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SERVICES FOR SCIENCE AND EDUCATION

Outcomes of Religion and Faith on Mental Health among the Seventh-day Adventists in Africa

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ABSTRACT

Numerous studies have linked and synchronized religious experiences with positive mental health. Despite the prevalence of mental health concerns, there is still a stigma attached to mental illness in many of the Seventh-day Adventist (SDA) churches in Africa. The predominant culture of silence, along with mistaken expectations and misguided attitudes, often causes suffering believers to feel ashamed, blamed, and alone in their experience of mental illness. This study aimed to assess the SDA church members' mental health in Africa. The paper summarized some of the most important factors that were found to correlate with the religious and mental health experiences of the SDA church in the continent of Africa. The study utilized a cross-sectional design and quantitative data collection method. The 213-item questionnaire contained closed and open-ended items and was administered by trained research assistants. The study revealed that married people in the church tend to have more positive mental health than those who are single, separated, divorced, or widowed, and older people tend to have more positive mental health than younger people ($p<.05$). Moreso, the older age group demonstrated more positive mental health compared with the younger age group ($p < 0.01$) in the church. Furthermore, 80.6% and 87.3% of the participants have never had any form of depression or suicidal thoughts, respectively. The demonstration of positive general mental health status by the church members in the continent of Africa has positive implications for the health principles taught by the church.

Keywords: attitude, knowledge, mental health, practice, religion, Seventh-day Adventist

INTRODUCTION

Religion offers people something to believe in and provides a sense of belonging and security for church members. Belonging to a religious organization reduces suicide rates, alcoholism, drug abuse, etc. The association between religion and suicide has been a significant research question from the earliest days of suicide research. For the past decade, research on this question has yielded mixed results. Some studies have found that suicide rates are lower among persons who have a religious affiliation [1], [2], [3]. There is confirmation to advocate that religion could help people to manage better with life stresses, reduce the incidence of depression and substance abuse, enhance social support, and provide sources of hope and meaning [4]. On the contrary, recent studies found an inverse association between religion and suicidal ideation. A study of meta-analysis done by [5] found that there was an inverse association between religion and suicidal ideation, suicidal plan, suicide attempt, $P<0.001$), and completed suicide, $P = 0.006$). The conclusion drawn by the authors is that religion can play a

protective role against suicidal behaviors. Secondly, Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices [6]. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Most studies report positive associations between religiosity and spirituality and aspects of mental health, while a small proportion report mixed or fully negative associations. Moreover, [7] found that unstable non-religious respondents and converts who perceived God as distant were more likely to experience anxiety in close relationships.

METHODOLOGY

The study utilized a descriptive cross-sectional design with a quantitative data collection method. This study was known as the African Seventh-day Adventist Health Study Phase 1. It included all the church members in the three Divisions in the sub-Saharan Africa region of the continent. The original study population included Seventh-day Adventist church members, and the population of the church in sub-Saharan Africa at the time of data gathering was about 8 million church members. Out of this population, a total number of 15 434 respondents were sampled through multistage and simple random sampling techniques. A criterion drew samples from big, medium, and small churches. In addition, samples were also drawn from rural and urban churches. Due to the different languages spoken in sub-Saharan Africa, the questionnaire for the study was back-translated into several languages. Professionally trained research Assistants collected data. A total of 21,000 questionnaires were collected, but a total of 5, 566 questionnaires were excluded because of incomplete information leading to a final sample of 15, 434. Participation in the survey was fully voluntary, so the respondents could stop responding to the survey at any time before or during the interview. The full study design was approved by the Ethics Committee of the University of Eastern Africa, Baraton, Kenya, and the data collection was also approved by the National Commission for Science, Technology & Innovation (NACOSTI), Kenya.

RESULTS

Table 1: Demographic Variables

	Demographic Variables	Frequency	Percent
Gender	Male	7,817	50.6
	Female	6,383	41.4
	Sub Total	14,200	92.0
	Mission	1,234	8.0
	Grand Total	15,434	100
Age Bracket	18-20 years	2,799	18.1
	21-30 years	4,331	28.1
	31-40 years	3,082	20.0
	41-50 years	2,138	13.9
	51-60 years	1,268	8.2
	Above 60 years	796	5.2
	Sub Total	14,414	93.4
	System	1,020	6.6
	Grand Total	15,434	100
Marital Status	Single	7,105	46.0
	Married	6,626	42.9

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	Separated	252	1.6
	Divorced	142	.9
	Widow/Widower	469	3.0
	Sub Total	14,594	94.6
	System	840	5.4
	Grand Total	15,434	100.0

There was a fair representation of gender in the study, though male representation (50.6%) was a little higher than female (41.4%). The SDA church is composed mostly of youths; hence, the age bracket of 21-30 years participated most in the study (28.1%). It is interesting to note that this age bracket is mostly single, and they ranked highest in participation (46%), followed by the married couple (42.9%).

Table 2: Comparisons of Marital Status and Mental Health

Multiple Comparisons						
Dependent Variable: Mental Health						
Games-Howell						
(I) Marital Status	(J) Marital Status	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Single	Married	-.13744*	.01295	.000	-.1678	-.1071
	Separated/Divorced/Widow/Widower	.04888	.02963	.225	-.0207	.1184
Married	Single	.13744*	.01295	.000	.1071	.1678
	Separated/Divorced/Widow/Widower	.18632*	.02980	.000	.1164	.2563
Separated/Divorced/Widow/Widower	Single	-.04888	.02963	.225	-.1184	.0207
	Married	-.18632*	.02980	.000	-.2563	-.1164
*. The mean difference is significant at the 0.05 level.						

Using the Games-Howell procedure, married people tend to have more positive mental health than those who are single, separated, divorced, widowed, and widower (Table 2). The one-way ANOVA test revealed that there is a statistically significant difference between married and single, separated, divorced, widowed, and widower (p=.000), 95% CI = (-.1071, .1678) and (p=.000), 95% CI = (-.1164, .2563). The mental health advantages accrue as individuals move from less attachment to more attachment [8], and thus, marriage has the most benefits, in part because relationships provide social integration and heightened feelings of self-worth and in part because those in a relationship are less likely to have experienced a recent breakup.

Table 3: Correlation of Mental Health and Age

Correlations				
		Mental health		Your age.
Spearman's rho	Mental health	Correlation Coefficient	1.000	.122**
		Sig. (2-tailed)	.	.000
		N	14818	14064

	Your age	Correlation Coefficient	.122**	1.000
		Sig. (2-tailed)	.000	.
		N	14064	14414
**. Correlation is significant at the 0.01 level (2-tailed).				

The study result showed that older people tend to have more positive mental health than younger people $p < 0.01$ (Table 3). Our younger adolescence is in a unique and formative time. Physical, emotional, and social changes, including exposure to poverty, abuse, or violence, can make adolescents vulnerable to mental health problems. Financial stresses, moving to cities, new jobs, and relationship changes are all quite common in young adulthood in Africa and can contribute to mental health struggles. Social stressors, growing into adulthood, may change the way their social life looks as compared to adolescence.

Table 4: Depression Among the Church Members

Item	Frequency	Percentage
Yes	2,785	18.%
No	11,575	75.%
Missing System	1,074	7.%
Total	15,434	100%

Depression is a serious mental illness that is affecting more of the world's population as the years go by. It is greatly underdiagnosed and can lead to complications such as suicide and the lack of economic output. Eighteen 18% of the study participants had some form of depression over the past 12 months, while 75% did not (Table 4). Christians suffer from depression and would want to know what to believe about it and how it relates to their faith. More so, families and friends of people with depression, the clergy, lay people within church communities, mental health professionals, and even academics who have an interest in religion and mental health would want to know how depression relates to their faith [9]. As one of the leading causes of disability, major depressive disorder (MDD) has been ranked as the third greatest cause of disease burden worldwide and is projected to rank first within the next decade [10], [11], [12].

Table 5: Thoughts of Suicide or Self-Harm

	Frequency	Percentage
No	13474	87.3
Yes	922	6
Total	14396	93.3
System Missing	1038	6.7
Total	15434	100

Reports of suicide and self-harm have become more prevalent as a result of mental illness and other causes. Six percent (6%) of the study participants in the last 12 months had some thoughts of suicide or self-harm, while a majority, 87.3%, did not (Table 5). Young people in sub-Saharan Africa experience significant adversities and systemic challenges despite technological advancements and the demographic transition that the region is experiencing. It is estimated that the global lifetime prevalence of suicidal ideation ranges between 3.1 and 56%

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[13], [14]. Suicidal ideation affects and disrupts the functionality of a human being regardless of age, gender, ethnicity, or even religion.

DISCUSSION

Mental health problems leading to suicide, especially among adolescents, are increasingly becoming an area of concern in global health. The global age-standardized suicide rate for 2019 was 9.0 per 100,000 population. According to the World Health Organization (WHO) age-standardized 2019 suicide estimates report, the African region carried the greatest suicide burden at 11.2 per 100 000 population, followed by Europe at 10.5 per 100 000 population [15]. This high suicide rate in Africa has been partly attributed to inadequate investment in the provision of mental health services in the continent [16]. The current study, using data from the African Health Study Phase 1, examined mental health status among the Seventh-day Adventist church members in sub-Saharan Africa. The church membership at the time of the study was about 10 million. The major strength of the study is the use of nationally representative survey data from over 30 countries in sub-Saharan Africa. The questionnaires used in the ASDAHS helped to obtain quantitative data on all the variables of interest in this study. The large sample size obtained from systematic random procedure allows the generalizability of findings to other homogenous populations.

Correlation of Mental health and marital status found that married people tend to have more positive mental health than those who are single, separated, divorced, widowed, and widower. They are also less likely to experience marital challenges, perhaps because religion offers couples theologically grounded guidelines on handling marital challenges when they arise. Given its deep connection with values that individuals apply in their daily lives, it is natural that religion and spirituality are considered influential social institutions having multifaceted relationships with aspects of people's lives, including their mental health and health-related lifestyle habits [17]. Although spiritual practices have gained clinical acceptance, mental health professionals have steered clear of religion-based applications such as prayer as a therapy [18]. Religious affiliation and religiosity can be linked to a person's sense of hope, coping, and social support networks [19], [20] and have been associated with improved health and quality of life and reduced depression and anxiety in users of mental health services [21].

Correlation of Mental and age also found that older people tend to have more positive mental health than the younger generation, $p < 0.01$. Moreso, 18% of the study population had some form of depression over the past 12 months, and 6% of the participants had suicidal thoughts or self-harm. [22] found in their studies that suicidal ideation among adolescents was 14% and that in-school adolescents were more likely to experience suicidal ideation. The study further found that those who received peer support and had one or more close friends were less likely to experience suicidal ideation. There is an urgent need to study mental health outcomes in low-resource settings like SSA because of the high unmet mental health needs due to unavailable human and financial resources [23]. Most studies report a positive association between religiosity and spirituality and aspects of mental health [24] such as higher life satisfaction and meaning in life [25] a lower prevalence of anxiety and depression [26], [27], suicidal tendencies [28], substance abuse [29], and better cognitive functioning [30], [31] suggested that vertical spirituality is important primarily for religious populations. It is noted that regardless of faith, even individuals from traditional, conservative, or religious societies that condemn the act of suicide may also go through suicidal thoughts to end their problems and sufferings, just as likely

as those from non-religious societies. However, individuals from religious and conservative societies would be less likely to have suicidal behavior, and they may not act upon their suicidal thoughts since suicide is condemned and doomed in their religion and is morally forbidden [32].

Depression is the most common of the psychological disorders and is on the rise. It is interesting to note that 75% of the church members are not depressed in any way. Much of the depression–religiosity research has been undertaken within Western industrialized nations. People with high levels of general religious involvement, organizational religious involvement, religious salience, and intrinsic religious motivation are at reduced risk for depressive symptoms and depressive disorders. Longitudinal research is sparse but suggests that some forms of religious involvement might exert a protective effect against the incidence and persistence of depressive symptoms or disorders [33]. The link between depression and religiosity raises the question as to the possible mechanisms through which religion might play this apparently protective role.

The current studies also found that 87.3% of the church members have never had any thoughts of suicidal ideation in their lives. [34] found that suicide attempts were more common among non-affiliated Christian patients than affiliated Christian patients. Many studies indicate religious affiliation is protective against suicide attempts and suicide but not suicidal ideation. Likewise, attendance at religious services is protective against suicide attempts but not suicidal ideation (after adjusting for social support). These studies suggest religion may inhibit a person from acting on suicidal ideas by providing access to a supportive community, shaping a person's beliefs about suicide, providing a source of hope, and providing ways to interpret suffering.

CONCLUSION

Faith communities have a unique role in suicide prevention, integrating faith into the suicide prevention discourse. Several barriers prevent them from living in this role, including silence around suicide, resulting in stigma based on old theological beliefs and an artificial divide between faith and suicide prevention. The findings of this study point to a significant role of religiosity and mental health and support the understanding of suicidal thoughts. The study results can be extrapolated from the Seventh-day Adventist church population to the general population. Ideally, research findings on the role of religion could help generate educational interventions so that clinicians can help religious patients access religious support and so that religious communities (and their leaders) can increase their awareness of what they are doing that is helpful and provide more of it.

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