls for the government to work hand in hand with the HSAs available in the communities to raise awareness on mental health[78].

In addition, the current national mental health policy was developed in 2000 and has outlived its lifespan. This leaves the country with an outdated policy as well as strategies which do not reflect the growing population as well as the current mental health challenges the country is facing. All these underscores the need for coordinated action to address existing challenges in mental health service delivery

[76] Micheal Udedi. *Improving Access to Mental Illness in Malawi*. July 2018

[77] Micheal Udedi. *Improving Access to Mental Illness In Malawi.* July 2018

[78] Micheal Udedi. July 2018

in Malawi[79]. A policy aimed at providing direction to decentralisation, integration, formulation of community-based programmes, provision of quality care and development of necessary human resources exists. Today, the country is operating without a mental health plan or policy[80]. The absence of an effective legislation and mental health policy is a manifestation of a deep-rooted structural discrimination for mentally ill people that exists in the country.

Lastly, despite the policy being in place, it has not been fully implemented due to inadequate funding thereby making mental health services inaccessible in the country[81]. Available data indicates that only 1.01% of the general health care budget is spent on mental health services. Challenges posed by the inadequate mental health care funding are therefore overwhelming. Medicines, human resource development, and infrastructure for mental health services depend on availability of adequate funding, which consequently has a bearing on access to care[82].One of the research respondent a church member from Zomba CCAP explained that:

> *"its really sad that the government doesn't pay much attention to the mental well-being of its people regardless of it being an instrument that is carrying away most youths in the country."*[83]

[79] ibid

[80] World Health Organisation. 2011 Report

[81] Kauye. F. Jenkins & A. Rahman. *Training primary health care workers in mental health and its impact on diagnoses of common mental disorders in primary care of developing country*. Malawi: A cluster -randomised controlled trial. Psycological medicine.2014. 44(03)

[82] Kauye. F. Jenkins & A. Rahman. *Training primary health carte workers in mental health and its impact on diagnoses of common mental disorders in primary care of developing country*. Malawi: A cluster -randomised controlled trial. Psycological medicine.2014. 44(03)p. 657-666

[83] FGD at St. Michael and All Angels church

As a researcher, In Malawi, many mental health conditions have received to little attention and concern by the general public, the general healthcare system and elected and appointed public policy makers, resulting in inadequate priority being given to these disorders. Therefore this serves as a wake-up call to the government of Malawi to invest more in addressing mental health issues.

4.3.2 Mental health challenges are increasing in Malawi

Mental health related problems are on the rise, this is evidenced by the dramatically rise in rate of suicide in 2023, with police blaming it on mental health issues due to relationship problems, financial problems and trauma. This revelation comes as the police statistics show that the current suicide rate is at 11.6 per 100,000 people, higher than the global average of 10.5 per 100,000. Police records further show that, for the past five years suicide cases in Malawi has increased, Police have registered 256 suicide cases in the half of the year 2023, an increase from 135 registered during the same period in 2022. The police records show that of the 256 people, 226 are male and 30 are female, whilst in 2022, 112 males committed suicide compared to 13 females[84]. According to the Deputy National Police Spokesperson Inspector, Harry Namwaza, he said that:

> "*The main factors fuelling suicide are failed relationships and debts, many people commit suicide when they are unable to pay back debts or they are going through difficult times. It is not only concerning but also necessitates for immediate action by the government and relevant stakeholders to decrease these suicide cases…* "[85]

This is in line with Dr. Patience Chimwaza, an occupational therapist at Umodzi Medical Rehabilitation centre who emphasized on the importance of raising

[84] Malawi police report August 2023

[85] Police Report 2023

awareness about the need to promote measures to reduce suicide attempts[86].One mental health therapist at Matawale Health Facility said that:

> "*for Malawi to properly deal with mental health related problems, firstly we ought to provide primary health care services in the rural communities, primary health care involves raising awareness and preventive knowledge on mental health, since most of the mental health care facilities are urban based people in rural settings have nil or little information on the problem.*"[87]

In line with this, one respondent, a church member at Zomba CCAP explained that:

> *"mental health related problems have risen in Malawi, this is not only evidenced by the rise in cases of suicide but also the rise in number of people who are into drug and substance abuse. Many people are taking alcohol on daily basis, this purely shows that they are trying to forget the hardships they are going through. Youths, even teenagers are taking alcohol, indulging themselves in illegal businesses it's now getting out of hand. Apart from drug and substance abuse, the level of aggression that people are portraying nowadays shows that people are struggling with mental health issues.*"[88]

As a researcher, from the report by the Malawi police service, one could clearly tell that mental challenges are on the rise in Malawi as the number of people who are committing suicide in Malawi has doubled over a year, number of youths engaging in in risky behaviours has also risen and the level of aggression has also outweighed that of peace.

[86] VOA report on mental Health in Malawi

[87] Respondent at Matawale Health Centre, 12 January, 2024

[88] Respondent at Zomba CCAP, 8th November,2023

4.3.3 Depression as the main mental health problem in Malawi

The study has evidenced that the main mental health disorder in Malawi is depression. Depression is a mental disorder that involves the loss of pleasure or interest in activities for a long period of time. A depressed mood is characterised by feeling irritable, sad and empty[89]. Depression causes difficulties in all aspects of life, including in the community, home, work and school. A depressive episode is categorised as mild-moderate and severe depending on the number and severity of the symptoms as well as the impact on the individual's functioning. There are three different patterns of depressive episodes namely: Single episode depressive disorder, this is the person's first and only episode of depression. Recurrent depressive disorder, this means that the person or the victim of depression has a history of at least two depressive episodes. Bipolar depressive disorder, means that the depressive episodes alternate with periods of manic symptoms which include euphoria or irritability increased activity or energy and other symptoms such as increased talkativeness, racing thoughts, increased self-esteem, decreased need for sleep, destructibility and impulsive reckless behaviour[90].

There are various contributing factors of depression in Malawi, these are results from complex interaction of social, psychological and biological factors. People who have gone through adverse life events are likely to fall victims of depression.

Firstly, adverse life events can cause mental health disorders as many people may fail to cope with the situations they are passing through. In an interview with a psychosocial therapist at Matawale Health Centre, he explained that:

> "*Apart from biological or genetic malformations as causes of depression, the adverse life events or challenges of life contribute much to mental disorders, for instance people who are bread winners or co-supporters of families face many challenges., one of it being the economic crisis that Malawi is facing now. They have many responsibilities, this makes many*

[89] WHO. World Mental Health (WMH) Surverys. Pschol Med. 2018.48. 9: 1560-1571

[90] ibid

men to fall victims of mental unrest. It is like they are carrying a heavy load with full of bundles of needs, thereby it comes very difficult for them to meet their required goals as co-supporter. This then, lead to high levels of aggression."[91]

To add up on the challenges of life as a cause of depression, a church elder at Blantyre CCAP, said that:

> *"As Christians, we are not immune to neither is our pastors, there are many issues out here that makes our lives to drop. There are issues to deal with education, where our children are out weighing the essence of education as most of them are unemployed, many graduates from various universities are hovering around Malawi without a hope of getting employed any time soon, those people are at the risk of developing mental health problem, they may be stressed, depressed and hopeless. Their solution to this is that they venture into drugs and others end their own lives. Apart from that there are marital issues where one partner is promiscuous and the other partner is likely to develop mental health problems, for instance the one being cheated on, will probably view his/herself as a less important being that can probably lead to anxiety as he/she might be thinking much on the possible outcome from the other relationship."*[92]

Secondly, depression is triggered by parental negligence or negative parenting. According to Charles Masulani, a mental health expert. stressed on negative parenting as one of the contributing factors of mental illness, he continues to argue that there are a lot of parents that stress their children and they have serious expectations of their children, the child might be doing well at school but not performing well upon negative confrontation by parents that child can develop mental problems that may lead to shocking behaviours. He gave an example of a

[91] Respondent, A Therapist at Matawale Health Centre, 12th January,2024

[92] Church elder at Blantyre CCAP, 14 September,2024

certain form four student who committed suicide in a process of denial upon learning that he did not perform well, he committed suicide in fear of confrontation by his parents.[93] In line with this, a psychosocial therapist at Matawale Health Centre said that:

> "*negligence by parents, is one problem we have here in Malawi, many parents overlook their children as they reach a certain age. They shoe less attention towards their children. This is when the society comes in with various ways of living being oriented to the child's life. Other parents do not even follow up about the education of their children, they do not even know their children's teachers, those who are associating with their children and they are not even aware of the teachers who are not in good terms with their children or even during holidays, they do not even bother to ask about their performance, their career dreams and they do not even ask them about their program of interest upon reaching tertiary level of education. Furthermore, when things went bad with their children, they do not pay a hearing ear but rather they use abusive languages towards the child thereafter the child is likely to develop a mental health problem. Just to add up, this year alone two teenagers have committed suicide because of poor parental approach to the teenager's needs. Looking deep into the matters that lead to them to come up with such a solution, they all had a misunderstanding with their parents. Therefore, parents should be aware that the children of the former ages are totally different from the latter children, Children of today are much exposed to the western cultures."* [94]

Furthermore, people are depressed as a result of societal accusations, these are negative identities towards a person by the community. For instance, people who are termed as witches, prostitutes, thieves, ritualist, murderers, these people are

[93] Malawi medical Journal 2023

[94] Respondent at Matawale Health centre, 12 January,2024

prone to various mental problems. They may be isolated from the community, they lack socialisation in due course they may develop a low mood or an anxiety. In a focus group discussion with members of Zomba CCAP, one respondent who happens to be a social worker uttered that:

> *"there are bad names attributed to people in many societies that can trigger mental problems, for instance when one is termed as a prostitute by the community, she will have uncontrollable thoughts on how she presents herself to the society. In the same sense those who are accused to be witches, they go on and find out how people perceive the concept of witchcraft where they will find out that, witches are not loved by the society, they are murderers. Those ideas will be imposed to them thereafter they will have a low mood, fall into depression and they can even be paranoid that one day the society might have them killed by mob justice."*[95]

Lastly, Trauma and palliative illnesses causes mental health problems. Trauma is a deeply disturbing experience, it can be physical or emotional stresses that has a very negative impact on the well-being of a person. For instance, the death of a loved one, others in the course of mourning or in disbelief they fall into depression. Palliative illnesses, are long term diseases these include advanced cancer, neurological diseases, kidney failure and chronic liver disease just to mention a few, the patients diagnosed with chronic illnesses might be mentally affected upon hearing the news about their health condition. In this stage of denial, many patients develop a slight change in their normal personality. The change alone attributes that he/she is mentally affected by the news. In an interview with a psychosocial-personnel at Matawale Health Centre, he said that:

> *"the way the medical personnel deliver massages of diagnosis to people may affect the patient's well-being. They should be kind and*

[95] Respondent at Zomba CCAP,8th November,2023

gentle enough when breaking the news to the patients and to their relatives."[96]

To add on trauma and palliative illnesses as triggers of mental disorder, Chorwe, Sefasi and Pindani in their study where they investigated on the prevalence of mental disorders among people who have HIV infection in Malawi[97]. They found out that people with HIV infection are also affected by mental health problems such as depression.[98] They found that there are very few studies that were conducted to investigate prevalence of mental disorders among people who have HIV infection in Malawi. They reviewed only four studies that had investigated the magnitude and nature of mental disorders that affect people who have HIV and AIDS in the country. It is clear that people with HIV and AIDS are also affected with various forms of mental disorders. A study that was conducted among HIV positive people who were attending Antiretroviral Therapy (ART) clinics in Mzuzu found 14.4% as a prevalence rate of psychological distress among these people. Similar studies have indicated that almost half of people who have HIV and AIDS in Africa suffer from some form of mental disorder, commonly depression[99] . This is true for Malawi where a study that was conducted among mothers of infants in Malawi, found that depression and anxiety are associated with HIV infection. They also discovered that the prevalence of substance use among people with HIV/AIDS in Malawi is high. For instance, one study revealed that 25.5% of cannabis (chamba) and alcohol abusers were HIV positive in the country[100].

[96] Respondent at Matawale Health centre, 12th January, 2024

[97] Chorwe.Sungani, G. Sefasi. A. & Pindani: *Mental Health problems Affecting people who have HIV/AIDS.* Open journal of Nursing.2015

[98] Chorwe.Sungani, G. Sefasi. A. & Pindani: *Mental Health problems Affecting people who have HIV/AIDS*. Open journal of Nursing.2015

[99] Chorwe.Sungani, G. Sefasi. A. & Pindani: *Mental Health problems Affecting people who have HIV/AIDS*. Open journal of Nursing. 2015

[100] Ibid

As a researcher, from the discussions it clearly shows that the government of Malawi is overlooking mental health problems regardless of its negative impacts, on weekly basis people are committing suicide, more especially youths and men but still the government of Malawi is still silent and reluctant to change the situation. Apart from that depression is indeed the co- mental disorder which is affecting a multitude of people in Malawi.

4.3.4 Misconceptions of mental health problems in Malawi that makes it hard to address the situation

Mental health conditions are explained as a taboo in most African communities and sometimes it is linked to superstitions practices such as witchcraft. People with this condition in Africa often face discrimination and deprivation of their fundamental rights. Globally, the attitude toward mental health illness assumes a similar pattern. Studies have documented that there is a negative attitude towards mental health issues, even amongst mental health professionals[101]. These poor attitudes amongst people and mental health professionals entrench stigma and discrimination.

Furthermore, across Africa, beliefs in supernatural causes of mental illnesses are widely held, Malawi is not left out. Malawian traditional beliefs in supernatural causes and remedies of mental illnesses influence people's knowledge and attitudes. Many traditional belief systems in Malawi attribute mental health problems to the influence of ancestors or bewitchment and traditional healers are therefore viewed as the experts in these matters. The traditional healers are consulted as either the first step in the pathway to biomedical mental healthcare or the sole providers of mental health care[102]. During interviews at Zomba CCAP and St. Michael and All Angels CCAP, some of the participants added their views

[101] Hanson. L. et al. *Mental Health professionals' attitudes towards people with mental illness*: Does they differ from attitudes held by people with mental illness?. Int. J.Sov paschiatry. 2013.

[102] ibid

on the African misconceptions towards mental health. The first respondent explained that:

> *"At my village, there was a certain young man who was studying at a certain University. He was believed to might have been bewitched by his jealousy distant relatives. Whenever it was time for him to go to school, He starts behaving like a mad person. Upon reaching his school premises, He could be completely mad. It's so unfortunate that He ended up committing suicide as he was depressed with the situation, it was so horrible and pathetic. People out here are so wicked and jealousy.*[103]"

The second respondent said that:

> *"Mostly, those who commit suicide, they do not commit it intentionally. In this life even though it is so hard to to sustain oneself but taking one's life is never an option for many people. Those who commits suicide are cast an evil spell upon them, the spell triggers an irresistible urge to end their own lives. I have witnessed with my own eyes a business tycoon who had everything and lacks nothing but ended up in ending his life. This event purely entail that some evil people were behind the act, not physically but spiritually for them to acquire his wealth.*[104]"

The last respondent added that:

> *"most mental health illnesses in Malawi are imposed by people. I have seen many rich people bewitching their own children or even their relatives to become beggars in the streets, as they beg in the streets the rich person makes more money. In cases where the mad person becomes more aggressive and even goes as far as beating people it entails that the business is not going on well. Apart from that, others become mad as a result of improper preparation of love*

[103] Respondent at Zomba CCAP, 14th, September. 2023

[104] Respondent at Zomba CCAP, 14th, September,2023

charms, therefore instead of the charm to lure the subject's mind, it hits back to the owner and he/she becomes mad[105]"

As a researcher, from the narratives by the respondents clearly entail that mental health issues are believed to be products of witchcraft in Africa. This poor knowledge and attitude towards mental illness exhibited by most African families, caregivers and society in general leads to poor health care-seeking behaviour for those affected, for instance, instead of the affected people to seek medical, they prefer to seek help from the witchdoctors. This course of action, further worsens their condition instead of making them better. consequently, in most cases, they present the problem to healthcare facilities only when they are too far gone and their mental health is too far deteriorated, with nothing much to be done to salvage the situation.

4.3.5 Barriers to mental health care in Africa

The World Health Organization (WHO) reports that mental illnesses are common and that more than 25% of people globally suffer from mental disorder in their lifetime[106]. The treatment gap of mental health between poor and rich countries is large with an estimation of 30-50% in developed countries and 76- 85% in developing countries[107]. WHO reports that higher income countries have more facilities and higher utilisation rates than low- and middle-income countries (LMIC). The global median of mental health facilities per 100,000 population is reported at 0.61 outpatient facilities, 0.05-day treatment facilities, 0.01 community residential facilities, and 0.04 mental

[105] Respondent at St. Michael and All Angels,8th November, 2023

[106] World Health Organisation (WHO). *The World health Report*, 2001. Mental Health new understanding, new hope.WHO

[107] WHO. Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. Geneva WHO

hospitals [108].According to WHO, more than116 million people across the African Region were already estimated to be living with mental health conditions pre-pandemic[109]. However, a number of challenges have been identified as significant contributors to the problem of mental health care disparities. Some challenges are related to the economic and development inequalities that are common to low and middle-income countries, while others are more specific to the social and cultural contexts in Africa. They simultaneously include multiple individual and community level factors, such as infrastructure, resource, psychosocial and socio-economic problems [110]. These challenges present as interrelated legislative, policy-making, institutional, organizational, community and professional problems. For example, one of the most significant problems, the lack of mental health policy, is both an infrastructure and planning problem; poor legal protection and lack of equity for people with mental illness are also caused by a lack of effective legislation; solutions to psychosocial problems would be improved with better epidemiological studies and culturally sensitive research; and stigma, discrimination and human rights abuses should also be addressed with laws and policies to enhance community-based interventions. Finally, all of these problems require comprehensive approaches and multi-level solutions in order to decrease the morbidity, disability and life disruption that can result from mental disorders and to improve individuals' well-being throughout the continent.

The scarcity of research mirrors is the main weakness of mental health services on the continent and the blind eye turned to the problem by many Africans and their governments. Worldwide, 24% of countries that reported to the WHO's Mental Health Atlas survey did not have or had not implemented stand-alone mental health policies; in Africa, this proportion rose to 46%. The region has 1·4 mental health workers per 100000 people, compared with a global average of 9·0 per 100000, and

[108] Lora A. & Saxena S. *Global mental Health resources and service*s : a WHO survey of 184 countries . Public Health Reviews 2012[34 (2)]: p1

[109] WHO, report on mental health 2022

[110] WHO, report on mental health 2022

also performs relatively poorly with regard to the number of psychiatrists, the number of hospital beds for patients with mental illness, and the coverage of outpatient facilities[111].

Consequently, the proportion of Africans who receive treatment for mental health problems is extremely low. While the global annual rate of visits to mental health outpatient facilities is high.[112] In Sierra Leone, for example, the treatment gap (that is, the proportion of those in need who go untreated) for formal mental health services has been estimated at 98·8%[113]. Mental health problems appear to be increasing in importance in Africa. Between 2000 and 2015 the continent's population grew by 49%, yet the number of years lost to disability as a result of mental and substance use disorders increased by 52%. In 2015, 17·9 million years were lost to disability as a consequence of mental health problems. Such disorders were almost as important a cause of years lost to disability as were infectious and parasitic diseases, which accounted for 18·5 million years lost to disability[114]. As Africa's population is expected to double over the next three decades, the pressures on young people in particular, who across the region are already struggling to earn a livelihood in highly competitive labour markets, are likely to ratchet up. Many will experience psychological problems as they fail to realise their ambitions, and some will turn to substance misuse as a means of alleviating their frustration[115]. Increased attention to mental health by governments, researchers, and journals is therefore essential. In 2013,

[111] WHO. Mental Health atlas 2014: Geneva:204-2015

[112] Ibid

[113] Yoder HN, Tol WA, Reis R, de Jong JT. *Child mental health in Sierra Leone*:

a survey and exploratory qualitative study. *Int J Ment Health Syst* 2016; **10:** 48.

[114] WHO. *Global Health Estimates 2016*: Burden of disease by cause, age, sex, by country and by region, 2000–2016.

[115]British Council. *Next generation Kenya*: listening to the voices of young

people. British Council. 2018.

the member states of the World Health Assembly committed to the Comprehensive Mental Health Action Plan, in which they pledged, among other national targets, to increase service coverage for severe mental health disorders by 20% by 2020 and to reduce suicide rates by 10%[116]. The third goal of the Sustainable Development Goals adopted by all the world's governments in 2016 also includes commitments to improve mental health and prevent and treat substance use disorders in the next 5 years and beyond[117].

Furthermore, the studies have noted basing on the WHO Mental Health Atlas, African countries struggle to raise the resources required to provide mental health care for their populations, and most spend less than 1% of their health budget on mental health. Most of this is spent on expensive and inefficient institutions. However, substantial trials confirm that practical, cost effective treatments for major psychiatric conditions including anxiety, depression, substance use and schizophrenia can be effectively and efficiently implemented in low-resource settings.[118] This can be evidenced by one Mental health specialist at ZMH, He said that:

> "*for long mental health has been overlooked, most mental health facilities in Malawi, lack resources these include, human resources and even treatment equipment, for instance to treat a patient diagnosed with schizophrenia requires many people to handle the patient as others become very aggressive and it becomes very difficult for a single person to administer the medicine*[119]"

Dr. Michael Udedi one of the most influential mental health specialist in Malawi, in July 2023 appealed to the government to recruit more nurses and psychologists, as at that time there were only 65 nurses at ZMH but the facility needs 333 nurses to attend

[116] Saxena S, Funk M, Chisholm D. *World Health Assembly adopts Comprehensive Mental Health Action Pla*n 2013–2020. *Lancet* 2013; **381:** 1970–71

[117] ibid

[118] World Health Organisation (WHO). *The World health Report*, 2001. Mental Health new understanding, new hope.WHO

[119] Respondent at ZMCH, 8th November, 2023

to the patients. However, the initial focus on closing this care gap in low income countries has been expanded in scope to focus also on promotion of well-being, prevention of risk factors (especially early in the life-course), and integrating mental health across sectors like education, livelihood and other areas of health.

As evidenced from the discussion, most of the African countries face social economic difficulties, this made it difficult for the continent to address mental illnesses even though it's on the rise. Mental health services are on high demand but there few infrastructures to accommodate the out growing population, the institutions lack health care providers. Therefore, the relevant stakeholders should consider all these and respond with urgency.

4.3.6 Religion influences mental health

The study through Blantyre CCAP Synod has established that positive association present in religious settings have an impact towards mental health. Religious conversion has generally been associated with positive mental health experiences. RI renders Psychotherapies, mainly cognitive-behavioural therapy that includes religious beliefs and practices, such as Bible reading and prayers successfully treat depression and anxiety. One respondent a church minister explained that:

> *"there is power in prayer, it changes people's perception of their troubles, those with adverse situations mostly they do not show up for services, we make a follow up on them, to find out what is keeping them. Upon learning about their adversaries, we read the bible, preach to them and pray with them.*[120]*"*

Dein a mental health researcher finds out that the incorporation of religious activities such as prayer, Bible reading and ritual into CBT or Christian-based CBT is more effective among Christian patients with depression and anxiety than traditional non-religious CBT[121]. In his study it was noted that one clinical trial found that cognitive

[120] Respondent at Zomba CCAP.

[121] Dein, S. Religon and Mental Health. Royale college of Psychiatrists.2013

behavioural therapy adapted to the religious values of the patient can be efficiently implemented by non-religious therapists[122].

Apart from the RIs rendering CBT, they influence healthy behaviours and lifestyle as sseveral illnesses are related to behaviour and lifestyle, thus how we carry ourselves everyday have important influences in our health. Most religions prescribe or prohibit behaviours that may impact our health. For instance, CCAP Blantyre Synod discourage smoking, drinking, fornication, adultery just to mention a few, this saves people from unnecessary stress and depression that might come with the said behaviours. For instance, beer drinking and smoking suppress people's normal brain capabilities thereby they are prone to make uninformed decisions that might expose their lives to various regrettable situations.

Furthermore, religious practices can help to maintain mental health and prevent mental diseases. They help to cope with anxiety, fears, frustration, anger, anomie, inferiority feelings, despondency and isolation. The most commonly studied religious practice is meditation. It has been reported that it can produce changes in personality, reduce tension and anxiety, diminish self-blame, stabilize emotional ups and downs, and improve self-knowledge.

In addition, Religious gathering in places of worship influence how people deal with stress, suffering and life problems. The activities in worship places generate peace, self-confidence, purpose, forgiveness to the individual's own failures, self-giving and positive self-image.

Lastly, Religious associations or sub ministries present at Blantyre Synod, foster improved mental health and more positive psychological states such as joy, hope, and compassion, bringing enhanced physical health through reduced burden on physical organ systems. The sub ministries have a greater availability of social support, a well-established salutary factor that may protect health in part by fostering effective coping with stressor.

[122] Ibid

4.3.7 Medical mental health care providers should consider patient's religion prior to treatment as medical care is never enough to promote mental health

Mental health care providers should consider their patient's religion prior to the provision of the service. Patients have spiritual needs that should be identified and addressed, but psychiatrists and other mental health professionals do not feel comfortable tackling these issues. Adequate training is necessary to integrate spirituality into clinical practice. The professional should have an in-depth knowledge of the cultural and religion environment where his/her work is being done. In the presence of psychopathology, religion may be part of it, contributing to the symptoms (obsessions or delusions for example). Sometimes, religion may become rigid and inflexible, and be associated with magical thinking and resistance. It may be helpful to integrate the patient into society, or motivate him/her to seek treatment[123]. Pruyse and Malony described the elements of a functional theology, present in all religions, which may promote good mental health in line with medical intervention. They are: awareness of God, acceptance of the grace and love of God, repentance and social responsibility, faith and trust, involvement in organized religion, fellowship, ethic, and tolerance and openness to the experiences of others. During assessment, the psychiatrist should be able to determine if religion in the life of his patient is important, has a special meaning, is active or inactive, involves values in accordance to his main tradition, is useful or harmful, and promotes autonomy, personal growth, good self-image and interpersonal relationships[124]. Furthermore, beyond listening and respect, appropriate referral, and support of spiritual needs. A brief spiritual history is necessary to become familiar to the patient's religious beliefs as they relate to

[123] Malony HN. *The clinical assessment of optimal religious functioning.* Rev Religious Res. 1988;30:3-15.

[124] Malony HN. *The uses of religious assessment in counseling*. In: Brown LB, ed. Religion, Personality, and Mental Health. New York: Springer-Verlag; 1994.

decisions about medical care, understanding the role religion plays in coping with illness or causing stress, and identifying spiritual needs that may require assistance. This is in line with one respondent at ZCMH, who explained that:

> "*consideration of our patient's religion assists us to properly treat their conditions and sometimes we make use of the hospital chaplain to render a religious based therapy.*[125]"

This then, entail that religion have a positive impact on mental health, as its concept of spirituality help people to tolerate stress and their situation by generating peace, purpose and forgiveness. The spirituality connection is bigger than ourselves., it helps people to look with themselves and understand themselves and their situations, therefore incorporate it into health practices for the mind, influences mental health and emotional well-being.

4.3.8 The role of the RIs in addressing mental health

Mental health issues directly and indirectly affect all of us. It's unfortunate that mostly those who are victims of mental health problems do not open up to seek help or to discuss with their friends and families. This difficulty of taking about it combined with poor public knowledge about mental health issues and the significant stigma and injustices with which they are associated with, adds more suffering to the victims of ill mental health and even to the ones closer to them. There is some work examining the incorporation of religious activities such as prayer, Bible reading and ritual into CBT. Some evidence suggests that Christian-based CBT is more effective among Christian patients with depression and anxiety than traditional non-religious CBT[126].

Pargament (2007) in *Spiritually Integrated Psychotherapy* provides a comprehensive overview of the inclusion of spirituality into psychotherapy and provides a number of illustrative clinical scenarios as to how this can be done. Rls are welcoming spaces

[125] Respondent at ZCMH, 8th November,2023

[126] Ibid

where people are invited to participate widely, and embraced for who they are and that they may find faith and hope in God. The RI can never be underestimated as it plays vital roles in the lives of people and even the society. It works by helping people to discover the hope and optimism that God gives in this life[127].

Basing on the interviews that were carried out at St. Michaels and All angels CCAP and Zomba CCAP. It has been noted that Blantyre Synod is taking part in dealing with mental health problems. As evidenced from the synod's mission statement which says:

"The mission of the church is the proclamation of the gospel for the salvation of mankind, the shelter, nurture and spiritual fellowship of the children of God, promotion of divine worship, the preservation of truth, the promotion of social righteousness and well-being of mankind[128]"

This statement alone clearly entail that Blantyre synod is concerned with the holistic well-being of its members. The reverend of Zomba CCAP said that:

> *"From the mission statement of Blantyre synod, you might as well perceive that mental health is not left out when we are talking about the promotion of well-being of mankind. When talking of a well-being we look at the person's entirety or holistically. This means that we are concerned about the physical, spiritual and the psychological well-being of a person. As mental health triggers are basically from physical stressors as a church we stress on the salvation of mankind through divine worship."*[129]

The Religious practices, both public and private religious practices can help to maintain mental health and prevent mental diseases. They help to cope with anxiety, fears, frustration, anger, anomie, inferiority feelings, despondency and isolation. The

[127] Ibid

[128] Blantyre synod Mission and Objectives.

[129] Respondent Church Minister at Zomba CCAP. 12th January, 2024

most commonly studied religious practice is meditation[130]. It has been reported that it can produce changes in personality, reduce tension and anxiety, diminish self-blame, stabilize emotional ups and downs, and improve self-knowledge. Improvement in panic attacks, generalized anxiety disorder, depression, insomnia, drug use, stress, chronic pain and other health problems have been reported. Follow-up studies have documented the effectiveness of these technique. Other religious practices such as personal prayer, confession, forgiveness, exorcism, liturgy, blessings and altered states of consciousness may also be effective, but more studies are necessary.

Furthermore, Spiritual direction by the church serves as a special relationship between two human beings to help in the development of the spiritual self. Its aims are to develop a relationship with God, to find meaning in life, and to promote personal growth. Several religious and psychological techniques may be used, and great similarities with psychotherapy can be found, as the same themes are discussed.[131]

Lastly, religion has many means where people are able to express their stress in times of social disorganization. certain religious rituals by means of techniques that elicit altered states of consciousness, can produce catharsis, dissociative states and a special milieu to express problems and suffering.

4.3.9 Fellowship as one of the CBT the RIs renders

Blantyre synod influences its members to take part in fellowship (s). Fellowship is the coming together of people to share the word of God and to share the aspects of life that affects them. So, this has an impact towards mental health as people are able to share with others the problems that affect their lives as mental health problems are

[130] Alexander Moreira Almeida. Religiousness and Mental Health. A review. Research gate, May, 2014. p 365

[131] Alexander Moreira Almeida. Religiousness and Mental Health. A review. Research gate, May,2014

worse when a person is isolated. The coming together of people influences socialisation where people are able to share their problems and those with problems are able learn new ideas of coping with the situations or on ways to overcome their fears and they have their mood uplifted. In line with the church elder who uttered that:

> *"you find that those who came for fellowship with gloomy faces, they switch completely upon hearing the word of God, their faces begin to shine and they smile.*[132] *"*

The fellowships are divided into many sections, there is the morning devotions, main service, mid-week services and youth services just to mention a few. For instance, the morning devotion ensures the well-being of the people as they prepare for that particular day where people pray for various things affecting their lives. And people are able to come forward with their problems affecting their lives. The fellowships create an environment form the people who seek assistance. Apart from sharing of the issues affecting them, they also open the flow for those with testimonies, testimonies are witnesses or evidences or affirmation of the goodness of God. These have an impact on mental health as those who might been affected with the same will have their faiths strengthened and as such testimonies may help the to heal from their pains.

Blantyre synod also offers psychosocial support to people through fellowship as members have a chance to share their situations. For example, those who have been diagnosed with palliative illness, those who have problems to meet their daily needs and those who seek for opportunities in life. The reverend at Blantyre synod said that:

> *"we were one a morning devotion fellowship when on youth cried bitterly upon being approached, He confessed to might been so stuck in life. He was a student who was passing through hard times, he got selected to pursue his education at the university of Malawi but he had no one to carter for his needs. As a church we supported him and bought him all the necessities required of a university student. And on*

[132] Respondent at Zomba CCAP, church minister, 12th, January,2024

top of that we render proper psychosocial to him when things are not well with him."[133]

As a researcher, from the narration, Fellowship is proven to be the most effective way the RIs uses to relieve people from tension and anxiety, through the social interaction people. As people associate they share new ideas and thoughts of daily living and this suppresses the ill desires that lures people's mind to fall into various ill practices. Religious settings brought forth ease and solace to the heavy-laden bodies.

4.3.10 Sacred religious texts as tools for behavioural change

Blantyre synod uses the Bible narratives as one of the tools to overcome mental problems, with reference from the bible the church preaches about hope to people or those who are struggling with mental problems. They achieve this by considering some of the characters from the bible who went through various hardships. For instance, the story of Job, He lost everything he owned and seeing all his children swept away as if they never existed, He had all the reasons to mourn and grieve to the point of developing a mental illness. In the book of Job chapter 3:26 there is a statement which says "I have no peace, no quietness; I have no rest, but turmoil." this portrays that job was battling with mental problems but He kept the faith in God who then blessed with good health again and wealth.

The story of Jeremiah also portrays that he battled with low moods and constant regrets, although he was a prophet was received great visions of God's glory. He struggled until he uttered the words of hate on Jeremiah 20:24, it says "cursed is the day I was born, why did I born? why did I ever come out of the womb to see trouble and sorrow and to end my days in shame? One is the respondent a Reverend uttered that:

"from the bible we have seen that many people struggled with mental problems, even Jesus at one point was psychologically affected by the

[133] Respondent church minister at Zomba CCAP, 12th, January,2024

trials he was subjected to face. He cried unto the Lord to let the burden pass him, so this clearly shows that he was depressed and disturbed. Even Paul and Job struggled in this life but they kept their faith in God[134]*"*

The synod also quotes Bible chapters and verses where God reassure his people of possibilities of goodness. The quotes are used to render psychosocial therapy to those who are weary with adversaries in life, some of the verses include: Philippians 4:6-7 "Be anxious for nothing, but in everything by prayer and supplication, with thanks giving, let your requests be known to God which surpasses all understanding, will guard your hearts and minds through Jesus Christ, Isaiah 41:10 " fear not, for I am with you, be not dismayed, for I am your God, I will strengthen you, I will help you, I will uphold you with my righteous right hand". The reverend at explained that:

"as where are preaching the word of God, we prepare sermons that incorporate the situations that people are passing through. This is the core area where mental health issues are tackled or when we want to come up with a theme for a sermon we consider the challenges that people are facing too, for instance recently, we had a devaluation, many people were confused on what will happen of them. Now in times like these or during the Cyclone Freddy, there was hunger especially in the southern region. We tried to prepare sermon top uplift people's hope and bring new though as we were supporting them with basic necessities. As Blantyre synod we are concerned with where there is no hope and we brought in home through our Lord Jesus Christ. We are then influencing our fellow from other religions to prepare sermons that suite the situations of people in our communities."[135]

Mental health and the bible begin with the mandate that God gave to humanity, this makes man fit to better understand the situations that are faced. The bible contains

[134] Respondent at St.Michael and All Angels, a church minister. 14th september,2023

[135] Respondent at Zomba CCAP. Church minister. 12 th January,2024.

books that are concerned with much pain for instance the book of Job, according to Christopher cook and Isabella Hamley note that the OT is the collection of texts shaped by pain and trauma for instance struggles for survival, slavery, exile, war and political oppression. These OT pains and trauma had theological and spiritual response[136].The bible renders the best solution the psychological pain as it reassures us on the possibility of gaining new strength and optimism.

4.3.11 Opportunities and challenges of the RIs in addressing mental health issues

The RIs have various opportunities that assist them to reach out to those who are mentally affected just as they have challenges in addressing the mental problems. The following are some of the opportunities and challenges encountered by the RIs when addressing mental health problems:

4.3.11.1 Opportunities

Firstly, Blantyre synod, have different ministries come together to share their lived experiences, this made it possible for the church to deal with mental problems at all angles and the ministries are based on age and gender, for instance they have a women's guild ministry (*Mvano wa Amayi).* This is where women are able to share their problems and they also share the word of God. Apart from that there is youth ministry for those unmarried adults and Sunday schools for children where they are imparted with the knowledge of God, the recommended behaviours. In other words, this is the foundation of Christian life. One of the respondents from a focus group discussion, said that:

> *"we also have men's ministry, it's a newly established ministry, it was established upon looking at the number of men who are committing suicide in Malawi. Apart from that men have a tendency of not sharing*

[136] Christopher cook and Isabella Hamley. *The Bible and mental health*: Towards a Biblical Theology of mental health. Westminster John Knox Press.2020

their problems. So, with this association they are able to share their problems thereby they will access to the new ways of dealing with issues.[137] ”

In line with this, another respondent a church member added that:

“men do not disclose their problems, they have an inner sense of stigma where they feel that the public will perceive them as being weak. They can have huge problems but they fail to share but with men’s ministry themed “chitsulo chimasula chitsulo chimzake” … “Iron sharpens Iron” from the book of proverbs. The theme alone tries to communicate to men to be able to learn from what others have to say on certain issues and for them to swallow their pride and seek support from their fellow men. In course of our association we also entertain ourselves for instance we do braii, we indulge in various sporting activities. With all these we easily forget about our problems and we develop a sense of belonging…[138] ”

Secondly, through fellowships conducted at Blantyre synod, the church is at the best position to learn more on the lived experience of people. This include the coming to light of people who needs to be assisted. For instance, for those who cease from attending the services. The church elder said that:

“we come to know that others are not showing up for the services through the fellowships, we visit them and find out, on what is keeping them. In other cases where we are unable to trace them we consult the home cell groupings to make a follow on them. Once we find out about the problems keeping them, we render assistance and counselling according to their situations.[139] ”

[137] Respondent at Zomba CCAP. Church member. 8th November 2023

[138] Respondent at St Michaels and All Angel, church member, 14 September,2024

[139] Respondent at Zomba CCAP. Church member. 8th November 2023

Furthermore, the concept of evangelism serves as an opportunity for the church address mental health issues beyond its premises. As part of the mission of Blantyre on objective 5.2.4: "To participate in God's activity in the world through love for others and ministering to the needs of the poor, the sick, the lonely and the powerless." They spread the gospel and help people with their needs for instance, through the establishment of a program called "faith and works" present at Blantyre synod, many people have their needs being attended to. They also work with organisations and have their own organisation, the church and society which made them possible to reach out to people in communities. For example, they are running a project together with Nkhoma synod, which is concerned with the fight of violence against women and children, this project has covered may areas for example in areas around Lilongwe, Machinga and Zomba. the beneficiaries for the projects are not only members of CCAP but also other members from various denominations.

In addition, the church offers workshops and seminars relevant to mental health that can educate the congregates, empower them and encourage family members and friends who are dealing with mental problems. For instance, Rev. Brino Chipewa of Ntcheu CCAP has been conducting seminars with his fellow reverends with an aim of curbing the effect of mental problems. They are preaching more on the "Essence of life", they are stressing on the love of one's life where people are reminded on the importance of life and come up with relevant options to sustain that particular life instead of ending it. For instance, they are advising people to save money and make valid investments to carter their families.

Lastly, religion are critical role players in saving lives and reducing mental health related problems. The church plays as a suppressor of mental health, this is achieved its idea of gathering people to worship, this is vital as those people are able to socialize thereby mental health problems are suppressed since mental problems makes people to be isolated. For instance, Ntcheu CCAP established a project for men, after looking at men's isolation in life. They put it in place bail out men from the fears that comes due to their family obligations. It also as act as a model in the society, people have confidence in the church therefore this create a space for the church to have influence on the lives of people. A church member responded that:

> *"the church is where we get most of our help from. During the time when Covid-19 hit Malawi we found our solace from the church as thy*

boosted our hope of a possible change, they stressed on the bible statement that says …this too shall pass…my family and I had our lives full of hope due to this."[140]

As a researcher, from the said opportunities, it is clearly observed that the church has many opportunities to utilise when dealing with mental health problems in Malawi. The Sunday schools should be fully utilised as many of the untamed behaviours that people are portraying are as a result of missing of religious based foundation upon their orientation to the world. Several explanations have been proposed to account for positive correlations between religion and mental health. These include positive cognitive appraisals, increased social support, healthy lifestyles (diet, less alcohol and drugs) and supportive relationships with God [141]. As many people have confidence in the church, many Christians view that the church provide a healthy environment for everyone unlike political affiliates. The church through the inspired word of God it gives a unique aspect on all aspects of life. It is the only body that renders support to mental problem at its entirety. More altruism and gratitude in the religious have been cited as mediating factors in the links between religion and mental health[142]. This is not to ignore the fact that at times religion may negatively impact on health through inducing guilt and dependency and in extreme cases may precipitate suicide[143].

[140] Respondet at St Michael and All Angels church. 12 September,2023

[141] Dein, S. Religon and Mental Health. Royale college of Psychiatrists.2013

[142] Schwartz, C. (2003). *Altruistic Social Interest Behaviors are Associated with Better Healt*h. Psychosomatic Medicine, 65, 778-785.

[143]Dein, S., & Littlewood, R. (2005). Apocalyptic suicide: From a pathological to an eschatological interpretation. International Journal of Social Psychiatry 51, no 3 (2005)

4.3.11.2 Challenges

Firstly, Stigma, is one of the challenges faced by the church in the course of addressing mental health problems. Stigma is a mark of disgrace associated with particular circumstance and affects the quality of life[144]. it is unseen and unintended, stigmatisation makes people who are experiencing a mental health challenge to feel ashamed and discouraged from seeking assistance from others.

Secondly, it is noted that most of the religious institutions fail to assist those affected with mental problems due to the rising of secularism. Secularism is the complete separation of religion and life, this is attributed mainly due to the coming together of countries through trade and communication. In this modern era there is an inclination of any religious ideology as influenced by people who termed themselves as *Atheists* or *Naturalists.* This has an influence into the societies where others tend to adopt these modern ideas. Others they even seek to completely destroy religion by mocking it and identify it as a weapon of social injustices. The ideas of secularism condemn all religious faiths and even religious initiatives. It is then difficult for the church to preach massages to those groups of people, as they may not take anything that comes from a religious people even though they might be facing challenges, they won't accept any form of assistance from the religion.

Furthermore, most of the religions have limited funds to address mental problems that come as a result of unemployment, as one respondent uttered that:

> *"this church is really rendering support to many people but it's unfortunate that we do not offer direct loans to youths who are struggling to acquire a job opportunity. But still there is hope for those who have a little something to access loan through the project of Bank mu Tchalitchi, this is a financial group formulated by members of CCAP to deposit their money and have an access to loans. However, many youths do not access this loan as they do not have money to be part of the financial group."*[145]

[144] Chichi Obuaya. Mental health stigma in the church (Church of England, 2022)

[145] Respondent at Zomba CCAP. Church member. 12th January,2024.

4.3.12 RIs imposing Mental health problems in Malawi

From the various interviews with church members attributed to some of the newly introduced religions as tools imposing mental problems rather than promoting it. One respondent explained that:

> *"the introduction of the modern-day ministers, these are people who claim to predict the future of people in the process of proclaiming the word of God. Most of them they do not undergo theological trainings as such, most of them do not know how to interpret the bible, they focus on the literal translation of the bible and they do not render the recommended psychosocial therapy. This brings confusion to the members, even the massages they deliver mostly are that of prosperity or physical satisfaction. With this idea of physical satisfaction many believers lose trust in religions for example, there are communities that defies most of the charity works by the church. Apart from that their ministration is concerned with offerings, the offerings have various names namely; a seed, tithe, blessing the pastor, development and thanksgiving. This idea of influencing people to give to the church are also some of the mental health problem triggers meaning to say that instead of the church to bail out people from various mental problems, the church itself is there to impose mental problems to people."*[146]

In line with this Dien, argued that religion is being known with valid attributes that positively impact people's mental well-being, however this is not to ignore the fact that at times religion may negatively impact on health through inducing guilt and dependency and in extreme cases may precipitate suicide[147]. For instance, a man in Phalombe committed suicide inside the church as the money he worked for in the farms amounting to K12,000 was taken by his wife who later then hand over it to the

[146] Respondent. Church member, 20november,2023

[147] Dein, S., & Littlewood, R. (2005). Apocalyptic suicide: From a pathological to an eschatological interpretation. International Journal of Social Psychiatry,

prophet as a seed.[148] These discussed ideas made it difficult for some other churches who come in good faith to support those in need.

4.4 Conclusion

This chapter presented the findings and discussions from the data which was collected through focus group discussions and in-depth interviews among the Blantyre synod congregates which includes church ministers, church elders and ordinary members, health care providers and police officers. The data collected has been analysed and discussed the possible highlights to the current situation. The researcher presented twelve findings. Amongst others it is noted that mental health issues are neglected in Malawi, mental health challenges are increasing in Malawi, depression is the main mental disorder, the RIs have a role to play in mental health. The next chapter, will present the conclusion of the study.

[148] Nyasa times news,2023

CHAPTER FIVE

CONCLUSION AND IMPLICATIONS

5.1 Introduction

This chapter presents the implications and conclusion basing on the research findings of the research on "The Exploration of the roles of Religious Institutions in mental health in Malawi. The case study of Blantyre CCAP synod". The chapter also brings up contribution of this study, and some suggested areas of further research to explore more on Mental Health in Malawi.

5.2 Summary of the Findings

The research study has established the following twelve major findings:

1. Mental health issues are neglected in Malawi.

2. Mental health challenges are increasing in Malawi.

3. Depression is the main mental health problem in Malawi.

4. There are various misconceptions on mental health in Malawi that makes it hard to effectively address the situation.

5. There are barriers to mental health care in Africa.

6. Religion influences mental health.

7. Medical mental health care should consider patient's religion prior to treatment as medical care is never enough to promote mental health.

8. RIs are at the best position to deal with mental health issues that requires CBT

9. Fellowship is one of the effective CBT the church renders.

10. Sacred religious texts are tools for behavioural change.

11. There are challenges encountered by the RIs in addressing mental health problems.

12. Some RIs are imposing mental health problems in Malawi.

5.3 Contributions of the Study

The study has contributed to one of the neglected aspects of mental health. The study mainly focused on Mental Health and Religion. It unveils the impact of Religious Institutions in curbing mental health related problems. Firstly, the study deployed Blantyre CCAP synod as an indicator to identify areas of opportunities, successes as well as areas that negatively impact the RIs in addressing mental health problems. Secondly, the study has unveiled the realities of how mental health issues are treated or handled by the government of Malawi, therefore, it serves as an eye opener to the government to further make strategies on how it can improve mental health care services in Malawi. Thirdly, the study will help some RIs who are not taking part in the mental well-being of people to identify and know their roles in mental health. Fourthly, the study has impacted knowledge of mental health in a religious point of view, this purely attributes that mental health issues are not dealt with within medical settings only but it also furthers to other entities, even at the Church. Lastly, as a researcher I have learnt a lot from this study. My previous knowledgee on mental health has been sharpened. The knowledge I have gained from this study will help me to understand mental health with a clear picture and I will be able to discover the reasons behind other people's ill behaviours and render possible support where necessary. This will act the same to everyone who will come across this research study.

5.4 Implications of the Study

The study has the following recommendations:

Firstly, the study has found out that mental health issues are neglected in Malawi, the government of Malawi does not allocate enough funds towards mental health, it does not recruit enough mental health care providers, the mental health policy was established way back in the early 2000, it cannot merely address the now mental health issues as the population of people has increased and also the mental health care infrastructures are few and are all urbanised, therefore making it difficult for those in rural areas to access its services. In this sense, the government of Malawi, should develop a mental health policy that will address the stated problems and guided by a set of goals that must aim at changing the negative perception of mental disorders by the public, reduce the incidences attributed by mental disorders and the prevalence of mental disorders including those that are associated with inappropriate use of addictive substances and providing adequate care for the mentally ill.

Secondly, to curb the increase in mental health challenges the government of Malawi should associate culture and religion as those two influences the value of understanding of concepts, in the case of mental health, the two scopes will help the society to understand the symptoms of mental illness, access to valid service providers, pathways through care, the way individuals and families can manage the illness, degrees of acceptance and support and the degree of stigma and discrimination.

Thirdly, the government through the ministry of education (MOEST) should incorporate mental health education in the curriculum as schools are environments that provides early opportunities for students to connect with the world, thus individuals beyond their confined immediate families the schools offers emotional milestones that contribute to the students' personality development. Therefore, incorporating mental health in education curriculum will probably ensure that students lead a productive and fulfilling life.

Mental health care providers should consider patients religion prior to treatment, they should support a healthy religious belief, challenging unhealthy beliefs, praying with patients more especially in selected cases and consult a well-trained chaplain. This serves as a psychological and a social factor that may assist in

healing. The psychiatrists should always demonstrate respect for the patient's religious and spiritual beliefs.

The RIs should provide counselling, prayer and support to people experiencing an adverse life situation. Counselling that should involve massages of hope and optimism, this can be applicable to people, who are experiencing adverse situation of unemployment, relationship issues and faith issues. Counselling help people to change their perception on the issues affecting their lives.

The RIs as assets that offer opportunities for people to develop coping skills against their adversaries, they should establish a set of principles and values that help an individual to navigate their lives and manage their stressors and distress, they should also focus on commending the required behaviours that are cantered on values such as honesty, integrity, justice, compassion, cooperation.

In addition, the RIs should work hand in hand with mental health care providers, this helps in the healing process of people with various mental illnesses, this creates a pampering environment for a steadfast recovery.

Furthermore, the RIs should incorporate teachings about the "Essence of life", they are stressing on the love of one's life where people are reminded on the importance of life and come up with relevant options to sustain that particular life instead of ending it. For instance, they are advising people to save money and make valid investments to carter for their families.

Finally, Mental health awareness campaigns should be provided and reach all stakeholders thus, community religions, community leaders, community members. If the community is not aware of mental health, then it will be a problem for them to change their ill perceptions of mental disorders and those affected will be left in a vacuum and face all sorts of discrimination.

5.5 Areas of Further Research

The topic "Exploration on the role of Religious Institutions in mental health in Malawi" is very complex to be tackled using a singular aspect, as issues to deal with mental health falls under many aspects for instance, to uncover the hidden

concepts about mental health, it's inevitable that the researcher will be concerned with mental health in medical settings, political settings, religious, culture and society. Therefore, through this study the researcher suggests the following areas of further research: "Exploring the behaviours associated with people with mental problems", "Assessing the lived experiences of people who attempted suicide", "The impact of community involvement in mental Health" and "Evaluating the impact of Primary Health Care in overcoming mental health problems."

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APPENDICES

Appendix 1: Study Questionnaire

Introduction

My name is Chifundo Orcilla Mtisau from the University of Malawi. I am currently conducting a study on Mental Health. Mental Health problem is a global health concern which is affecting all continents. There has been a steady rise in suicide, drug and substance abuse just to mention a few. In Malawi mental health cases are increasingly becoming a big concern as enormous number of people are taking away their own lives, indulging in various illegal activities and emerging in poor health decisions.

This research will therefore explore the role of Religious institutions in mental heath using Blantyre synod as a case study, since various researches and clinical evidences have suggested that the church can be the most influential body to lower the risk of mental health related problems. The findings from this study will provide valid information on how the church can contribute in mental health.

You are therefore, been randomly selected to participate in this study and you are free to choose whether to participate in this study or not.

Your contribution will be highly appreciated

Title: The role of Religious Institutions in mental health. The case study of Blantyre CCAP Synod

1. Sex: a. Male b. Female

2. Age: a. 16-20 b. 21-25 c. 26-30 d. 31-35

e. 36-40 f. 41-45 g. 46-50 h. 51 and above

3. vocation: a. Employed b. Unemployed c. student d. Business person

4. Marital status : a. Married b. single c. Widowed

5. Highest level of education: a. No formal education b. Primary c. Secondary

d. Tertiary

Section A: General Question

Q1. Have you ever heard of Mental Health?

Section B: The situation of mental health in Malawi

Q1. What is the situation of mental health in Malawi?

Q2. Who is likely to be the victim of mental health in Malawi?

Q3. What are the most root causes of mental health problems in Malawi?

Q4. Negative impacts of mental health?

Section C: Contributions of Malawi Government towards mental health

Q1. What is the government of Malawi doing to curb the situation of mental health?

Q2. Do you think the strategies put in place are rendering out positive results?

Section D: The role of the church in mental health

Q1. How would the church be of help in mental health?

Section E: Recommendations and Advices

Q1. What advice would you give to address the challenges of mental health in Malawi?

Q2. What recommendations would you give to the church pertaining to the issues of mental health?

Appendix 2: Questions to Medical personnel from Matawale Health facility and Zomba Mental Hospital

1. What is your understanding about mental health?

2. What is the situation of mental health in Malawi?

3. What are the root causes of mental health?

4. Describe some of the categories of mental health related illnesses?

5. How would you detect or predict a mental health illness in medical settings?

6. Who are likely to be the victims of mental health?

7. What kind of strategies do medical facilities use to overcome mental health problems?

8. Narrate how you counsel a person with a life threatening illness or a palliative patient?

9. How can a person maintain a good mental well being?

10. What happens to those who spent a longer period in psychiatric hospitals?

11. Apart from medical attention, what else has been proven to curb mental health problems?

Appendix 3: Questions to church leaders from St. Michael and all angels CCAP and Zomba CCAP

1. What is your understanding about mental health?

2. What is the situation of m,mental health in Malawi?

3. What roles are you playing as church leaders to reduce the rise of mental health related challenges?

4. Explain on the church's teachings on mental health

5. Is there any challenge that can prevent the church to participate in mental health in malawi?

6. Do you have sessions that involve church members to discuss on issues affecting their lives?

7. As a church leader how would you counsel people who are passing through hard times?

8. How does the bible address mental health issues?

9. Is the church concerned with mental health?

10. Imagine, if you were to be a chaplain in a mental health institution , what would be the basis of your preaching?

Appendix 4: Focus Group Discussion Questions

1. What's your understanding about mental health?

2. What are the causes of mental health in Malawi?

3. What roles are you playing as Christians to overcome mental health problems?

4. What strategies can you partake to prevent issues of suicide , drug and substance abuse and prostitution amongst youths?

5. Narrate any story you have heard in relation to mental health

6. Have ever been diagnosed with a mental health related illness or being mentally affected ?

7. As Christians how would you render support to people or a person going through hard times, attempted to commit suicide

8. How would you render or help non- Christians in regard to mental health?

9. What advice and recommendations would you give to churches on mental health?

10. How can church members be models in the communities they are based?

Appendix 5: Letter of Introduction

SCHOOL OF HUMANITIES AND SOCIAL SCIENCES

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12th January, 2024

TO WHOM IT MAY CONCERN

REFERENCE LETTER FOR MS. CHIFUNDO MTISAU (MA/TRS/05/21)

The bearer of this letter **Ms. Chifundo Mtisau (MA/TRS/05/21)** is a UNIMA student pursuing a Master's Degree in Theology and Religious Studies at the University Of Malawi. As part of the requirement for the degree she is supposed to conduct research and write a dissertation.

We would therefore, deeply appreciate any assistance you could give her in terms of responding to questionnaires and/or interviews.

Yours faithfully,

H. Mvula, PhD

HEAD - TRS