Your A-Z on Mental Health
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Prof David Musyimi Ndetei

Acrodile Publishing Ltd
ACKNOWLEDGEMENTS AND DEDICATION

This book is a result of collective effort by people of various backgrounds all working together for a common goal. I am grateful to them all for their efforts. I am also grateful to Grace Mutevu for coordinating this exercise and Africa Mental Health Foundation for all the administrative and logistical support. Very special thanks to the Publisher Acrodile and in particular Christabel Otsyeno. They trusted me to do the job on the basis of my ideas and concepts rather on the basis of an already available manuscript. I cannot thank them enough for such trust in me. They remained supportive and available all the way from translating the ideas and concepts to a manuscript and a book.

Finally, I thank my patients and their relatives who have been and still remain my best teachers in psychiatry and mental health and who inspired me to produce a book like this one. This book is my thank you to them for being good teachers and I dedicate it to them and the general lay public.

Prof. David M. Ndetei
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According to the World Health Organization, mental disorders currently account for about 12.5% of the total burden of disease. This is expected to rise to 15% by 2020.

Whereas the resource-rich countries have the ability to address the problems posed by mental disorders, this is not the case with poor developing countries, most of them in Africa. For most countries South of Sahara and outside South Africa, and with the exception of Kenya, they have one psychiatrist for more than one million populations. The Kenyan situation of one psychiatrist for about half-million population is no solace at all. Most of the psychiatrists (just about 70 in May 2009) are to be found mostly in the main urban areas where many are not involved in day-to-day clinical work for the general public who cannot afford private treatment. Similarly, we have a gross deficiency of other health professionals with an interest in mental health.

The long and short of it is that many people in Africa with mental illness grope in the dark. They have no access to appropriately trained mental health workers to turn to. They do not even know when they have mental disorders except when they are grossly disturbed when friends and relatives go seeking for the hardly available services.

It is therefore necessary to impart some knowledge to the general public so that at least they can recognize the more subtle disorder in addition to the severe ones. Through knowledge they can have increased awareness and seek help from friends. More importantly, they will understand themselves.

The book covers a wide range of topics. It includes mental health disorders and how they are generally recognized and managed,
covering the whole spectrum of life. It also includes description of subjects of interest in relation to mental disorders. These include rights of people with mental disorders and the spiritual aspects of mental disorders to emphasize the fact there is nothing demonic about mental disorders any more than anything being demonic about malaria. People also find themselves in special situations, such as the prospects of death and dying, either of a relative or friend. People also have to deal with emotions as a result of the death of a relative or a friend. Of special interest is the person who is facing imminent death of self and knows about it. There are also those who actually think of taking away their lives.

Besides describing those common situations, the book also addresses various approaches to the management of various mental health disorders and situations, by mental health workers but most importantly what they can do for themselves in their homes and in mitigations against the costs and stigma of mental illness. The book has given a chance to people with mental disorders to express themselves.

It is hoped this book will serve to demystify mental disorders, and in the process significantly destigmatize people with mental disorders and in the process allow them together with their relatives, to come forward and demand for equal treatment, services and rights from the health professionals, policy makers, and medical insurers. This book is a must reading for everybody who cares for their mental well-being and that of others.

Signed by

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PART I
GENERAL INTRODUCTION
CHAPTER 1

WHAT IS MENTAL HEALTH AND WHAT IS A MENTAL DISORDER?

David M. Ndetei

Mental Health

The World Health Organization defines health as “the state of physical, psychological (mental), social well-being and not just the absence of disease.” When we talk about mental well-being, then, we talk about how well we feel about such things as happiness, peace of mind, ability to meet the demands of life, relationships with others, joy, satisfaction with ourselves and others (especially our families and social associates), our desires, ideas, ambitions, and other similar matters. Mental health, then, is much more than just being free of mental disorders.

Mental health should not only be considered in relation to an individual but also to members of a community and to the nation as a whole. For example, many communities in various countries are mentally unhealthy given the strife, violence, and hate in them.

Healthy Ways of Expressing Emotions

In real-life situations, there will be challenges such as loss or rejection, disappointment, disagreements, and other similar experiences, which stir up strong emotions such as hurt, anxiety, anger, guilt, and depression. In order to maintain or sustain good mental health, we
must learn and practice healthy ways of coping with such challenges. If not done, we may develop physical and social complications. For example, if someone hurts you, the best way to deal with it is not to bottle up the hurt. You need to evaluate and determine the source of your hurt and express your feelings about it with a caring listener.

In the same way, if you are anxious about anything, a healthy approach is to discuss the issue with a trusted friend. You can then together try to identify the causes of the anxiety and the positive ways of confronting them. The best way, of course, is to minimize the anxiety altogether. You can also handle anger and guilt in the same way as hurt and anxiety.

If these conditions are not properly handled, they have the potential to affect your blood pressure and adversely affect your heartbeat, which can lead to headaches and other complications of high blood pressure and heart disease. They can disturb the way your body uses sugar, which can result in diabetes. They may also affect your lungs and air passages, which can cause asthma. Stomach and intestinal ulcers and depression are also common complications of these conditions.

When people become depressed, they feel sad, unhappy, discouraged, and low-spirited. If depression is allowed to persist, it may lead to the physical complications detailed above. Severe depression may cause suicidal thoughts and plans, which may eventually turn to reality.

Mental Disorders

People have a mental illness, if there is a departure from mental well-being severe enough to interfere with their mental health. Mental disorders can be caused by physical diseases, such as infection of the brain by parasites (e.g., malaria), viruses (such as that which causes AIDS), and bacteria. It can also be caused by physical accidents or through assault, which involves the head. Cancer of the brain and a stroke (i.e., a rupture or a clot in the brain) can lead to destruction of brain cells. There are also certain generalized diseases of the body that
can have adverse effects on the brain, such as uncontrolled diabetes and diseases of the kidney, the liver, and other bodily organs.

All the above physical conditions lead to diseases of the brain generally referred to as organic diseases of the brain. However, there is a wide range of mental disorders that do not have discernible physical causes, only chemical changes that do not necessarily physically injure the brain cells. These are called functional mental disorders. Other causes of mental disorders include social and emotional stressors, depending on the type of mental health disorder. These will be discussed under the appropriate chapters. In addition to their specific symptoms, mental disorders have an effect not only on the individual but also on others, especially the family and the society in general. These effects will be discussed under specific mental disorders.

From the above, it can be seen that there are three possible broad categories of causes of mental disorders biological, psychological, and social. They tend to act in combination and in a complementary manner. The management of mental disorders also involves all these broad approaches: biological, psychological, and social.

A commonly asked question is whether mental disorders are inherited or not. While it is true that some mental disorders tend to run in families, it is also equally true that there are many people with mental disorders whose families do not have a history of mental disorders. It is the same as the fact that there are many physical conditions that run through families, such as obesity, diabetes, high blood pressure, and certain types of cancer, as well as several other ailments. It is misleading to see mental disorders as the only conditions that run in families.
CHAPTER 2

SPIRITUALITY AND MENTAL HEALTH

Gregory Kivanguli Nzioka

Editor's note: The writer is a long-serving trained clergyman who holds a Masters degree in Pastoral Counseling from one of the leading universities in Kenya. He is a dean of students and a lecturer in one of Africa’s leading theological colleges based in Nairobi. Since he is writing on an area that is not talked about much, references have been retained at the end of the chapter for those who are interested in further reading.

- David M. Ndetei

Understanding Spirituality, Religion, and Health

Attempts have been made by various authors to define and distinguish between religion and spirituality. We shall examine some of these definitions.

Spirituality

Spirituality can be described using one or more of the following elements:

- A sense of purpose
- A sense of connectedness---to self, others, nature, “God” or Other
- A quest for wholeness
- A search for hope or harmony
- A belief in a higher being or beings
• Some level of transcendence, or the sense that there is more to life than the material or practical
• Those activities that give meaning and value to people’s lives.

In an effort to make sense of the world, human beings use spirituality as the vehicle through which meaning is sought. It will therefore vary according to age, gender, culture, political ideology, physical or mental health.

Spirituality has also been described as that aspect of human existence that gives it its humanness. It concerns the structures of significance that give meaning and direction to a person’s life and helps them deal with the challenges of existence. As such, it includes such vital dimensions as the quest for meaning, purpose, self-transcending knowledge, meaningful relationships, love and commitment, as well as [for some] a sense of the Holy among us. The above description of spirituality supports the view that humans are social, biological, emotional, physical and spiritual beings, and any understanding of the relationship between spirituality and mental health exists within that integrative context.

Spirituality has broadened its meaning into a more diffuse human need that can be met quite apart from institutionalized religious structures. It is the outward expression of the inner workings of the human spirit. Spirituality is an intra-, inter-, and transpersonal experience that is shaped and directed by the experiences of individuals and of the communities in which they live out their lives. There are internal, group, community and transcendent elements to spirituality.

Religion

Religion has been defined as:

• Belief in a divine or superhuman power or powers to be obeyed and worshipped as the creator(s) and ruler(s) of the universe. It constitutes the expression of such a belief in conduct and ritual.
• Any specific system of belief, worship, conduct, etc., often involving a code of ethics and a philosophy [e.g., the Christian
religion, the Buddhist religion]. It includes any system of belief, practice, ethical values, etc., resembling, suggestive of, or likened to such system (humanism as a religion).

It is difficult to distinguish a spiritual person from a religious one and so religion and spirituality have further been defined as follows:

- Religion is an organized system of beliefs, practices, rituals, and symbols designed to:
  ¾ Facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality), and
  ¾ Foster an understanding of one’s relationship and responsibility to others in living together in a community.
- Spirituality is the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community.

The difference between religion and spirituality can be further clarified in the following figure:

**Characteristics Distinguishing Religion and Spirituality** (Source: Koenig, McCullough, and Larson, 2001).

<table>
<thead>
<tr>
<th>Religion</th>
<th>Spirituality</th>
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<tbody>
<tr>
<td>Community-focused</td>
<td>Individualistic</td>
</tr>
<tr>
<td>Observable, measurable, objective</td>
<td>Less viable and measurable, more subjective</td>
</tr>
<tr>
<td>Formal, orthodox, organized</td>
<td>Less formal, less orthodox, less systematic</td>
</tr>
<tr>
<td>Behaviour-oriented, outward practices</td>
<td>Emotionally oriented, inward directed</td>
</tr>
<tr>
<td>Authoritarian in terms of behaviours</td>
<td>Not authoritarian, little accountability</td>
</tr>
<tr>
<td>Doctrine separating good from evil</td>
<td>Unifying, not doctrine oriented</td>
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The Major Dimensions of Religion

Twelve dimensions of religion have been identified including:

1. Religious belief

This is the most basic level of religion. Religious belief is often measured in terms of orthodoxy of belief. It involves the extent to which the individual beliefs conform to the established doctrine of a religious body. For example, to what extent do the individual's beliefs conform to the Christian faith as established in the early ecumenical creeds and confessions of the church?

2. Religious affiliation or denomination

Religious affiliation refers to identification with a particular religious group. However, this affiliation does not necessarily indicate the level of religiousness of the individual.

3. Organizational religiosity

Organizational religiosity refers to participation in church, synagogue, or temple activities and is a measure of the social dimension of religion. It can be contrasted to nonorganizational religious activities such as personal prayer, scripture reading, or religious TV viewing, all of which can be done in private. The lowest level of organizational religiosity is church or synagogue membership. Typically, organizational religiosity refers to attendance at religious services. It can also refer to religious social activity such as attending church or synagogue dinners, socials, picnics, or other social meetings. It means participation in Bible or scripture study groups, or home fellowship groups, including holding church offices, such as deacon or elder. Other dimensions of organizational religiosity include participation in communion and giving financial support to the church.

4. Nonorganizational religiosity

Private prayer is considered the primary religious activity that defines this category. The capacity to experience God through prayer is the
centre of Christian spirituality. Prayer is a conversation with one’s creator. It may be divided into six categories depending on the activity involved: petitionary prayer, intercessory prayer, prayer of adoration, prayer of confession, contemplative prayer, and meditative prayer. Each of these forms of prayer is briefly discussed.

- **Petitionary prayer** involves making specific, directed requests or petitions to God; a specific outcome is requested (e.g., please heal my painful knee).
- **Intercessory prayer** involves praying for another person or persons and is also usually (although not necessarily) directed to a specific divine being for a specific outcome.
- **A prayer of adoration** involves praising, thanksgiving, or displaying honor or love toward God or other divine being.
- **A prayer of confession** involves admitting to a particular sin or mistake and asking forgiveness from God; part of this prayer may also involve some type of penance or activity directed at correcting the mistake.
- **A contemplative prayer** is usually nondirected and is without any specific goal attached to it. In the Christian tradition, it may simply involve listening to God, with or without reference to a specific topic. In other traditions, it may involve sitting quietly and clearing the mind or thoughts and is thus similar to meditative prayer. Meditation usually involves clearing the mind of thoughts and focusing, concentrating, or directing attention to a specific word or phrase. The most common example of meditation is Buddhist meditation or transcendental meditation or mindfulness meditation. Meditation does not necessarily have to relate to the transcendent.

There are several themes regarding the psychological effects of prayer.

- **Prayer is associated with a subjective experience of well-being.** Compared with those who do not pray, or who pray infre-
quently, those who pray frequently often tend to experience more purpose in life, greater marital satisfaction, religious satisfaction, and a general sense of well-being. An even better predictor of well-being is the extent to which people experience a subjective sense of God’s presence while praying. Those who experience prayer as a deeply significant, even mystical, experience have a greater sense of well-being than others.

- Prayer is a helpful resource in coping with various medical problems. Studies have demonstrated that prayer is often used by those experiencing high levels of physical and emotional discomfort.
- Several studies on the relationship between psychological symptoms and prayer indicate that prayer appears to be positively related to abstinence for those in alcohol treatment and negatively related to fears of dying.
- One well-designed study demonstrated the effectiveness of intercessory prayer. Patients in a coronary care unit were randomly assigned to either the control group or the group that met outside the hospital on a regular basis. Neither the patients nor the researchers who assessed the outcome knew to which experimental condition the patients were assigned. On some (but not all) of the outcome measures, the recipients of intercessory prayer were healthier upon discharge from the hospital than the control group.

Other nonorganizational religious activities include reading religious scriptures or inspirational literature, watching religious television, and listening to religious radio.

5. Subjective religiosity

Subjective religiosity taps that internal sense of religion’s importance in the individual’s life. It deals with the question—how religious does a person consider himself to be? This is an entirely subjective dimension that relies upon self-report. While related, subjective
religiosity is not the same as religious commitment, or intrinsic orientation. A person may see herself as very religious and yet score relatively low on more objective measures of religious commitment or intrinsic motivation.

6. Religious commitment/motivation
Religious commitment is a term used to reflect degree or level of religiosity. It attempts to capture how internally committed the persons are to their religion. Intrinsic religious motivation or intrinsic motivation is one of the best indicators of religious commitment. The intrinsically religious persons find their master motive in religion. Other needs, strong as they may be, are regarded as of less ultimate significance, and they are, so far as possible, brought into harmony with religious beliefs and prescriptions. Having embraced a creed, the individual endeavors to internalize it and follow it fully. It is in this sense that they live their religion.

In contrast, the extrinsically religious person is interested in religion only in order to achieve a different, nonreligious goal. Persons with this orientation are disposed to use religion for their own ends. The person may find religion useful in a variety of ways—to provide security and solace, sociability and distraction, status and self-justification. In theological terms, the extrinsic person turns to God, but without turning away from self.

7. Religious “quest”
Religious quest is a religious orientation that is distinct and separate from either intrinsic or extrinsic religiosity.

8. Religious experience
Religious experience is that dimension of religion that includes: religious conversion (gradual and sudden types), “born again” experiences, mystical experiences, physical or emotional healing, and other experiences relating to God, the transcendent, or ultimate reality.
Religious conversion may involve a gradual turning to religion or transforming of nominal belief into something deeply personal and meaningful over a period of many years. Religious experience may also be very dramatic and completely life-changing, to an extent of altering the personality. Among the conservative or evangelical Protestant Christianity, to be “born again” is to have a personal life-changing experience with Jesus Christ that “saves” the person experiencing it. This phrase is drawn from the account in John’s Gospel chapter three, where the Pharisee Nicodemus encountered Jesus.

Other religious experiences include:

- Mystical experiences that involve “becoming one” with the universe or with God, or related phenomena.
- Physical or emotional healing initiated by a spiritual or religious activity. Religious conversion may be accompanied by such physical or emotional healing, which people tend to remember long afterward and retell as their “testimony”.
- Feelings of closeness to God or the transcendent, feelings or awe or wonder related to other spiritual experiences, or fear and terror related to negative religious experiences.

9. Religious well-being

Spiritual well-being is composed of religious well-being and existential well-being. Existential well-being has to do with general well-being and life satisfaction whereas religious well-being deals with feelings of having a personally meaningful, satisfying and fulfilling relationship with God.

10. Religious coping

Religious coping involves religious behaviours or cognitions designed to help persons cope with or adapt to difficult life situations or stress. Examples of coping activities include: praying to God to change a situation or to give emotional strength (petitionary prayer), consciously deciding to “turn a situation over to God,” reading inspirational
scriptures for comfort or relief of anxiety, talking with a minister or chaplain to help work through a problem, or employing any other religious thoughts or behaviours that are used to relieve stress.

11. Religious knowledge
Religious knowledge concerns the amount of information and knowledge that person has about the major tenets or doctrines and history of their religious faith. For Christians, this knowledge is commonly measured by asking about familiarity with the Ten Commandments, the Sermon on the Mount, the two great commandments, the names of biblical prophets, etc.

12. Religious consequences
Devout religious belief and practice should also have practical consequences in the way people live. This may involve giving money to support the church, the poor, or the hungry (tithing and gifts), acts of altruism (helping a neighbor in need), volunteering (offering one’s time and talent for a good cause), or helping out in church (e.g., as a part time custodian, secretary, or deacon).

Religion to the lay person means a realm of influence and existence beyond an individual’s control or comprehension (mysticism, supernatural), faithful devotion to a deity, religious beliefs and observances, and a set of normative values and behaviours. The essential element in all religion is a belief in spiritual beings.

Health Benefits of Spirituality
Religious involvement has been found to be significantly correlated with the following:

- Well-being, happiness, and life satisfaction
- Hope and optimism
- Purpose and meaning in life
- Higher self-esteem
- Bereavement adaptation
• Greater social support and less loneliness
• Lower rates of depression and faster recovery from depression
• Lower rates of suicide and fewer positive attitudes toward suicide
• Less anxiety
• Less psychosis and fewer psychotic tendencies
• Lower rates of alcohol and drug use and abuse
• Less delinquency and criminal activity.

Religion is thought to comfort, relieve pain and suffering, make life worth living, provide hope and meaning, and help people cope with problems. Persons with strong religious beliefs have been found to have lower distress levels than persons with weak beliefs. Identification with institutions, religious or nonreligious, by choice versus by default, may be an important factor in psychological well-being.

Religious involvement is associated with better physical and mental health. Religion can be especially helpful to those whom society has marginalized, and religious involvement is more helpful when circumstances have exhausted a person’s resources and when it is well integrated into a person’s life. Positive religious coping is characterized by faith in God (or a higher power); the belief that God loves, cares for, and strengthens one; and the sense that one is working with God to manage and cure illness. Negative religious coping is characterized by feeling punished or abandoned by God, believing that illness is a result of sin, and similar cognitions. Substantial evidence suggests that positive religious coping is associated with better illness course and outcome and that negative religious coping has the opposite effect, especially with regard to increasing depression and anxiety.

The positive impact of religion and spirituality on health has been found in the areas of prevention, recovery, and coping ability in a wide range of conditions, including high blood pressure, cerebro-vascular disease, heart disease (including substantially increased survival in the elderly after heart surgery), immune system dysfunction (increased survival time in AIDS patients), improved coping with cancer, in living with pain and disability, and smoking prevention. Attending religious services more than once weekly increases the lifespan.
There are four mechanisms by which religion benefits health. These mechanisms are briefly discussed.

Health Practices

Religious participation promotes good health habits that in turn have positive effects on health and longevity. Some religious faiths explicitly prescribe good health habits. For example, the Mormon religion prohibits smoking, alcohol, and sex outside of marriage as well as providing guidelines for diet, amount of sleep, and time spent with family. Other religions like, Seventh day Adventists and Black Muslims have strict rules about health habits. Most religions teach their members to take care of their bodies. Many religious organizations adhere to the tenet that “the body is the temple of the soul,” and gratitude for good health and the gift of life is an integral part of many religions.

Social Support

One of the consequences of religious involvement may be access to and opportunities to develop social ties with more people with whom one shares a worldview than are available to nonreligious persons. These higher levels of social support may promote better health and longer life among religious persons. Attending services increases the likelihood of developing social networks and support systems more than private devotions or religious coping.

Psychosocial Resources

Another mechanism that may partially explain the health benefits of religious participation is psychosocial resources such as self-esteem, self-efficacy, and mastery. There is evidence that these psychosocial resources are associated with better health. Self-esteem, self-efficacy, and mastery have been demonstrated to mediate the effects of several other social factors that predict health and mortality, including socioeconomic status, stressful life events, chronic stressors, and social support.
Sense of Coherence or Meaning
Sense of coherence has three components: meaning, predictability, and manageability. Beliefs that the world is meaningful, predictable, and manageable are important “resistance resources” that permit individuals to experience stress as less threatening, to cope more effectively with it, and to be less likely to experience stress-related illness.

Factors Mediating the Relationship between Spirituality and Mental Health
Rather than assuming that effects of spiritual or religious activity reflect the intervention of a divine being or god, other factors may explain and account for those effects. These factors are:

- Coping styles,
- Locus of control,
- Social support and social networks,
- Physiological mechanisms, and
- Architecture and built environment.

Coping Styles
Religious coping has been conceptualized as a mediator to account for the relationship between spirituality and mental health. There are three types of coping: collaborative, deferring, and self-directing styles.

- The collaborative style refers to an individual who enters into collaboration with God when problems arise. God is seen as a partner in the problem-solving process and the responsibility for a solution is perceived by the individual to be a shared process.
- A deferring approach is one in which individuals take a passive role in the resolution of problems, trusting God to fully resolve the problem without their intervention.
- The self-directing person assumes full responsibility for their problem solving and is theoretically based on the belief that
God has provided (or will provide) the skills necessary for successful coping.

Studies have shown that the three styles of coping mentioned support the important role religion plays in problem solving.

**Locus of Control/Attributions**

One of the ways in which an individual makes sense of the world is the way in which they interpret and give meaning to events or experiences. Proposed causes—or attributions—for events have long been considered important mediators of mental health. An internal locus of control—where the individual believes that they have some power over a given outcome—is usually associated with better mental health than an external locus of control. Religious beliefs and practices play a key role in the development of a strong internal locus of control.

**Social Support**

The support an individual derives from the members, leaders, and clergy of religious congregations is widely considered one of the key mediators between spirituality and mental health. Spiritual or religious support is a valuable source of self-esteem, information, companionship, and practical help that enables people to cope with stress and negative life events. The spiritual community provides support by

- Protecting people from social isolation
- Providing and strengthening family and social networks
- Providing individuals with a sense of belonging and self-esteem
- Offering spiritual support in times of adversity.

**A Physiological Impact**

Certain expressions or elements of spirituality may positively affect various physiological mechanisms involved in health. Emotions encouraged in many spiritual traditions, including hope, contentment, love and forgiveness, may serve the individual by affecting the neural...
pathways that connect to the endocrine and immune systems. Negative emotions that are actively discouraged in many religions, like anger or fear, trigger the release of neurotransmitter norepinephrine and of the endocrine hormone cortisol. Sustained levels of these can lead to inhibition of the immune system, increased risk of infection, elevated blood pressure, and increased risk of stroke and cardiovascular disease. Meditation and silent prayer may reduce the levels of norepinephrine and cortisol, thus reducing feelings of stress and the mental health problems associated with it.

Architecture and the Built Environment

Some people find solace in the significance of specific “spiritual” buildings and architecture, such as churches, temples, or mosques. This sense that architecture can have a spiritual impact is also reflected in the language associated with religious buildings. In many temples, synagogues, and churches, the “inner sanctum” (or “holy of holies”) is traditionally symbolic of the closed room, only accessible to priests and those with divine authority. Many temples, mosques, and churches are imbued with symbolism throughout their design. The walls and the columns of the traditional Christian church represent Heaven and Earth and a cathedral is a visual encyclopaedia illustrating creation. The size of the building can also be very powerful. In many contexts, some individuals find that large spaces or buildings instill in them a sense of their own significance which, paradoxically, makes them feel bigger, greater, or more “connected.” This has long been expressed through art, nature, and music, all of which can be important vehicles of spirituality for many people.

Clinical Indications for Spirituality and Religion

1. Spirituality and Depression

Religious/spiritual factors have generally been found to be linked with lower rates of depression. Persons who both participated in a religious
group and highly valued their religious faith have been reported to be at substantially reduced risk of depressive disorder, while those with no religious link may raise their relative risk of major depression by as much as 60%. Lack of organizational religious involvement was linked with a 20--60% risk of experiencing a major depressive episode. Valuing one’s religious faith is centrally important and actively belonging to a religious group may develop spiritual roots that provide meaning as well as support from others, creating anchors of hope and caring that might help protect against depression.

It can be concluded that:

• Many expressions and elements of spirituality are helpful in reducing depressive symptoms and/or increasing general well-being.
• People who are not affiliated with any religion are at elevated risk for depressive disorder and depressive symptoms.
• Some aspects of religious involvement are associated with less depression. People who are frequently involved in religious community activity and who highly value their religious faith for intrinsic reasons may be at reduced risk for depression. Even when these persons experience depression, they recover more quickly from it than those who are not religious.
• Certain measures of religious involvement---particularly private religious beliefs---are not as strongly related to depression as are organizational religious activities or intrinsic religious commitment.
• Religious involvement plays an important role in helping people cope with the effects of stressful life circumstances.
• Religious or spiritual activities may lead to a reduction in depressive symptoms, and that religiously accommodative psychotherapy is at least as effective as secular psychotherapy for depression.
Case Story

Banda (not his real name) lay in a coma in the intensive care unit (ICU) at a city hospital. He had attempted suicide by swallowing broken glass. His family requested this author to visit Banda and offer prayers. After the request by Banda’s family, I immediately rushed to the hospital and headed straight for the ICU. Banda lay there unconscious and on life-support equipment. I stretched out my arms and touched him and whispered words of hope and comfort from the Bible. I spoke into his ears that God loved him and that He would heal Banda. Then I offered a prayer and left. I did not go back to the hospital to see Banda.

Nearly a year later, I was supping in an upcountry hotel with friends when a gentleman walked over to where we were seated and shouted as pointed at me: “This man saved my life when I was dying.” At that time I did not recognize him, so I was curious to know how I had saved his life. He then informed me that he was the patient I had prayed for in the ICU of a city hospital. He told my friends that when prayer was offered he actually heard although he had been in a coma, and it was that prayer that made him to live. We then exchanged our addresses and he asked if he could come and see me, to which I obliged.

When Banda visited my counseling office, I established that he had been suffering from depression for a while. Coupled with counseling were prayer, the reading of relevant scriptures, and the involvement of his family for support. Ten years later, Banda is fine and appreciates benefits he has received from spiritual and religious resources.

2. Spirituality and Anxiety

The symptoms commonly associated with anxiety can be emotional, intellectual, physical, and/or social (see the chapter on “Anxiety disorders”). Stress and anxiety can have spiritual symptoms, including:

- A loss of meaning in life;
- Obsessional religious thoughts and actions;
- Feelings of alienation and indifference;
- Loss of previous spiritual belief;
Spirituality and mental health

- No sense of the future;
- Fear of death;
- Fear of the consequences “sins” or religiously—defined “bad” behaviour; and/or
- An inability to focus on “God” or to meditate.

Many studies have demonstrated the benefits of spirituality on patients experiencing anxiety. Anxiety has been found to be more common in women who did not use positive spiritual coping mechanisms, especially those who are younger and with more advanced stages of disease. Reduced levels of anxiety associated with spiritual activity have also been found in medical patients in later life, women with breast cancer, middle-aged people with cardiac problems, and those recovering from spinal surgery. People with serious medical illness who are involved in some form of religious activity seem to have some protection from anxiety related to dependency, loss of control, and end-of-life issues.

Case Story

Gloria (not her real name), a middle-aged professional was referred to this author by her sister. For several weeks, she had been experiencing unbearable panic attacks. She talked of moments when she would experience a panic attack while driving alone in her car. Then she could pull over and stop by the roadside and just “freeze” inside her car. This made her stop driving; for fear that she might be involved in an accident.

The initial interview and assessment revealed that Gloria’s problem had started earlier than she realized. Some significant family members had told her things that demeaned and scared her. Consequently, she developed a low self-esteem. Then she found herself in a difficult marriage in which she experienced severe verbal and physical abuse. These experiences made her develop such intense fear that she began to experience panic attacks.

Counseling and therapy included discussions about God as being the source of self-worth, hope, peace, and joy. She was helped to “unlearn”
the negative things people said about her. We read the Bible and prayed together. After three one-hour sessions spanning three weeks, the panic attacks stopped. It is now several years since this author counseled Gloria, and the problem has not recurred. She continues to drive without any fear.

3. Spirituality and Post-Traumatic Stress Disorder (PTSD)

PTSD is a delayed reaction to an abnormal, traumatic life experience, such as war, terrorism, a car or aircraft accident, a natural disaster, or a physical, sexual, emotional, or psychological abuse (see the chapter on “PTSD”). Religion and spirituality are highly valuable to people in times of crisis, trauma, and grief. These studies show first, that religion and spirituality are usually, although not always, beneficial to people in dealing with the aftermath of trauma. Second, they show that traumatic experiences can lead to a deepening of religion or spirituality. Third, that positive religious coping, religious openness, readiness to face existential questions, religious participation, and intrinsic religiousness are typically associated with improved post-traumatic recovery.

Case Story

Mark (not his real name) was injured during a terrorist attack on the American Embassy Building in 1998. He sustained serious body injuries on the head, face, and arms. That experience also left him apprehensive and emotionally unstable hence he ended up in hospital for psychiatric care. He lost hope and trust in this world and began to wonder whether there was any need for him to live. It was then that he was referred to this author for further psychosocial care.

After the intake interview, Mark and this therapist worked out an intervention plan that included several spiritual activities and exercises. These spiritual activities and interventions included prayer, reading of the Holy Bible, and use of other Christian literature. Four weeks after the initial interview, Mark showed remarkable recovery from post-traumatic stress symptoms. For example, fear and apprehension significantly diminished,
sleeping normalized, and appetite improved a great deal. Within three months of therapy, Mark fully recovered from the effects of that traumatic experience and his emotional function was fully normalized.

4. Spirituality and Schizophrenia

Within psychiatry, schizophrenia is seen as a severe and enduring mental illness characterized by disruption in cognition, perception, and emotion (see the chapter on “Schizophrenia”). For many living with schizophrenia, religion and spirituality have an important and positive role. Religion and spirituality play a central role in the process of reconstructing a sense of self and recovery. For individuals who share the same religious values as their family, religiosity can be a cohesive and supporting factor. Similarly, people with schizophrenia find hope, meaning, and comfort in spiritual beliefs and practices.

Certain religious expressions of spirituality may become part of the problem as well as part of the recovery. Some individuals are helped by their faith community, uplifted by spiritual activities, comforted, and strengthened by their beliefs. Others are rejected by their faith community, burdened by spiritual activities, disappointed and demoralized by their beliefs.

Religion and spirituality are relevant in the lives of many people with schizophrenia and in many cases seem to offer valuable benefits to living with and recovering from the illness. Religion provides a powerful source of comfort and hope for many persons with chronic mental illness. Religious or spiritual interventions may help these persons utilize their spiritual resources to improve functioning, reduce isolation, and facilitate healing. By mobilizing volunteers from within the congregation, religious communities can play an important role in helping to meet the emotional needs of persons with schizophrenia or other chronic mental illness. This may become increasingly important as societal resources to care for these persons diminish.

The benefit of religion and spirituality in patients with schizophrenia has been demonstrated at the Mathari Hospital, the national teaching and referral mental health institution in Kenya. Religious and spiritual
exercises organized by both the Chaplaincy and Occupational therapy departments have been found to provide encouragement, comfort, and hope to chronic mental patients. It has been observed that patients who are agitated, violent, and antisocial calm down when they join others in singing spiritual songs and hymns during religious services.

REFERENCES


CHAPTER 3
THE LINKAGES BETWEEN SPIRITUALITY, RELIGION, AND MENTAL HEALTH: AN AFRICAN PERSPECTIVE

Andrew Zamani

N.B. The writer of this chapter is a senior clinical psychologist who practices, researches, and teaches in a leading medical school in Abuja, Nigeria. He ventured into an area that is normally not talked about openly. The references for his write-up have been retained at the end of the chapter for readers who may want to read more on the topic.
- David M. Ndetei

Religion is a system of belief and practices by which a group of people interprets and responds to what they feel is supernatural and sacred. It has both obvious and hidden functions. The manifest functions include:

• Defining the nature of relationship between humans and the ultimate reality,
• Providing humans with symbols to remind them of their obligations in their relationship with ultimate reality, and
• Prescribing a series of behaviours consistent with beliefs and practices.
Some latent functions are:

- Enforcing social control,
- Unitig humanity,
- Bridging social gap, and
- Provision of purpose and meaning to life.

The practice of religion is referred to as religiosity. It involves partial, real, or disguised demonstrations of piety by religious principles. Religiosity is the external proof of affiliation to a way of life through the performance of rituals and the use of prescribed symbols. It differs, however, from spirituality, which reflects the impact of religion on the character and disposition of the individual. Spirituality is a derivative of religion. It is described as the sacred realm of human experience—“Where the deeply personal meets the universal.” It is the quality of humankind, which strives for inspiration, reverence, awe, meaning, and purpose. It is also the outcome of religious experience. It is the aspect, which goes beyond the physical to make the unseen and unknown either a myth or reality. Paradoxically, religion originates from spirituality; spirituality sustains it, too.

The Interface between Religion and Mental Health

Religion is “the existential struggle of [humans] to discover who [they are] and to identify [themselves] in relation to the basic anxieties of [their] humanity” (Oates 1973: 54). It is often associated with a typical attitude by which individuals relates to the world around them. The way they perceive and relates to their environment largely determines their mental health status.

Their pattern of the conception and interpretation of events is significantly related to mental health status. In the same manner, mental health has been ascribed to attributional styles, with external attributions predicting poorer mental health status than internal attributions. With external attributions, they assume less responsibility for themselves, while the reverse is true for internal attributions.
Mental health refers to a state of complete harmony between the individuals and their environment, characterized by optimal physical well-being, emotional stability, positive orientation, highly developed sense of morality and reasoning, ability to learn from experience, self-understanding, and acceptance. It describes a human condition of a relatively high integration of the intellect, memory, will, and imagination. This implies that when there is a dysfunction in any of the domains of behaviour or disharmony between individuals and their environment, mental illness results.

Some major causes of mental illness include:

- Failure of social institutions in their socialization and nurturing functions;
- Stressful environmental and interpersonal demands;
- Failed expectations and personal losses;
- Moral aberrations and disturbed conscience;
- Rigid lifestyle and unwillingness to learn from experience;
- Social rejection and alienation;
- Inheritance of traits of abnormal behaviour;
- Drug and substance abuse;
- Altered bodily functions due to infections and biochemical activities;
- Emotional conflict; and
- Poverty.

What then is the relationship between different kinds of religious experiences and mental illness? It is difficult to make a definitive statement in this regard. A few suggestions have been made, which are shown below.

1. Failed religious obligations and the pervasive sense of loss of control over negative influences and tendencies may be responsible for guilt feelings, sense of reproach, death wish, and suicidal tendencies among people suffering from depression.
2. Severe mental disorders characterized by complete disorientation, bizarre behaviour, and loss of touch with reality have often been accompanied by disturbances in perception (hallucinations) and thinking (delusions) that have high religious content. Sufferers may hear voices commanding them to fast, pray, sing, or perform a ritual. As for delusions, they may regard themselves as some mighty religious figure in history or ascribe to themselves supernatural powers to perform “wonders” or unspeakable “miracles.”

3. It has been observed that the public tends to label deviants or generally unlikable or “different” people as abnormal. In religious circles, people are apt to ascribe causes of such deviant behaviour to demon possession or some preternatural causes like witches and wizards.

4. Conception about illness determines the nature of help-seeking actions taken about it. Those who believe in demonology tend to patronize diviners and spiritualists.

5. Religious conflicts and experience may cause, maintain or complicate mental disorders. This fact is demonstrated by the case studies below:

Case Study 1

Lucy, 29 years old and single, presented at the outpatient psychiatric clinic with complaints of headache, earache, insomnia, “heat in the head,” fear of crowds, palpitations, low self-esteem, and excessive worry over her health status. She has had these complaints for a period of five years running. The onset was associated with fear that the prophet, whose church she attends, would expose her unfaithfulness to her boyfriend. She was diagnosed as suffering from neurotic depression with physiological symptoms.

Case Study 2

Tina is a 38-year-old elementary school teacher, readmitted into a Nigerian psychiatric facility after a relapse from depression. Her employers had noticed that she suddenly became withdrawn, mute,
and perplexed following an instruction that she should move from her official quarters to a rented one. The illness started after a divorce from her husband and separation from her three children. The marriage had been very unstable for five years, complicated by their religious differences. She was a committed Catholic, while her husband was a nonreligious alcoholic.

The husband objected to her religious zeal. He ascribed her stubbornness to third-party influence from the church. On the other hand, she complained about his indulgences and regretted marrying him. She was the first of her parents’ four surviving children and described her relationship with them as cordial, in her childhood. She was particularly proud of the attention and affection she received from them as a child. Her relationship with her siblings was also cordial.

Her premorbid personality was described as reserved and aggressive. The major stresses associated with her crises were:

- The loss of her parents within an interval of seven years, which prompted her suicide attempt;
- The abandonment by her husband soon after her first delivery;
- An unstable job history, which had adverse influence on her economic status and living conditions, and
- Conflict with husband on religious orientation, with corresponding guilt on marital choice.

The following items have been suggested about the relationship between spirituality and mental health:

- The lack of or a weak religious upbringing makes one vulnerable to mental illness.
- Religion provides all humans the basis to develop faith and find meaning in life.
- There is always a spiritual element in every social relationship, which promotes bonding, mutual respect and well-being.
- When a vacuum is created by poor or lack of spiritual upbringing, people tend to find devious ways of filling it.
Humans are constantly searching for meaning in life and would always find answers to complement their worldview.

Religion and Treatment Systems

Religious practitioners in Africa and around the world are under serious attack for exploiting and manipulating their followers. It is difficult to differentiate between Christian and Muslim clerics and sorcerers or diviners and even professional hypnotists and psychodramatists in terms of their methodology. They stir emotions and elevate religious worships to sensational encounters. Worshipers are controlled by hypnotic suggestion to believe in cure claims and miracles. Despite the upsurge of religious worship, dependency complex is fast setting in. Adherents no longer take responsibility for themselves but surrender to clerical whims. This is indeed a season of mass hysteria, as worshippers obey their leaders’ instructions unquestionably, including the sale or surrender of their own properties. Consider the case study below.

Case Study 3

Christina was a 26-year-old homemaker, who manifested classical signs and symptoms of HIV and AIDS. Following repeated ill health, she went to screen for the virus at a hospital, where she tested positive. The news was grave and devastating. She rejected the diagnosis and chose instead to pray for God’s care. The more she denied the possibility of infection, the more the reality stared her in the face. She summoned courage one day to admit to it, when her pastor made a prophetic declaration, “A woman in the congregation afflicted by HIV and AIDS has just been cured.” She presented herself to him after the program. He reaffirmed the healing and urged her never to go to hospital for further care unless to verify through a laboratory test. Her health status deteriorated over a period of one month, until she consulted at the hospital. She was retested and confirmed to be HIV-infected. Severe depression set in, alleviated with antidepressants and psychotherapy. She eventually accepted her condition and began antiretroviral therapy.
The linkages between spirituality, religion, and mental health: an African perspective

The contributions of religious and spiritual practices to mental health have been adequately documented (see the chapter on “Spirituality and mental Health”). While the concept of spirituality is seen as being inclusive and affects everybody, religion is seen as being potentially divisive and relevant to few people. However, both religious and spiritual beliefs and practices have been shown to prevent many physical and mental illnesses, reducing both symptom severity and relapse rate. They speed up and enhance recovery, and render distress and disability easier to endure. They also affect the mode of presentation of mental disorders. Undoubtedly, all mentally ill patients have spiritual needs whose care can bring about significant relief symptoms and improvement of general well-being.

Religion builds faith and meets social needs, while spirituality is the means by which people find meaning and purpose in life. In times of pain and suffering, therefore, people are able to cope or find the courage to go on. Spirituality is a core personality function, which should always be appropriated to achieve positive outcomes of irreversible recovery processes or spontaneous healing. One sees a prominent role for religious practitioners in this regard. It enables them to acknowledge the worldview of patients and the resources available to them to improve their health status. This implies that they should promote the development of individual skills and potentials, even in the context of illness for peak personal experiences, enhanced well-being and positive illness outcomes.

It is difficult to differentiate between the treatment methods of traditional medical practitioners and those of orthodox religious healers. Both are based on the theory of either personal responsibility or external affliction. The first theory requires individuals to confess and pay back for their shortcomings. Guilt feelings are induced to lead sufficiently to penance. For the latter theory however, the exorcist approach is preferred. Persecutory images and symbols are conjured to inflict the victim attitude sufficiently in the mentally ill or sufferer, for the removal or deliverance of these forces. The healer then assumes an omnipotent status that requires continuous subservience and reverence from the clients or subjects.
Challenges for Integrated Mental Health Care

The role of spirituality in mental health care has been neglected. One major reason for this is the emphasis by mental health disciplines like psychiatry, psychology, and nursing on the scientific approach. This approach posits that all behaviours must be observable and measurable; whatever cannot be observed does not exist. Hence, practitioners have thrown out the role of spirituality in the diagnosis and treatment of mental disorders.

Religious practitioners themselves are victims of the neglect of the significance of physical and biopsychological causes of mental disorders in favor of environmental and spiritual antecedents. They accuse scientists of over intellectualization and exaggerated confidence in their assumptions on abnormal behaviour. Meanwhile, orthodox religious clerics condemn traditional mental health care systems. Inadvertently, the ensuing crisis of confidence prevents them from cooperating to mobilize appropriate resources to tackle the increasing rates of mental disorders. Most of what presents to clerics as human problems, however, is psychopathology, while what constitutes mental affliction in the clinical setting has spiritual components.

There is need for orthodox mental health practitioners and clerics to forge a partnership that leads to a better appreciation of the phenomenon of mental illness. This brings about improvement in treatment approaches and reduction in the burden that it imposes on society. Areas of collaboration should include research, training and dialogue sessions, facilitated by theological institutions, universities, traditional medical practitioner associations, and the professional associations of all known mental health disciplines.

Mental health promotion programs should identify and utilize resources in medicine, psychiatry, psychology, and religion to enhance well-being. The resources in religion aid character and moral development as well as provide the framework for coping with pain and suffering, among others. Spirituality enables people to find meaning and purpose in their lives and to improve the quality of social relationships. Medical and psychological care, on the other hand,
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repair the psychological damage caused by affliction and reposition the individual for personal growth and spiritual renewal. For the sake of emphasis, personal growth, and spiritual renewal are the hallmarks of mental health.

REFERENCES


Parents play the most influential and important role in child development. Children completely depend on them for fulfillment of both emotional and physical needs. The interaction and emotional relationship between parents and their children shape the children’s personality and mental and physical development. The parent-child relationship gains importance due to its long-lasting effects on a child’s personality. Parenting has been called the world’s most difficult job, as it offers no pay, no benefits, no vacation, and precious little thanks. Many argue that it’s more than just a one-time genetic contribution.

What makes parents different? What makes them the same? The answers to these questions are as diverse as the number of people and parents in society. There is no book or college on child rearing that answers these questions and there is no clear path for family happiness. A popular quote says, “The first half of our lives is spoilt by our parents and the last half by our children.” The most difficult task in parenting is to create a base for children, so they can achieve self-actualization.

Bringing up children is an illustration of life’s mixed blessings: full of good times and bad times, frustrating challenges, and elating successes, a baby’s first steps and first words, a teenager’s first love, a grown child’s first baby. All these are important transitions that
parents remember. Children come with heavy responsibilities, which drain finances, energy, and time. The road is difficult and there are no guarantees on the outcome. Parenthood thrives on challenges and our worth in life is quantified by the successes and failures in tackling them. Parents find the greatest challenges in the following areas:

- **Good nutrition.** All parents want their children to be healthy. As elementary schoolchildren go through remarkable physical changes, their food intake becomes a critical aspect of their growth and development. Recent research shows that nourishing food not only makes a child healthier; it makes them more emotionally stable. It also improves school performance. Paying attention to our children’s diets then pays high dividends. Because children tend to rank their parents’ views on food very poorly, it is up to the parents to ensure that nutritious food is included in family menus.

- **Children’s education.** Parental involvement in schools has become a major educational issue. There is an increasing concern about the quality of education in any country today. Countries take a greater role in monitoring and maintaining academic standards. Communities are more watchful of the expense of public and private education. Local schools are concerned with providing high-quality teaching and other services even with dwindling resources. Parents want assurance that their children will receive adequate preparation to lead rewarding adult lives.

**Parenting Styles**

Parenting styles are defined as the “manner in which parents express their beliefs about how to be a good or bad parent. It is the characteristic pattern of behaviour exhibited by a given parent toward a specific child.” At least 99% of parents want to be good. They adopt different parenting styles for raising their children. Some spank, some reason, some are strict and others are lax. Some seem indifferent, while others
liberally hug their children. Differences in parenting styles may be organized and categorized into four main types:

- **Potters** mould children into the kind of persons they feel society requires.
- **Gardeners** create conditions necessary for the children’s growth, providing nutrients, and eliminating obstructive forces.
- **Maestros** conduct development. Like great leaders, however, they allow some flexibility for the children.
- **Consultants** transfer more authority for growth to the child, but they are readily available to provide requested advice.

Another way of categorizing differences in parental styles is to delineate how parents approach the child rearing task. The most important of these are presented below:

- **Parental belief 1**: Parents are wise, so children should trust only their parents. Parents with this belief think that they have a good understanding of the world, so their children should follow their advice. They teach their children to rely on their word and to discount what others say.
- **Parental belief 2**: Children should have unquestioned loyalty. Parents who believe this is essential train their children to trust and respect and never doubt them. Children learn to say nothing bad about their parents.
- **Parental belief 3**: Children should be treated as the equals of parents. Parents who hold this belief are likely to create a democratic home atmosphere and to encourage their children to express their own thoughts and to develop their own opinions. Children are taught to judge and evaluate their parents’ opinions and decisions, as they do other people’s opinions and decisions. They learn that it is permissible to disagree with their parents.
- **Parental belief 4**: Homemaking is a dull job that homemakers would like to escape. Parents who believe this feel that children
limit their freedom and hinder them from both doing short-term tasks and making more long-term commitments. They socialize their children to devalue homemaking. They feel hampered in attempting activities that provide them with a sense of accomplishment.

- Parental belief 5: Children are demanding. Parents with this view acknowledge that they can get upset with their children for no specific reason. They understand that friction inevitably arises in the course of people living together.

From these views, we recognize four standard styles of parenting, which correspond to a balance of love and limits.

1. Rejecting/neglecting: low love and low limits
2. Authoritarian: low love and high limits
3. Permissive: high love and low limits
4. Democratic or balanced (authoritative): high love and high limits.

These views bring two basic ingredients in parenting, which stick in the upbringing of children: love and structure. The terms love and limits describe a parent's discipline orientation. Parents oriented toward a “relational discipline” are said to use love as their primary style of parenting. Parents who use “action discipline” are said to use limits as their primary style of parenting. All parents incorporate both love and limits in their style of parenting. The balance of love and limits determines a parent's particular style. Each style has strengths and weaknesses inherent in them. It is learned from the important parental figures in our lives.

Permissive parents use love as their primary style because they consider it more important than limits. The balance of love and limits increases attachment with their children and is used to teach right from wrong. They end up spending a lot of time communicating, negotiating and reasoning with the children. The value is on “increasing their children's self-esteem” or “making them feel special.”
Authoritarian parents use limits as their primary style and consider limits as more important than love. The value is on "teaching respect" and "providing structure." A loving relationship is essential for children to develop confidence and self-esteem. Parents show love in different ways according to their personal style and cultural background. Love is shown by smiles, hugs, compliments, interest in the children and time spent with them.

The investment of daily quality time devoted entirely to the children (without distractions from phones, TV, or computers) is the foundation of a good relationship. It also helps children turn to their parents, when they are upset. Those who do not experience a warm and loving relationship with their parents are at risk for low self-esteem and lack of self-confidence. They may try to find negative ways to get attention and to feel good such as acting out, impressing their peers or using drugs and alcohol.

As children get older, parents need to change the ways they show love to provide guidance. A baby thrives on rocking, broad smiles, and singing, while a teenager is likely to feel cared for by a parent who is a good listener. Because teenagers need to develop responsibility and the ability to make healthy, independent decisions, parents should negotiate with them about issues such as relationships.

Children also need structure and monitoring. From an early age, they benefit from routines that help them know what to expect each day. Parents show them the limits of acceptable behaviour by setting clear rules and expectations. Parents do this to help them learn that their actions have consequences. By noticing and commenting on good behaviour, parents strengthen good habits. The use of physical punishment, which is an external control method for teaching right from wrong, has been shown to cause behavioural problems in children. Children under this parenting approach are usually quick to react and rarely get their parents to negotiate. The appropriate uses of brief timeout and brief withdrawal of privileges are effective alternatives to physical punishment, scolding, and yelling. Without structure, children may have difficulty learning self-control. They may
experience conflict with authority figures, if they fail to learn how to follow rules. Parents provide an important model for their children’s behaviour. Children learn from watching their parents’ appropriate (e.g., problem solving, tolerance, communication) and inappropriate (e.g., yelling and physical aggression) behaviour.

Parents can be challenged in their roles, especially when dealing with work stress, life issues or family health problems. Children also present a variety of challenges, depending on their temperament, developmental level, learning style, and cognitive abilities.

Parents’ Role in Child Upbringing

Wide variations occur from one society and culture to another, regarding family size, child upbringing methods, extended family sharing in child-related tasks and the parental beliefs. Many theories of child upbringing stress that the mother is the primary caretaker and parenting tends to be viewed as primarily a maternal duty. Parenting has often been referred to as mothering because of the assumption that the birth, the nurturing, and the responsibility of child rearing belongs to women. The role of the father in parenting is deemphasized. However, fathers play important roles in the children’s lives. Extended family members, especially grandparents, also help in child rearing tasks. Fathers play the breadwinner’s role.

However, with the current effects of urbanization and migration, children live in a nuclear family setting, where both fathers and mothers work. This has resulted in both of them having little time with their children, compared with traditional families.

Parental Interactive Practices and Psychosocial Development of Children

Different kinds of parental upbringing behaviour toward children, particularly parental sensitivity, have an impact on the development of cognitive abilities. The different types of parental upbringing behaviour include:
• Parental overprotection. This involves "smothering" children's growth. Overprotective parents constantly watch over their children. They protect them from the slightest risk, overly clothe and medicate them and decide for them at every opportunity. Overprotection has a negative influence on child development. In fact, attention has been paid particularly to the concept of "overprotection," exemplified by the "protective mom." She is spitefully described as "cushioning and protecting her boy against any major step in his progress towards maturity." Parental overprotection is, therefore, regarded as harmful in its deprivation of care. It also has a determining influence on the development of a wide range of disorders, including major psychoses, most neuroses, personality disorders, sexual disorders, and several psychosomatic disorders.

• Parental Rejection: Parental rejection is closely related to "masked deprivation." This is shown in various ways, including physical neglect, denial of love and affection, lack of interest in the children's activities and achievements, harsh or inconsistent punishment, failure to spend time with the children and lack of respect for the children's rights and feelings. In a minority of cases, it also involves cruel and abusive treatment. Parental rejection has been reported in a wide variety of mental and physical health issues. Rejection has been implicated in several psycho-physiological problems such as allergies, asthma and other respiratory ailments, and hypertension. Rejection has also been implicated in numerous forms of psychiatric disorders, including neuroses, emotional adjustment disorders, and schizophrenia.

Most parents today are too busy with daily activities, which translate to less time spent reviewing school records and playing with the children. Childhood and adolescence are the formative years for a child, which may make or break them. They are the ones likely to take care of you in later years, so prepare them well.
CHAPTER 5

THE FIGHT AGAINST STIGMA BECAUSE OF MENTAL DISEASES

David M. Ndetei

N.B. This material is adapted from the section on stigma, published by the World Psychiatric Association (WPA), with the kind permission of Professor Norman Sartorious, former president of the WPA. - David M. Ndetei

Introduction

The fate of those who suffer from mental illnesses is stigmatization. Stigma creates a cycle of discrimination and social exclusion for those who suffer from a mental disorder, as well as all those associated with them. More than the illness itself, stigma is the single most important barrier to the quality of life of people with mental disorders, their family members and friends. It is also a major impediment to mental health reform and service development. Stigma is one of the main barriers, if not the main one, to the appropriate treatment and rehabilitation of those who suffer from mental illness. Better treatment of the mentally ill requires the universal realization that good mental health is the key to good physical health. This will come not only with improvement of mental health care facilities, but also through the elimination of mental illness stigma and a partnership with the public to reach these goals through education and open discussion.

A majority of people with mental illnesses are now treated in the community, where negative public opinions can have significant
consequences, ranging from human rights violations to discriminatory unemployment and housing practices and diminished self-esteem. Stigma and the expectation of stigma can also produce disruptions in family relationships and reduce normal interactions. Stigma and its consequences, therefore, pose major obstacles to recovery and promote psychiatric disability.

Stigma has become a frequent answer to many questions about the social burden and psychological suffering associated with major chronic health problems, prominently including mental illnesses. Stigma has been identified as a hidden aspect of the burden of mental illness. The efforts described in this book have, as their objective, the relief of this burden, through mobilizing family and community support and the appropriate use of existing mental health services.

The Global Fight against Stigma

The stigma attached to mental illness is the greatest obstacle to the improvement of the lives of people with mental illnesses and their families. The results of stigma are:

- Lower priority for mental health services,
- Difficulty in getting good staff to work in these services,
- Continuing problems in finding employment and housing for people who have had an episode of mental disorder,
- Social isolation of people with mental illness and their families, and
- Poorer quality of care for physical illnesses, occurring in people diagnosed as having had psychiatric illnesses.

The history of the stigmatization of mental illness is long. However, it is probable that intolerance to mental abnormality (and the rejection of people with it) has become stronger in the past two centuries because of urbanization and the growing demands for skills and qualifications in almost all sectors of employment. This, however, is only part of the story. Mental illness is also linked to stigmatization, discrimination and intolerance in rural settings and in all countries, regardless of their level of industrialization and the sophistication