PASTORAL CARE AND MENTAL HEALTH LITERACY. A CASE STUDY OF PASTORS' PSYCHOLOGICAL DISTURBANCE MANAGEMENT IN REDEEMED CHRISTIAN CHURCH OF GOD, OGUN STATE, NIGERIA.

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ABSTRACT
Pastoral care serves as a vital framework for addressing mental health literacy among religious leaders, particularly in managing psychological disturbances within faith communities. This study explores the intersection of pastoral care and mental health literacy, with a focus on the psychological distress experienced by Pastors in the Redeemed Christian Church of God (RCCG), Ogun State, Nigeria. Employing a descriptive method with a qualitative case study approach, the research examines the prevalence of psychological disturbances among pastors, their coping mechanisms, and the effectiveness of structured mental health literacy programs in enhancing their well-being. Findings reveal that while pastors function as primary sources of emotional and spiritual support for congregants, they often lack adequate mental health literacy, leading to difficulties in managing their psychological challenges. The study stressed the impact of targeted training interventions on improving mental health awareness, reducing stigma, and fostering a supportive environment for pastoral leaders. It also highlights the role of faith-based institutions in integrating mental health education into pastoral training curricula and establishing peer support networks to enhance psychological resilience among religious leaders. The research contributes to the growing discourse on mental health literacy within religious settings, advocating for a holistic approach that combines theological insights with psychological expertise. Recommendations include the development of structured ministry-based training in mental health literacy programs tailored to the unique needs of Pastors, with the establishment of collaborative partnerships between religious institutions and mental health professionals.

Introduction

Humans are functions of mental and physical states. There were indicators from research findings by the Royal College of Psychiatrists, United Kingdom (2013) on the necessity to attain equality between mental and physical health, our health and total wellbeing in the context of the resultant effect of the interplay between both conditions (Kolappa et.al., 2012)

Recent spiritual health systems approach by the church's understanding of mental health issues among Clergies for improved ministers' health is gaining global ecclesiastical attention. Emphasis is on the management of the mental health status of Clergies and the laities. This unique approach focuses on the literacy health system and pastoral care, the effect of both could either make or mar the ministerial efforts of clergies and the future of the global church. Very few studies have explored Pastoral Care and Mental Health Literacy regarding Pastors Psychological Disturbance Management in Redeemed Christian Church of God (RCCG) Ogun State, Nigeria. Studies focusing on mental health system governance are even more of a rarity. This paper evaluates the role of mental health literacy in Pastor care in the RCCG, to understand the challenges, opportunities, and strategies for strengthening it.

Jesus Christ is undoubtedly the focus of the Holy Bible. Nevertheless, He is not the only concern of the entire Bible itself. Therefore, when we talk about gospel evangelism as presented in the Bible, we must be aware of other essential matters of crucial relevance in the Scriptures. However, if there are accounts of mental illnesses in the Bible, they present Jesus Christ as Saviour, Healer, and Restorer. Success in Christian ministry also revealed how we genuinely view mental health, fully considering what we know about mental illness conditions and how we treat affected persons in our midst in the full awareness of their diminishment or afflictions.

A prominent narrative in the New Testament is the demoniac recorded in chapter five of Mark's Gospel who might have been afflicted by evil forces— as the text suggests with the invasion of the pigs by the evil spirits— but he also manifested symptoms medically referred to as mental illness. This man harmed himself and lived as many manic depressives as possible or psychotics when left uncared for or un-medicated. Indeed, mentally ill people of his time were treated and viewed much like this man. However, Jesus responded to this man with compassion that his community and family did not show to him. Jesus treated him as a human being and not simply as a collection of demons. Thus, he became a liberated man who was later commissioned to witness Jesus Christ in his community rather than coming after Christ.

Social discrimination is the willingness to engage in relationships of varying intimacy with a social challenge. That is an indicator of public attitudes towards persons with mental illness (Lauber et al, 2004). The Synoptic Gospels portray much of Jesus Christ's ministry as having compassion for the severely mentally ill. Jesus' willingness to relate, fellowship and closely interact with them and accept them as liberated members of God's kingdom speaks to something significant about how we should view the mentally ill. This argument, therefore, presents the Church with a special responsibility towards the mentally ill. This responsibility is part of our humanity. God, by His grace, is the river of hope from which the mentally ill have also come to drink.

The need for collaborations between Clergy and mental health professionals to enhance mental health service utilisation is becoming more urgent due to the alarming numbers of Clergies suffering mental health difficulties and the increasing global influence of African Clergies and RCCG Pastors. That is also coming on the heels of increased ministerial performance pressure placed on African Clergies. Over time, what the mental health challenge has created is overwhelming, particularly for RCCG Pastors and other Clergies in Ogun State, Nigeria.

Mental health, though private and personal in context, if improperly managed, could have grave consequences on the individual, organisational, and national wellbeing. The alarming rate of mental health challenges and the cost of intervention call for great concern. More troubling is the effect of the same on religious leaders, particularly clergies across Nigeria. The culture of indifference, denial and evasion has contributed in no little measure to the mental health crises in the Church and the nation (Lyon, 2010).

COVID-19 Pandemic brought to the fore an untold hardship and realities of the state of the global human health system and the universal condition of the sector leading to the characterisation of Africa as a weeping child. Though much earlier considered insignificant despite its relevance, the impact of the socio-economic state of the world and its attendant effect on the mental health condition of the global man went a long way in escalating the adverse impact of the current Pandemic. These cumulatively influenced religious organisations and sister agencies to emphasise on studying the effect of the global Pandemic on the emotional and psychological state of her pastors.

This essay title is quite significant and apt considering the gap in the existing literature on mental health policy involving Church and professional mental health literacy. Mental health literacy among the first-generation of African Christian Clergy globally (including those in the diaspora-based clergies of historical African descent born outside the continent) remain primarily under-investigated. Hence, it is important to investigate the need for mental literacy levels of African Pentecostal clergies in Ogun State, Nigeria, to have clearer understanding that could better the collaborative potentials between clergymen and health care professionals.

The essay addressed identified literature gap by examining demography, educational background, policy and opportunities variables with the mental health literacy of pastors affiliated with the Redeemed Christian Church of God (RCCG) in Ogun State. Mental health professionals, the Church, and the Clergies can access available information to assist in the support, promotion, and management of mental health care issues. The same could be disseminated to communities, and by extension, for use in Christian evangelism assignments.

This essay primarily examined the effect of Mental Health Literacy on Pastoral Management of Psychological Disturbances Among Clergies in Ogun State, Nigeria. Various debates and arguments abound of the perceived and precise role the Church should play in enhancing the mental wellbeing of her clergies across boards, taking to account the various challenges witnessed and the attendant future consequence of same to the Church. It is understood that this could well be dealt with by systemic collaboration between mental health care professionals and the Church using the platform of Christian Social Responsibility (CSR). Various debates and arguments are in the space on the role of the Church in managing the mental health condition of her congregation and the Pastors are in the public domain. This, however, could be a collaborative effort between the Church and the State.

The developmental relationship between Church and State is also essential because the Church seems overwhelmed by the burden of congregation management, social and material supports for her teaming crowds to alleviate current economic pressures made worse by the current COVID-19 Pandemic. The essay also examined the challenges associated with the potential interventionist role of RCCG Ogun State Nigeria in advancing and coordinating mental health healing processes/procedures through Pastoral Care and Mental Health literacy as it bothers on the Clergy's psychological disturbance management.

In advancing the work, we defined mental health, identified related theories, theological perspective on Mental Health and related Illness, Nigerian experience in Mental health, Workspace experience, the role of clergies in mental health care, attendant challenges associated with its mismanagement, and impact on performance and wellbeing. Biblical and contemporary theories were crucially engaged, RCCG's responses to mental health challenges, and various lessons learned with a future proposal.

Matters of spirituality were present at the forefront of human awareness during crises, significant illness conditions or social transitioning; spirituality encompasses what is considered the most meaningful and central of human existence. In this regard, manifestations of body-soul connections do become more evident during experiences of psychological disturbances (Lyon, 2010). As a result, people with mental health struggles stand to benefit from a more holistic level of care involving incorporating spiritual care into their formal mental health interventions. This interventionist approach requires a growing reliance on clergy professionals to become involved in mental health care delivery. As it already stands, clergy professionals are the primary resources of mental health care and support for tens of millions of Nigerians.

Clergies are essential partners in mental health care delivery because professionals in formal mental health disciplines have distinct but limited competency in the way and manner, we assess the religious and spiritual issues of patients. Provision of care in areas of mental health is, therefore, increasingly presenting faith-based providers with more unique opportunities to work together with mental health professionals in the best interest of the communities they serve.

The Theorical Framework is premised on the Bryant-Davis and Wong Theory which highlighted the growing necessity for both mental health professionals and Clergy professionals collaborations and the importance of understanding the interdisciplinary

perspective of care provisions, which ultimately facilitate the holistic recovery of those dealing with serious mental illnesses (Tepper et al., 2001). However, there is a shortage of research on clergy professionals' knowledge levels of psychological disturbances and the attitudes of clergy professionals to mental health interventions (Bryant Davis and Wong, 2013).

In Ogun State Nigeria, the need for the Church, clergies, and mental health professional's collaboration in mental health service delivery is essential by the increased influence of Clergies as religious leaders in Nigeria, and precisely in Ogun State (Sigmund, 2003). Most renowned African churches have Nigerian origins, a country with the largest Pentecostal population in Africa, recognisable presence, and global influence of RCCG.

For Africans, religion and culture strongly influence help-seeking behaviours with consequences for underutilising mental health services. Religious/spiritual help methods serve as their first approach to dealing with mental illness. Onyigbuo and et al highlight religious coping styles from the predominant systems to mental health care for Nigerian immigrants in the United Kingdom (Onyigbuo et al., 2016).

Islamic Worldview on Mental Health

Islam is a monotheistic Abrahamic religion with growing adherents. It is a socio-political system structured around human social philosophy and existentially wide-ranging procedure of answering and explaining humans religiously, intellectually, and daily trials. Conversation of issues relating the mental health was once considered taboo in the Muslim community owing to the lack of adequate education in medical science culture, mental health, the space of religious studies in health management, and the collective responsibility of all stakeholders (https://archive.islamonline.net). The natural mindset in Islam is the belief in supernatural and faith-based affliction and healings owing to the belief in supernatural beings called Jins. Islam-based patients try religious approaches to achieve mental health concurrently with modern methods (Islamonline Archieve, n.d).

Most Islamic Clergies are not well equipped to assist members or themselves in caring through mental difficulties occasioned by stress, emotional and psychological breakdowns. Positive thoughts and actions are considered adequate when addressing all Imam. It is believed it is a test of faith scenario from God. Integrating religious belief, philosophy and mental health practice could significantly help practitioners of Islam. Numerous scholarly works on the essentials of Islamic religion and mental health professional collaboration that could bring about enlightenment in Islam are also ongoing in several climes.

Theological Perspective on Mental Health and Related Illnesses

From the theological point of view and the assertion of Apostle John in 3 John 2, we could deduce that mental health is considered key to personal and emotional wellbeing and interpersonal relationships which are fundamental for optimal quality of life (Baumann, 2007).[1] A mental illness refers to problematic health conditions involving changes in emotion, thinking or behaviour (or a combination of these) and associated with distress or inappropriate functioning. Whether the resultant complex behaviour is considered normal or abnormal would depend on the context surrounding the behaviour and subject to the influence of time and culture.

In some instances, conversations on mental illness and its validity could become controversial, especially among the Christian faith. Christian Scriptures never explicitly discuss mental illness in terms of how it was defined in the ancient Judeo-Christian times. It is essential to acknowledge that the Bible is neither a textbook on mental health nor a manual for mental health care. Nevertheless, the Bible deals with mental health care because mental health is a significant aspect of human life. Accordingly, it is essential to explore a theological review of mental health in the light of the Biblical words about human essence and existence. Biblical perspectives of the essence of human existence

[1]. Anja Esther Baumann, "Stigmatisation, Social Distance and Exclusion Because of Mental Illness: The Individual with Mental Illness as a 'Stranger'," International Review of Psychiatry 19, (2007): 2.

may be presented in three following central underlying concepts (Solomon, 1996):[2]

1. **Humans are created beings** — unique among the entire created order of God, as humanity is fashioned by God distinctly in His image and after His likeness. The doctrine of God's image echoes throughout the Biblical scriptures and is rooted in the opening chapter of the book of Genesis:

> *Then God said, "Let Us make man in Our image, according to Our likeness; let them have dominion over the fish of the sea, over the birds of the air, and over the cattle, over all the earth and over every creeping thing that creeps on the earth." So, God created man in His own image; in the image of God, He created him; male and female He created them. (Genesis 1:26-27, NKJV)*

Because a loving, sovereign, and majestic God created humanity in His identity, then, humans individually possess inherent dignity. This intrinsic poise as a unique creation of God is emphasised—

> *"For You formed my inward parts; You covered me in my mother's womb. I will praise You, for I am fearfully and wonderfully made; Marvellous are Your works, and that my soul knows very well." (Psalm 139:13-14, NKJV)*

2. **Humans are social beings** — uniquely created to live together in a community—

"And the Lord God said, "It is not good that man should be alone; I will make him a helper comparable to him." (Genesis 2:18, NKJV). As such, it would be contrary to Divinity's purpose for humanity to assume most humans prefer self-imposed or circumstantial-directed solitary living. Having been created in God's image and after His likeness, humanity is created to need relational communion of relationship with God and with one another. The Apostles' Creed which has been used as a statement of faith since the third century A.D, refers to the belief in the "one catholic church," which is also referred to as the "one universal church" Apostles' Creed: Traditional and Ecumenical Versions-The United Methodist Church (Ashwin-Siejkowski, 2009). The "Church" is from the Greek word, *ekklesia*, which implies "gathering." (Park, 2015). Accordingly, the Church is called the body of Christ as a metaphor to emphasise the diversity of the people— "For as the body is one and has many members, but all the members of that one body, being many, are one body, so also is Christ. For by one Spirit, we were all baptised into one body—whether Jews or Greeks, whether slaves or free—and have all been made to drink into one Spirit. For the body is not one member but many." (1 Corinthians 12:12-14, NKJV)

The Church is not a collection of persons but a new assemblage that shares life like a family bond to one another in unity. Humans are most comfortable when connected emotionally and socially; this sense of communal living fosters a sense of security and togetherness. Invariably, the Church is meant to bring all people together to get everyone on the same page to be a wholesome order. Christian discipleship should be communal living oriented with substantial investments in daily interpersonal interactions and active community engagement.

3. **Humans are embodied beings** — this concept of humans as embodied Spirit of God presented in the book of Genesis' account of humans is a resultant formation of the coming together of material clay and the breath of God— "And the Lord God formed man of the dust of the ground, and breathed into his nostrils the breath of life, and man became a living being." (Genesis 2:7, NKJV). Account of the Scriptures that immediately followed the creation of humanity describes the fall of man following incoming of sin and the need for redemption of the body (Genesis Chapter 3).

Some theological propositions have presented a worldview platonic moral polarisation of the Spirit and the body in which one is perceived as morally desirable and the other undesirable (Robert, 1999). However, Apostle Paul probably challenged such dualization of human existence in his notion where he instructed the Corinthian Church that the human body is a temple of the Holy Spirit— *"Or do you not know that your body is the temple of the Holy Spirit who is in you, whom you have from God, and you are not your own? For you*

[2]. Robert Solomon, "Biblical Perspectives on Mental Health Care," International Review of Mission 88, (1999): 350.

were bought at a price; therefore, glorify God in your body and in your Spirit, which are God's." (1 Cor. 6:19-20, NKJV)

The Bible describes redemption provided for us through the grace of God as coming through the salvation provisions of Jesus Christ, bringing into unity the three aspects of humanity, i.e., the body, the spirit, and the soul, into an experience of order otherwise known as Shalom. The Scriptures affirm the fundamental unity of humankind and attempt to dichotomise the body and the Spirit existentially, morally, and even functionally. Salvation in Christ is brought about to re-establish the original Shalom experience in the human essence. Shalom can be understood as the peace experienced between the body, the soul, and the spirit as these three persons of humanity function together for the same purpose. With this understanding of the concepts of human existence and essence, we may now explore mental health and related illness as depicted in the Biblical texts. Aside from the narrative account of Mark Chapter 5, several other textual references to possible mental illness are found throughout the Holy scripture. Some Bible-based behavioural manifestations of psychological disturbances in various patterns of expressions suggestive of guilt feelings, grief, depression, suicidality, and psychotic illnesses, are cited below:

King David wrote of his anguish, loneliness, fear of the enemy, his heart-cry over sin, and the guilt he struggled with because of sin in many of the books of Psalms. He said, "My guilt has overwhelmed me like a burden too heavy to bear" (Psalm 38:4, NKJV).

Job suffered significant losses, devastation, and physical illness during his trial, and as a result, he struggled through the furrows of intense emotional/mental pains: "Why did I not die at birth? Why did I not perish when I came from the womb?" (Job 3:11, NKJV) He further said, "I am not at ease, nor am I quiet; I have no rest, for trouble comes" (Job 3:26, NKJV). "My soul loathes my life; I will give free course to my complaint; I will speak in the bitterness of my soul" (Job 10:1, NKJV).

Prophet Jeremiah became overwhelmed with despair and a profound sense of failure as he experienced constant rejections from the people he loved and had reached out to in obedience to his calling by God. Jeremiah said, "Cursed be the day in which I was born! Let the day not be blessed in which my mother bore me!" (Jeremiah 20:14, NKJV) "Why did I come forth from the womb to see labour and sorrow, that my days should be consumed with shame" (Jeremiah 20:18, NKJV). It is not a far-fetched conclusion if inferred that these above Scripture narratives are instances of Biblical characters going through a phase of depression.

Descriptions of suicide acts are also well documented; interestingly, of the five records of suicide in the Bible, none could be linked to mental illness; but the consequence of attempting to restore or protect honour after shame or an act of wrongdoing. Honora suicide is a process whereby a person commits suicide to escape the guilt of an immoral action, transgression, or defeat in battle. Honour suicide is distinguished from regular suicide in that the subject either is actively deciding to kill themselves privately or publicly for the sake of restoring or protecting honour. Judas Iscariot, a classic example, after he betrayed Jesus Christ, got overwhelmed by the guilt of betrayal and remorse of shedding innocent blood, he committed suicide.

Further analysis of other mental concepts in the Bible reveals descriptions consistent with delusions and hallucinatory experiences. Prophet Jeremiah noted pathological false beliefs otherwise known as delusions in psychiatric phenomenology:

> *"And the Lord said to me, "The prophets prophesy lies in My name. I have not sent them, commanded them, nor spoken to them; they prophesy to you a false vision, divination, a worthless thing, and the deceit of their heart." (Jeremiah 14:14, NKJV).*

Likewise, the priest Ezekiel's experiences as recorded in Ezekiel 2:2; 11:5; 33:30 and 38:10 which is of mixed visions and hearing the voices of God have been a subject matter of scrutiny in the field of psychiatry. While the relevance of such experiences to the psychiatry terminology of delusions and hallucinations is highly debatable, it is worth mentioning that no basis for contention was provided in the ancient Judeo-Christian texts to suggest contemporaries of those who had such experiences considered them as psychotic. Nonetheless, afflictions of madness and accusations of delirium and insanity were observed noted in some, including monarchs, Old Testament prophets and New Testament apostles:

1. King Nebuchadnezzar was afflicted with psychosis and loss of reason by God for his pride:

> *"While the words were still in the king's mouth, there fell a voice from Heaven, "O King Nebuchadnezzar, to you it is spoken: The kingdom has departed from you, and you shall be driven from among men, and your dwelling shall be with the beasts of the field. And you shall be made to eat grass like an ox, and seven periods of time shall pass over you until you know that the Most High rules the kingdom of men and gives it to whom he will." Immediately the word was fulfilled against Nebuchadnezzar. He was driven from among men and ate grass like an ox, and his body was wet with the dew of Heaven till his hair grew like an eagles' feathers, and his nails were like birds' claws. At the end of the days I, Nebuchadnezzar, lifted my eyes to Heaven, and my reason returned to me, and I blessed the Most High, and praised and honoured him who lives forever, for his dominion is an everlasting dominion, and his kingdom endures from generation to generation" [Daniel 4:31– 34; English Standard Version (ESV)]*

Reflective directions on ancient sacred texts are often biased towards psychiatry. However, insights into concepts of psychiatry are not usually offered. It is recognisable that psychiatry as a field of medicine relies upon objective criteria for its diagnosis formulations and interventions. However, such objectivity becomes highly vulnerable if a psychiatrist confidentially attributes experiences, beliefs, or behaviours from one culture to another without proper cultural context (Pies, 2007).

Similarly, attributions of religious experiences, beliefs and behaviours require referencing cultural norms of the faith tradition, its local community, as well as to self-understanding of the individual. In many parts of the world, people hold worldviews of a three-layered or sphered universe. One layer is Heaven, as some call it, where God resides. Another layer is the Earth, where human beings live, and there is the intermediate layer referred to as the Spirit world, where spirit beings operate. These three spheres influence one another. While there is the danger of spiritualising everything as stated by C. S. Lewis' warning 'seeing demons everywhere, behind every bush and under every table (Lewis, 2001)' There is also the danger of ignoring the embodiment of humans as spirit beings. As a result, Psychiatry cannot completely view faith-based doctrines such as whether people hear God's voice. Such is theology rather than science, and answers to such questions will depend on theological views of human experiences rather than on scientific explanations based upon the presence or absence of psychopathology. Although, scientific explanations may need to be considered in some situations.

What is the role of the Clergy in Mental Health Care? Clergies are religious leaders saddled with the responsibility to tending and caring for the congregations. In ancient Bible days, Priests played the physician's role by examining anyone infectious with a disease, and the same today. The outcome would determine what further medical or spiritual assistance is to be sought by the concerned. Religiosity and spirituality play significant roles in mental health care. Religiosity is defined as a collection of beliefs, practices and rituals related to sacredness. Spirituality, on the other hand, was not so easily defined. However, Christina Puchalski contends, "spirituality is the reflects ways we seek to express meaning and purpose and the way they experience their connectedness to God, to self, to others, to nature and the significant or sacred (Puchalski, 2014)"[3] According to DSM-5, religion is part of the cultural context of an illness experience; as a result, providing culturally appropriate mental health care is a critical and vital part of health care delivery (Puchalski, 2014). That is, however, subject to the availability of relevant knowledge and related documents.

Such culturally appropriate health care delivery must be tailored to religious beliefs and practices within the context of a subcultural entity (Alarcon, 2014). More than 80% of Africa's Clergies, most especially in RCCG, Nigeria, use religious beliefs and activities to cope with everyday difficulties and frustrations (Teeper et al., 2001); Furthermore, 1-in-4 prefer to seek

[3]. Christina M Puchalski, "The Fica Spiritual History Tool# 274," Journal of Palliative Medicine 17, (2014): 1.

help from the Clergy as their first treatment contact for mental health problems (Wang et.al). Within any Christian-based congregation, 25% of the people deal with mental illness either directly or indirectly (Stetzer, Ed., 2018).

Clergy professionals are regularly the first point of contact for any mental illness. As such, they act as 'gatekeepers' between individuals experiencing mental illness and the formal mental health care system. (Vander Waal et al., 21012). In a survey conducted among religious ministers, a significant proportion attributed symptoms of mental illness to socio-religious causation 'lack of trust in God' and was less likely to agree with the biological nature of mental illness conditions (Scott et al., 2013). Because the Clergies are often the first point of contact to mental health care for religious people, it is essential to understand the role of religious institutions in mental health care service delivery.

As it is, there is a limited understanding of faith-based mental health delivery structure. Counselling services as provided by the Clergies are inadequate, poorly coordinated and of low frequency (Hays et al., 2011). Given that, Clergies are not formal mental health professionals, this lack of training in mental health is expected. Considerable number of research studies have demonstrated that clergy professionals usually understand general mental health issues but feel inadequately prepared to recognise or treat serious mental illnesses (Vermaas et al., 2017). In most cases, clergy professional's skill does vary from low knowledge ability for trauma and stress-related disturbances to moderate knowledge ability for mood disorders and suicide (Chevalier et al., 2015).

Both the mental healthcare professionals and the Clergies have continued to agree on the potential of collaborations and having mutual referral partnerships (Weaver et al., 2003). Nonetheless, research also shows that faith-based providers are reluctant to collaborate with formal mental health care systems for several reasons, including lack of specialised training, limited financial resources, and lack of familiarity with the mental health system (Rabbia, 2006).

The low levels of collaborative processes between Clergy and mental health professionals have been a matter of historical perspectives. Before the 18th century, the practices of religion, medicine, and psychology were overlapping and complementary pedagogies (Rutz, 2916). However, with the advent of scientific advancement, increasing tensions arose between the medical and spiritual disciplines (Rutz, 2006). Over time, the medicalisation of the mental health field gradually alienated the faith leaders who were considered trusted healers and counsellors of their local communities (McMinn et al., 2010). Amidst the growing differences, Clergy and mental health professionals continue to view one another with suspicion and distrust; clergy professionals tend to disagree with psychological theories dealing with issues of morality and sin.

Likewise, mental health professionals perceive religious beliefs and practices as 'narrow and irrational'(Weaver et al., 2003). A notable example from 1907 was Sigmund Freud's view of God as an "illusion" and religion as "universal obsessional neurosis" (Belzen, 2009). However, in more recent times and particularly in the past three decades, integrations of spirituality within mental health care service provisions is continuing to gain renewed attention and the increasing quest for cooperation and interactive collaborations. The historical distrust between psychology and religion poses a significant barrier to Christian clergy referrals to mental health professionals and the challenges of mental health literacy levels. Low levels of mental health literacy present a key reason for the wide health care disparities observed. However, they found no significant differences in mental health literacy levels among the main denominational groups: Catholic, Evangelical, Protestant, Historically Black Protestant, and the Mainline Protestant (Weaver et al., 2003). Christian clergy professionals acknowledge that their training for addressing psychological problems is limited and refer severe mental illness to formal mental health professionals (Payne, 2014). However, in actual practice, clergy referrals to mental health professionals are uncommon, reportedly accounting for less than 10% of such referrals (Vernaas et al., 2017). Inability to recognise serious mental health illness was highlighted as a primary factor responsible for the low referral rate (Avvaci, 2016).

There exists limited information regarding pastoral counselling services as provided by African American clergy. Much of the counselling performed by the Clergy— individual pastors being concerned with their parishioners' emotional and behavioural conditions— are consistent with their theological and pastoral

training (Wang et al., 2003). For instance, parishioners with grief and loss, physical illness and marital conflicts have long been part of religious duties. Moreover, Clergies are also more likely to be sought out with critical and severe mental illness (Neighbor et al., 1998). Therefore, mental health education for clergy professionals is warranted to facilitate the more effective mental health-counselling professional and clergy partnership as advocated by the Church.

Conclusion

RCCG clergies in Nigeria demonstrate positive perceptions of mental health awareness, endorse mental-health professionally provided interventions, as well as embrace biological psychological-social model of psychological disturbances. Given the favourable findings, we can assume that mental health awareness is improving among RCCG pastors. Nevertheless, the issue of internalized negative perceptions and fears, which has undermined the desire for immediacy of people with mental illness, and to view people with mental illness as 'welcomed strangers' is existent among RCCG pastors (Baumann, 2007).

Summary and Recommendation

The holistic perspective of human beings as embodied spirit being is essential in understanding mental health. On the one hand, there is the solid scientific model of mental health, which tends to view human existence primarily in anatomy and physiology. On the other hand, lies the intangible moral psychology and spiritual dimensions of human existence. Mental health care needs to go beyond that of sharing the Gospel of Christ so that people will come into the community of a church. The type of community in Christ, to be presented by the Church, should be a community that provides for a safe and nurtured space for human souls to be healed, find growth, and pursue their maturity physically, spiritually, and emotionally. The following recommendations are here suggested:

1. Need for an aggressive transfer of relevant knowledge on mental health literacy

2. Need for holistic support for clergies with mental and psychological pressures

3. Need for strategic performance expectations of Clergies with no medical side effects

4. Need for development of a consistent Church policy on spiritual and social mental health management system for Clergies and the laities

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