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# Religion, Literature, Medicine and Music as Therapies of Depression and Mood Disorders in the United Republic of Tanzania: A Psycho-Ethical Reflection

**Mabula Masalakulangwa**
**St. Paul's University**

## Abstract

*This study focuses most especially on two age groups: i) children ages 8-18, and youth ages 18-28. The most common types of mood disorders among children and youth are major depression, dysthymia (dysthymic disorder), bipolar disorder, mood disorder due to a general medical condition, and substance-induced mood disorder. Dysthymia is a milder, but long-lasting form of depression. It is also called persistent depressive disorder. There is no clear cause of dysthymia disorder, but mental health professionals think it is a result of chemical imbalances in the brain. Some types of depression seem to run in families, but no genes have yet been linked to depression. There is no clear cause of mood disorders. Rapid changes in health care technology are advancing mental health care. Religion and medicine in the form of live interactive music has demonstrated its ability to improve access to high-quality mental health care, specifically in the therapy of patients with depression and mood disorders. The objectives of this study are four-fold: i) To review the advances in religion, literature, medicine, and music in the therapy of depression and mood disorders among children and youth. ii) to examine the evolving and innovative models of care, iii) to synthesize literature, music, poetry and lessons learned about mental health, and iv) to examine current and future pediatric and adolescent pragmatic implications for the treatment of depression and mood disorders in various clinical settings. Religion, literature, medicine and music have important and expanding roles in addressing the pediatric and adolescent mental health burdens of depression and mood disorders. Qualitative research methods are employed in this study. Theories used are Religious Therapy (RT), Literature Therapy Theory (LTT) Well-Being-Theories (WBT), Logotherapy (LT) and Music-Therapy Theory (MTT) in the context of gestalt integrated therapy. The American Psychiatric Association defines dysthymia as depressed mood most of the time for at least two years, along with at least two of the following symptoms: poor appetite or overeating; insomnia or excessive sleep; low energy or fatigue; low self-esteem; poor concentration or indecisiveness; and hopelessness. The study concludes that religion, literature, medicine and music hold promise on the treatment and therapy of depression and mood disorders.*

***Key Words**: Anxiety, Depression, Emotional Instability, Dysthymia, Mood Disorders.*

## 1.0 Introduction

In 2018, an estimated 47.6 million children and youth aged 18 or older (19.1 percent) had any mental illness (AMI) in the past year. An estimated 11.4 million adults in the nation had serious mental illness (SMI) in the past year, corresponding to 4.6 percent of all U.S. adults. According to 2019 data from the World Health Organization (WHO), 1 in every 8 people in the world has mental health issues. In Tanzania, 5 out of 100,000 people, especially children and youth have committed suicide out of mental health problems such as anxiety, depression, anger and drug abuse in the last five years, statistics have shown (Worchel *et al.*, 1983, pp. 240-244; Atkinson

*et al.*, 1993, p. 222). However, the World Health Organization (WHO) Tanzania mental health profile of 2017 estimates the burden of mental illness in terms of disability-adjusted life years at 2,727.86 per 100,000 population. Female children and youth female youth are nearly twice as likely to suffer from major depression than male children and male youth. However, male and female children, male and female youth are equally likely to develop bipolar disorder. While major depression can develop at any age, the average age at onset is the mid-20s.

According to clinicians from my fieldwork, the number of psychiatrists in Tanzania varied between 30 and 50. The last official count I identified mentions only 18 psychiatrists (Jenkins *et al.*, 2010). The year 2022 was a remarkable year for data for children with the first-ever paperless census and Tanzania Demographic and Health Survey completed. The census shows that the population of Tanzania is at 62 million, an increase of 37% from 2012 (~60 million in Mainland and ~1.9 million in Zanzibar).

It is estimated that, at a given time, 5–10% of the population are suffering from identifiable depression needing intervention. Tanzania is one of the poorest countries in the world, with a gross national income of $300 per capita in 2003. The occurrence of mental health disorders is not uncommon in Tanzania.

The problem of this study is compounded by the fact that there are very few psychiatrists, few therapists, few clinical psychologists, and or the psychological assessment experts. The prevalence is very high, the magnitude of the problem is becoming a life-size challenge. The current study proposes religion, literature, medicine and music in the therapy of mood disorders and depression among children in the United Republic of Tanzania. The largest city of Tanzania, Dar es Salam, had a population of around 2.7 million people in 2022. On the shore of Lake Victoria, Mwanza ranked as the second most populated city in the country, with some 437 thousand inhabitants. Zanzibar City, the capital of Zanzibar's archipelago, had around 404 thousand dwellers. The biggest or largest cities in Tanzania are Dar Es Salaam, Mwanza, Arusha and Dodoma. Based on 2012 estimates, more than a third of households live below the basic needs poverty line, earning less than $1 a day, while 20% of the total population live below the food poverty line. However, it is the rural communities of Mainland Tanzania and Zanzibar who are mostly affected by poverty. The study is conducted under NIMR ethical Clearance Number No. NIMR/HQ/R 3525, Extension NIMR/HQ/R. 1975 for Tanzania Mainland, and Ethical Clearance No. ZAHREC 2021/25 for Zanzibar. The prevalence of depression is within the range of the worldwide prevalence. Past psychological trauma - PTSD and a family history of depression are significant risk factors, while insufficient income or poverty is not protective as poverty itself is a disease (Hollander *et al.*, 2003, pp. 40-44). The problem(s) of this study have not been adequately given the attention they deserve as the next section of the study namely systematic literature review reveals.

## 2.0 Systematic Literature review

This chronological literature review describes each work in succession starting with the earliest available information. Typically, in the methods section of a chronological review, this study groups together the sources in order of their publication date. It discusses published information in a particular subject area, and sometimes information in a particular subject area within a certain time period. It is not just a simple summary of the sources, but it usually has an organizational pattern and combines evaluation, summary and synthesis.

Abramson Seligman and Tisdale's view of the attribution process in learned helplessness has been applied to the psychological illness of depression. They contend that depressed children and youth are those who are more likely to view their situation with a bias toward internal, stable, and global attribution. When asked to indicate reasons why certain negative events occur, depressed children and youth are more likely than non-depressed children and youth to attribute the events to internal, stable and global dispositions (Worchel *et al.*, 1983, p. 222). This serves as the best starting definition of the problems(s) of this study. The problems of depression and mood disorders are recognized throughout the history of medicine (Strathern, 2005).

Jenkins *et al.* (2010) rightly note that, although most developing countries are expected to achieve the Millennium Development Goal of a 50% reduction in the number of people living on less than $1 per day by 2015, this is unlikely in many sub-Saharan African countries including Tanzania (Jenkins *et al.*, 2010, pp. 2543–2558; UN, 2007). The current study aimed at examining the relationships in urban Tanzania between the rates of common mental disorder (CMD), such as depression and anxiety, and socio-economic factors, demographic characteristics and social functioning, but it was not specific about depression and mood disorders among children and youth. Another shortcoming is that the study only focused on two urban areas of Tanzania of differing levels of poverty where it did not find a significant difference in rates of CMD between areas although the poorest area did have higher rates of disorder (Jenkins *et al.*, 2010). It is true that CMD is highly associated with exposure to traumatic life events in urban Dar es Salaam, particularly events involving relationship difficulties and financial instability, but it is supposed to cover a wider ground. The effect of social support was counter intuitive and deserves further research. Even if efforts to address poverty and disadvantage in low-income countries such as Tanzania will need to take mental health into account and address the difficult circumstances and environments within which people live and work, covering the United Republic of Tanzania is still important.

Moledina *et al.* (2018) rightly state that, "Depression is a common condition in developed countries and is a growing problem in developing countries like Tanzania." Their study aimed at finding the prevalence of depression in a predominantly migrant Asian community and the behavioral, familial, social, and medical factors influencing depression (Moledina *et al.*, 2018). The shortcomings of this study were that it is limited to one ethnicity. True that depression was prevalent in 6.5% of the study population. It is also true that, history of psychological trauma, a positive family history of depression, and a low income were significant risk factors for depression. It is further more true that recurrent thoughts of death/suicide were more common in the depressed group. But the study does nothing on the country-wide scale, Tanzania to be Tanzania it must be the United Republic of Tanzania.

Clarck *et al.* (2020) aimed at a review of literature on child and adolescent mental health in Tanzania. Their study, which was an extensive literature search of PubMed, Scopus, MEDLINE and EMBASE was undertaken to identify studies that focused specifically on mental illness in children and young people in Tanzania (Clarck *et al.*, 2020).

The study was very important as it reviewed 23 studies which were included in the final synthesis, which could be broadly split into studies focusing on the prevalence and incidence of child and adolescent mental illness. The study successfully hypothesized causes and correlations, it identified treatments and interventions and qualitative studies of human experience (Clark *et al.*, 2020). They rightly concluded that there is a dearth of published research regarding child and adolescent mental health in Tanzania. They also added that,

although some high-quality studies allow good insight into the epidemiology of mental illness, interventional studies are often small and low-power, and significant correlational relationships are yet to be drawn. There is significant scope for further child and adolescent mental health research in Tanzania (Clark *et al.*, 2020). They convincingly discuss orphans and institutionalized youth, physical abuse and violence, mental illness, but they leave out depression and mood disorders in Zanzibar (Clark *et al.*, 2020). African girls and young women are discussed, but not to the line of depression and mood disorders. Although they are discussing bullying (Clark *et al.*, 2020), they did not link Trauma-Focused Cognitive Behavior Therapy (TFCBT) to depression and mood disorder. As way of recommending therapy, they recommend TFCBT, food security, mental health interventions, and also tools to identify mental illness; they have also left out religion, literature, medicine, and music as the newly recommended therapy. Biomedical humanities are also left out, but they seem to be holding promise in addressing the problems of the current study.

To sum up, the review model follows the systematic data processing approach comprised of three steps, namely: i) literature search and screening; ii) data extraction and analysis; and iii) writing the literature review. The review creates a wider background of the current study, it defines the problem(s), and proposes the way forward. What comes next is the methods and methodologies.

## 3.0 Methods and Methodologies

This study aims to provide an overview of the use and assessment of qualitative research methods in the health sciences and methods in behavioral research studying behavior (Cosby, 2007, pp. 66-90). Using qualitative designs will equip us with better tools to address a greater range of research problems, and to fill in blind spots in current neurological research and practice.

This study employs Qualitative Research Method. Qualitative research is a type of research that aims to gather and analyze non-numerical data in order to gain an understanding of individuals' social reality, including understanding their attitudes, beliefs, and motivation. The study uses observation: recording what the researcher has seen, heard, or encountered in detailed field notes. This includes reviews of library sources, stories, music, poetry, multimedia sources, and journal articles dating from 1900 to 2024.

The aim of this study is to provide an overview of qualitative research methods, including hands-on information on how they can be used, reported and assessed. This study is intended for beginning qualitative researchers in the health sciences who want to broaden their understanding of qualitative research. The methods of qualitative data collection most commonly used in health research are document study and observation. The theories used are: i) Religious therapy, ii) Well-Being theories, iii) Logo-Therapy, and iv) Music Therapy.

### Religious therapy

Stress is can be defined as a state of worry or mental tension caused by a difficult situation (Ridley, 1999, pp. 147-66). Stress is a natural human response that prompts us to address challenges and threats in our lives. Religious Cognitive Emotional Therapy (RCET) is a new form of cognitive therapy that uses basic religious beliefs and insights in psychotherapy. RCET is a new integration of cognitive, humanistic, and existential theories that is combined by religious beliefs and insights. Religion can support positive change during the counseling

process. A person's spiritual beliefs and faith community are sources of strength in the course of therapy. Religious involvement creates a feeling of belonging and connection. Personal spirituality, meanwhile, can provide meaning and purpose.

The most commonly studied religious practice is meditation. It has been reported that it can produce changes in personality, reduce tension and anxiety, diminish self-blame, stabilize emotional ups and downs, and improve self-knowledge. Religion serves several functions for society. These include i) giving meaning and purpose to life, ii) reinforcing social unity and stability, iii) serving as an agent of social control of behavior, iv) promoting physical and psychological well-being, and v) motivating people to work for positive social change.

Religion can provide patients with a sense of peace and calm, as well as a supportive community of people. To sum up, religion is a powerful tool for coping with stress by providing individuals with a sense of control, community and meaning in their lives. Religions and related social and cultural structures have played an important part in human history. As mental structures, they influence the way we perceive the world around us and the values we accept or reject. As social structures, they provide a supporting network and a sense of belonging.

Given this approach, Durkheim proposed that religion has three major functions in society: it provides social cohesion to help maintain social solidarity through shared rituals and beliefs, social control to enforce religious-based morals and norms to help maintain conformity and control in society, and it offers well-being. Religion may benefit psychological well-being because it encourages supernatural beliefs that can help people deal with stress. Social psychologists identify "stress buffering" mechanisms, such as a perceived connection with the divine, as key ways people may deal with difficult and negative life events.

**Literature therapy**

Literature therapy incorporates the foundational principles of CBT and provides exercises designed to help the readers or audiences overcome negative feelings. CBT is most commonly provided face-to-face by a therapist and has demonstrated efficacy on children and adolescents with depression and (or) anxiety problems. Everyone experiences different types of pain and react differently. Mental health is the person's condition with regards to their psychological and emotional wellbeing. "Many...can disrupt our emotional health" creating a variety of emotions such as "sadness or anxiety". *Things Fall Apart* was written to express the painful lives of the people. The language used throughout the story is centered, orderly and gets right to the point without romanticizing anything and reels the reader into the lives of Okonkwo and his clan as they fight for freedom (Achebe, 1958). Okonkwo's depression is one good example of how literature therapy is helpful.

**Well-Being theories**

Abraham Maslow (1962) was one of the first in the field of psychology to describe 'wellbeing', with his characteristics of a self-actualized person. The description of self-actualization is a foreshadowing of the PERMA model, which outlines the characteristics of a flourishing individual and Wellbeing Theory (WBT). The PERMA model of wellbeing outlines five key pillars for flourishing and thriving at work and beyond: Positive emotions, Engagement, Relationships, Meaning, Accomplishment. The four dimensions or aspects of wellbeing are: i) spiritual wellness. Spiritual strength is that force that drives us to make sacrifices for others, our nation, and the greater good; ii) Emotional wellness refers to building an awareness of and

accepting one's feelings and moods, iii) physical wellness and iv) social wellness (Seligman, 2012, 2018).

**Logotherapy**

Personality is any person's collection of interrelated behavioral, cognitive and emotional patterns that comprise a person's unique adjustment to life. These interrelated patterns are relatively stable, but can change over long time periods (Ridley, 1999, pp. 161-84). When they change, Logotherapy is an intervention. Logotherapy was developed by neurologist and psychiatrist Viktor Frankl and is based on the premise that the primary motivational force of an individual is to find meaning in life.

**Music**

Music therapy is a healthcare profession in which a qualified music therapist designs sessions with specific, individualized goals in mind. Therapeutic music is a method for relaxing or lifting emotions in times of need. It can involve a range of experiences. Bruscia (1998) identified four main music therapy methods: i) Receptive ii) Recreative iii) Creative and iv) Improvisation. These are based on improvisational, compositional, and music listening opportunities that music therapists engage with clients.

Music therapy is the use of music and/or elements of music (like sound, rhythm and harmony) to accomplish goals, like reducing stress or improving quality of life. A healthcare provider called a music therapist talks to you to learn more about your needs, music preferences and experiences, and designs each session specifically for you. They also evaluate your progress each step of the way, and may work with your other healthcare providers to coordinate your care. Children benefit from music therapy as well as people of all ages. Music therapists work with people of all ages, including young children and adolescents. They can design sessions to suit the child's unique needs. Music therapy may support many aspects of the child's development, including their behavior, learning and emotions.

**4.0 Results, findings and discussion**

Depression is one of the many mood disorders, which are characterized by extreme and unwarranted disturbances in emotion or mood. First and foremost, it is paramount to have a good grasp of the symptoms of major depressive disorder. People with major depressive disorder feel an overwhelming sadness, despair, and hopelessness and they usually lose their ability to experience pleasure, joy and happiness. This very well means "panic disorder" (Akinson *et al.*, 1993, p. A-36; Hollander *et al.*, 2003, pp. 1-21) and "generalized anxiety disorder" (Hollander *et al.*, 2003:26). They may have changes in faith, appetite, weight, or sleep patterns. They may also have loss of energy, enthusiasm, and difficulty in thinking or concentrating. Key symptoms of major depressive disorder are psychomotor disturbance (Sobin *et al.*, 1997). For example, body movements, reaction time and speech maybe so slowed that some depressed people seem to be doing everything in slow motion. Others experience the opposite extreme and are constantly moving and fidgeting, wringing their hands, and pacing. Depression can be so severe that its victims suffer from delusions or hallucinations, which are symptoms of psychotic depression. And the more deeply a person descends into depression over an extended period, the more s/he withdraws from social activities (Goudy, 2023; and Armstrong, 2024).

According to the American Psychiatric Association (1994), one year after their initial diagnosis of major depressive disorder, 40% of patients are without symptoms; 40% are still suffering from the disorder, and 20% are depressed, but not enough to warrant a diagnosis of major depression. Slightly less than one half of those hospitalized for major depressive disorder are fully recovered after one year. For many, recovery is added by antidepressant drugs. However, some studies show that psychotherapy can be just as effective. Some people suffer only one major depressive episode, but 50-60% of patients will have a recurrence. Risk of recurrence is greater for females and for individuals with an onset of depression before age 15. Recurrences may be frequent or infrequent, and for 20-35% of patients, the episodes are chronic, lasting 2 years or longer.

Overall signs of a mood disorder may include: Sad, depressed, irritable, angry, or elevated mood that appears more intense than the child usually feels, lasts for a longer period of time, or occurs more frequently. Trouble with family, including difficult behavior. Many factors increase the risk of developing or triggering teen depression, including: Having issues that negatively impact self-esteem, such as obesity, peer problems, long-term bullying or academic problems. Having been the victim or witness of violence, such as physical or sexual abuse or family difficulties. Most common causes of depression in children include: i) bullying, ii) physical, emotional or sexual abuse, iii) a family history of depression or other mental health problems.

Mental health problems ranging from depression to bipolar disorder are known as mood disorders, or affective disorders. In any of these disorders, a serious change in mood shapes the child's emotional state. Unlike a normal bad mood that a child feels occasionally, a mood disorder involves thoughts and feelings that are intense, difficult to manage, and persistent. A mood disorder is a real medical condition, not something a child will likely just 'get over' on his/her own.

Today, clinicians and researchers believe that mood disorders in children remain one of the most under-diagnosed health problems. Mood disorders that go undiagnosed can put kids at risk for other conditions, like disruptive behavior and substance use disorders, that remain after the mood disorder is treated. Children and teens with a mood disorder do not always show the same symptoms as adults. It can therefore be difficult for parents to recognize a problem in their child, especially since he or she may not easily express his or her thoughts or feelings.

The causes of mood disorders are not well understood. Imbalances in brain chemicals play a role. Environmental factors, such as unexpected life events and/or chronic stress, can also contribute to a mood disorder. Mood disorders often run in families, so there is a genetic component. Children who have relatives with depression are at increased risk for depression. In addition, a family history of bipolar disorder may predispose a child to have bipolar disorder or other mood disorder. Sometimes, extreme stress or a life event can 'turn on' a gene, causing the disorder to develop. This can happen especially with depression.

The risk of depression in women is nearly twice as high as it is for men. Once a person in the family has this diagnosis, their brothers, sisters, or children have a higher chance of the same diagnosis. In addition, relatives of people with depression are also at increased risk of bipolar disorder. Women also may be anxious. If they have bipolar disorder, they will likely have extreme mood swings. Their feelings may range from being very sad, empty or cranky to being

very happy — going back and forth between each mood. Mood disorders are more common in women.

According to WHO (2023), depression is a common mental disorder. Globally, an estimated 5% of adults suffer from depression. More women are affected by depression than men, depression can lead to suicide especially in children and youth, there is effective treatment for mild, moderate and severe depression.

Depressive disorder (also known as depression) is a common mental disorder. It involves a depressed mood or loss of pleasure or interest in activities for long periods of time. Depression is different from regular mood changes and feelings about everyday life. It can affect all aspects of life, including relationships with family, friends and community. It can result from or lead to problems at school and at work. Depression can happen to anyone. People who have lived through abuse, severe losses or other stressful events are more likely to develop depression. Women are more likely to have depression than men.

An estimated 3.8% of the population experience depression, including 5% of adults (4% among men and 6% among women), and 5.7% of adults older than 60 years. Approximately 280 million people in the world have depression. Depression is about 50% more common among women than among men. Worldwide, more than 10% of pregnant women and women who have just given birth experience depression. Although there are known, effective treatments for mental disorders, more than 75% of people in low and middle income countries receive no treatment. Barriers to effective care include a lack of investment in mental health care, lack of trained health-care providers and social stigma associated with mental disorders.

Mood disorders are a real medical disorder. A psychiatrist, a psychotherapist, a clinical psychologist, or other mental health professional usually diagnoses mood disorders through a complete medical history, psychological assessment, and psychiatric evaluation. Mood disorders can often be treated with success. Treatment may include: i) Antidepressant and mood stabilizing medicines—alone are not recommended by the current td, but they may (when necessary) work well especially when combined with psychotherapy have shown to work very well in the treatment of depression (Santrock, 1997, pp. 505). Cognitive Behavior Therapy (CBT) is highly recommended by this study (Carlson *et al.*, 2007, pp. 596-97). Psychotherapy—most often cognitive-behavioral and/or interpersonal therapy (Carlson, *et al.*, 2007, p. 500). This therapy is focused on changing the person's distorted views of himself or herself and the environment around him or her. It also helps to improve interpersonal relationship skills, and identifying stressors in the environment and how to avoid them. ii) Family therapy (Carlson, *et al.*, 2007, pp. 599-600). iii) Other therapies, such as electroconvulsive therapy – ECT (Carlson, *et al.*, 2007, pp. 606-7), and trans-cranial magnetic stimulation – TMS (Carlson, *et al.*, 2007, pp. 16-7).

Families play a vital supportive role in any treatment process. There is that power of the family depression and mood disorders therapists have underutilized. When correctly diagnosed and treated, people with mood disorders can live stable, productive, healthy lives. At this time, there are no ways to prevent or reduce the incidence of mood disorders. However, early diagnosis and treatment can reduce the severity of symptoms, enhance the person's normal growth and development, and improve the quality of life of people with mood disorders. A mood disorder is a mental health class that health professionals use to broadly describe all types of depression and bipolar disorders. The most common types of mood disorders are major depression, dysthymia (dysthymic disorder), bipolar disorder, mood disorder due to a general medical

condition, and substance-induced mood disorder. There is no clear cause of mood disorders. Healthcare providers think they are a result of chemical imbalances in the brain. Some types of mood disorders seem to run in families, but no genes have yet been linked to them. In general, nearly everyone with a mood disorder has ongoing feelings of sadness, and may feel helpless, hopeless, and irritable. Without treatment, symptoms can last for weeks, months, or years, and can impact quality of life. Depression is most often treated with medicine, psychotherapy or cognitive behavioral therapy (CBT), family therapy, or a combination of medicine and therapy. In some cases, other therapies, such as electroconvulsive therapy and trans-cranial magnetic stimulation may be sparingly used.

This study recommends religion, literature, medicine and music in the helping patients and or clients who undergo depression and mood disorders. Furthermore, psychotherapists need to have proper understanding of sensation and perception (Santrock, 1997, pp. 100-147), motivation and emotion (Santrock, 1997, pp. 366-409); personality (Santrock, 1997, pp. 410-445); abnormal psychology (Santrock, 1997, pp. 446-477); therapies (Santrock, 1997, pp. 478-513), and health psychology (Santrock, 1997, pp. 514-547) for social adjustment.

## 5.0 Conclusions

The United Republic of Tanzania, now more than ever before, needs to invest more on understanding stress, anxiety, depression, mood disorders psychopathology, and psychotherapy. The meaning of health is not easily understood outside religion, literature, music, arts medicine and psychotherapy. The axes of concern in personality need the interdisciplinary approach as it is in this study. Religion, psychology and health are interrelated. Mental health is a generic attitude. There is always need to acknowledge the impact of the hospital institution in order to understand God and human beings including their predicament. Behavioral sciences, religion and health meet in the human personality, but human beings have no reliable art of listening to the voices of their bodies and also fail to correlate religion and psychopathology to interpret existential problems. The religious life has a bearing on mental health as it is like love, a medicine to many diseases. Meaninglessness, meaning and health are elucidated by religion, literature, music, and arts where there is the spiritual dimension of health to today's world. the patient is not only the patient, but also the penitent as well. Owing to this, the four stages of therapy are i) confession, elucidation, education, and transformation. These stages are reached or facilitated by religion, literature, music and arts. Most of the depression disorders, anxiety, mood disorders, and/or the emotional instabilities are due to unresolved grief and grief may come from guilt. Religion, literature and music explicate sin, illness, and guilt. They also inculcate values in sickness and health. The treatment or therapy of depression and mood disorders call for an interdisciplinary treatment, as far as meaning, values, and religion are concerned. All education ceases when depression and mood disorders prevail. Then they prevail, they impinge complex or advanced cognitive process thinking, reasoning, critical thinking, creative thinking, decision-making and problem-solving (Santrock, 2006, pp. 282-301). Religion, literature, medicine, and music hold promises on the treatment and therapy of depression and mood disorders.

## References

Achebe, C. (1958). *Things fall apart*. London: Penguin Classics.

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders*, American Psychiatric Association, Arlington, VA, USA, 5th edition, 2013.

Armstrong, A. (2024). *Healing thought the Vagus nerve: Improve your body's response to anxiety, depression, stress and trauma through nervous system regulation*. Kindle Edition.

Atkinson, R. e*t al*. (1993). *Introduction to psychology*. Eleventh Edition. Fort Worth, TX: Harcourt Brace College Publishers.

Belgum, D. (ed.). (1967). *Religion and medicine*. Ames, Iowa: Iowa State University Press.

Carlson N. *et al.* (2007). *Psychology: The Science of Behavior*. Sixth International Edition. Boston, MA: Pearson Education, Inc.

Clark *et al.* (2020). "Holes in the wall: examining gaps in knowledge in child and adolescent mental health in Tanzania – scoping review", In *Tropical medicine & international health, a European Journal* TMIH. Sustainable Development Goals SGDs 2. 3.3 and 3.4.

Clayman, B. C. (1993). *Genes and inheritance*. Pleasantville: Reader's Digest Association, Inc and the American Medical Association (AMA).

Cosby, C. P. (2001). *Methods in behavioral research*. Ninth Edition. Boston, MA: McGraw Hill Company, Inc.

Freud, A. (1935). *Psychoanalysis for teachers and parents*. Trans. Barbara Low. New York: W. W. Norton Company.

Goudy, R. J. (2023). *Guided pathways to healing: journaling past anxiety and depression*. Independently Published.

Hollander, E. *et al.* (2003). *Concise guide to anxiety disorders*. Washington, DC: American Psychiatric Publishing, Inc.

Jenkins, R. *et al.* (2010). Common mental disorders and risk factors in Urban Tanzania. *International Journal of Environmental Research and Public Health*, vol. 7, no. 6, pp. 2543–2558, 2010.

Moledina, *et al.* (2018). Prevalence and associated factors of depression in an Asian Community in Dar es Salaam, Tanzania. *Psychiatry journal*. Vol. 2018 | Article ID 9548471. Hindawi.

Ridley, M. (1999). *Genome: The autobiography of a species in 23 chapters*. New York: HarperCollins Publishers.

Santrock, W. J. (1997). *Psychology*. Boston, MA: McGraw Hill Company, Inc.

Santrock, W. J. (2006). *Educational psychology*. Boston: McGraw Hill Company, Inc.

Seligman, M. (2012). *Flourish: A visionary new understanding of happiness and well-being*. Aminjikarai, Chennai: Atria Books.

Seligman, M. (2018). *On mental thoughtfulness*. Boston, MA: Harvard Business Review.

Sobin, C., & Sackeim A. H. (1997). Psychomotor Symptoms of Depression. *The American journal of psychiatry.* American Psychological Association (APA) *154*(1), 4–17.

Strathern, P. (2005). *A brief history of medicine: from hippocrates to gene therapy*. London: Robinson.

United Nations (UN). (2007). *The millennium development goals report*. United Nations: New York.

Worchel, J. e*t al*. (1983). *Understanding social psychology*. Homewood, IL: The Dorsey Press.