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# Perception of Clergymen on the Care and Stigmatization of Persons with Mental Illness in Nigeria

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***Author's contribution***

*The sole author designed, analyzed, interpreted and prepared the manuscript.*

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## ABSTRACT

**Objectives:** This study was designed to investigate clergymen's training, knowledge, perception and experience of mental illness.
**Methods:** The study adopted both quantitative and qualitative study designs conducted among a total of 148 student population of the Nigerian Baptist Theological Seminary Ogbomoso. The stratified random sampling technique was used for the quantitative approach using the (Community Attitudes towards Mental Illness (CAMI) scale and the socio-demographic questionnaire while purposive sampling of the respondents was used for the qualitative approach. Data collated for the quantitative technique was analyzed using the Statistical Packages for the Social Sciences (SPSS) version 21.
**Results:** The Focused Group Discussions (FGDs) and Key Informant Interviews (KII) respondents believe that all mental illnesses are traceable directly or indirectly to spiritual factors, that certain sociocultural discriminations exist and that the local church is a healing community. The Community Attitudes towards Mental Illness (CAMI) benevolence subscale reveals that 76.4% of them want tax money to be spent on treating mental illness although 57.4% view mental hospitals

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as prisons. The Social restrictiveness subscale showed that 46.6% did not agree to engage women with a previous history of mental illness as babysitters and 37.2% did not agree to have them as neighbours. On the community mental health ideology subscale; about 70.3% have them live in neighbourhoods although 82.4% of them feel the mentally ill are awkward.
**Conclusions:** With improved mental health knowledge; the Baptist clergymen may ensure referral to orthodox medical services, encourage compliance and banish discrimination against the mentally ill crucial for the WHO scale up program in Nigeria.

*Keywords: Clergymen; mental illness; stigmatization; Nigeria.*

## 1. INTRODUCTION

"Globally, discrimination against persons with mental illness is a matter of public health concern. Stigma is a social construction that defines people in terms of a distinguishing characteristic or mark and devalues them as a consequence. A stigmatized person may be regarded as not quite human. According to Goffman's original formation, stigma can either be discrediting (when it is obvious to others) or discreditable (when it is not obvious to others). This depends on the nature and severity of the illness, the individual's responses to it and their willingness to reveal it to others. Stigma is thus defined as the situation of the individual who is disqualified from full social acceptance" [1].

"This encourages denial of interest in the compassionate care of the mentally ill and unduly cautions victims of mental illness against seeking and abiding by proven treatments and it discourages well-intended and otherwise highly-qualified practitioners from addressing this chronic medical condition with clients who may have no other real point of contact with the medical establishment other than a traditional health provider or a spiritual healer. Stigmatization deprives victims of mental illness of their full measure of human dignity and participation in the wider society by undermining social support and compromising the opportunity for treatment. And this is done by individual and institutional discrimination resulting from misconceptions, prejudicial stereotypes and negative public and professional attitudes about mental illness" [2].

In a study conducted in Northern Nigeria, it was found that respondents responded with fear, avoidance and anger to those who were observed to have a mental illness. The stigma linked to mental illness in that community can be attributed to a variety of factors including lack of education, fear, religious reasoning, and general prejudice.

"The average Nigerian, irrespective of their educational status, still believes in supernatural and preternatural causes in the etiology of mental illness. This belief system is embraced by some syncretic churches and makes them very popular in both rural and urban areas. Practitioners of healing in these syncretic churches are referred to as spiritual healers. Their healing centres have been reported to constitute a significant aspect of patients' pathway to mental health care with about 13-68% of patients having visited them before presenting to a psychiatric hospital" [3].

A great majority of Nigerians are religious, and separating religiosity from our patients' experiences with mental health problems is practically impossible as the average Nigerian believes the etiology of mental illness is supernatural [4]. "In developing countries, the clergy plays an important role in the pathways to care for people with mental illness as established by many studies" [5].

"More than half of the people surveyed in Nigeria believe that supernatural or spiritual factors are responsible for the cause of mental illness and spiritual healers are sought by the mentally ill and/or their relatives for diverse reasons and especially at the early stages of the illness. This orientation readily makes the average people believe that the most effective care could only be obtained from non-medical sources such as the clergy or traditional healers" [6].

Although studies have established the role of the clergy as a significant part of the pathway to mental health care in Nigeria, no study emerges that has specifically examines the knowledge, quality of training in mental health and attitudes of the clergy concerning the care and response to the stigmatization of mental illness. This study is therefore designed to investigate the training, knowledge, perception and experience of the clergymen in the Baptist denomination to mental illness with a view of developing a synergy

between the orthodox mental health caregivers and the clergy geared towards prompt referral, support and advocacy for the benefit of the mentally ill and in support of the WHO program of bridging the treatment gap, especially in the low and middle – income countries like Nigeria.

## 2. METHODOLOGY

### 2.1 Study Design

Both quantitative and qualitative study designs were adapted. This mixed method of investigation was adopted because most studies on stigma in Nigeria had adopted the quantitative method.

### 2.2 Technique

Following a review of the literature on previous studies [7] examining the attitudes of clergy toward mental illness, we chose a convenient sample of two hundred subjects for the study. This figure we believe adequately covers non-response and inadequately-filled questionnaires. The student population of the Nigerian Baptist Theological Seminary, Ogbomosho was subjected to a stratified random sampling technique. The total number of students population was obtained from the administrative department. This population was subdivided according to their year and program of study for sample allocation. Subjects were selected randomly by balloting technique.

The sampling of respondents for the semi-structured interviews and focus group discussions was purposive. Respondents for the key informant interviews were selected mostly because they were known to be resourceful people and had an experience that was particularly relevant to the study.

### 2.3 Study Instrument

Data collection was done by a 2-section self-administered questionnaire. “Section 1 comprised the socio-demographic characteristics of respondents, including the number of years in ministry. Section 2 was the Community Attitudes towards Mental Illness (CAMI) scale developed by Taylor and Dear” [8]. This instrument comprises 40 items divided into 4 priori subscales of ten items each viz: *Authoritarianism, Benevolence, Social Restrictiveness and Community Mental Health Ideology*.

### 2.4 Procedure

For the quantitative data, questionnaires were distributed to students at convenient agreed appointments. Some questionnaires were filled and returned to the researcher immediately, while others were collected at an appointed date. A total of 148 questionnaires were retrieved and analyzed.

For the qualitative approach, detailed information to participants concerning participation and the consequence of the study was provided and thus participation was voluntary. With the consent of individual Participants, all sessions were digitally recorded and transcribed verbatim. Eight semi-structured interviews were held with the principal/faculty officers of the Seminary and Pastors on the mission field in Ogbomosho Township and two focus group discussions for undergraduate and postgraduate students were conducted with 12 members each. Thus, for in-depth data, selections were purposively made of the President of the seminary, faculty heads and the principal administrative officers of the seminary and 4 Baptist pastors in the metropolis. Data was elicited over one month.

### 2.5 Data Analysis

The quantitative Data was analyzed using the Statistical Packages for the Social Sciences (SPSS) version 21 statistical software, and results were presented in tables while the qualitative data were transcribed using the traditional manual approach of handwriting before they were typed into Microsoft Word for storage. Also, through a manual approach, the research themes were identified and sorted into likely and unlikely opinions based on the research objectives and assigned to appropriate research objectives. Some of these opinions were presented verbatim in the report.

## 3. RESULTS

Two hundred copies of questionnaires were distributed while one hundred and forty–eight were used for analysis following sorting. There were twenty – five (25) females which represent 16.9 percent and one hundred and twenty-three (123) males represented 83.1 percent. All have one form of formal education or the other ranging from secondary (3.4%) to tertiary (63.5%) and postgraduate (33.1%). About 91.2% had not received any form of mental health training in the past (Table 1).

**Table 1. Socio-demographic characteristics of the student population studied**

| Variable | N (%) |
|---|---|
| Age groups | |
| 18-25 years | 45 (30.4) |
| 26-30 years | 49 (33.1) |
| 31-35 years | 17 (11.5) |
| 36-40 years | 18 (12.2) |
| 41-45 years | 10 (6.8) |
| 46-50 years | 4 (2.7) |
| 51-55 years | 1 (0.7) |
| 56-60 years | 1 (0.7) |
| 61-65 years | 3 (2.0) |
| Gender | |
| Male | 123 (83.1) |
| Female | 25 (16.9) |
| Level of Education | |
| No Education | - |
| Primary Education | - |
| Secondary Education | 5 (3.4) |
| Tertiary Education | 94 (63.5) |
| Postgraduate | 49 (33.1) |
| Received any mental training | |
| Yes | 13 (8.8) |
| No | 135 (91.2) |
| Any previous family experience | |
| Yes | 15 (10.1) |
| No | 133 (89.9) |

Clergy attitudes on the authoritarianism scale are largely stigmatizing with 73.0% of respondents thinking that there is something about the mentally ill that makes it easy to tell them from normal people; 70.3% of them thought that mentally ill persons should be controlled and disciplined as young children while 57.4% disagreed that less emphasis should be placed on protecting the public from the mentally ill although only a few of them 14.9% disagree that mentally ill should not be treated as outcasts (Table 2).

The majority of the clergymen interviewed scored quite high on the benevolence scale which is not unconnected with the peculiarity of their training and role as clergymen although 57.4% of them feel that our mental hospitals seem more like prisons than places where the mentally ill should be catered for.

Only 37.8% of them agree that the mentally ill should be isolated from the rest of society and only 9.5% disagree that the mentally ill should not be denied their rights although about half (46.6%) disagree that most women who were once patients in mental hospitals can be trusted as babysitters.

On the CMHI subscale majority of the clerics are impressively well disposed to having community-oriented care for the mentally ill although only 48.6% of them agree that locating mental health services in residential neighbourhoods does not endanger residents and about 43.9% agree that residents have good reason to resist the location of mental health services in their neighbourhoods.

**Table 2. Authoritarianism subscale**

| Questions | N | % |
|---|---|---|
| A person should be hospitalized as soon as he shows signs of mental disturbance. (Strongly Agree/Agree) | 119 | (80.4) |
| There is something about the mentally ill that makes it easy to tell them from normal people. (Strongly Agree/ Agree) | 108 | (73) |
| Mental patients need the same kind of control and discipline as young children. (Strongly Agree/ Agree) | 104 | (70.3) |
| The best way to handle the mentally ill is to keep them behind locked doors. (Strongly Agree/ Agree) | 23 | (15.5) |
| One of the main causes of mental illness is a lack of self-discipline and willpower. (Strongly Agree/ Agree) | 53 | (35.8) |
| Mental illness is an illness like any other. (Strongly Disagree/ Disagree) | 76 | (51.4) |
| Less emphasis should be placed on protecting the public from the mentally ill (Strongly Disagree / Disagree) | 85 | (57.4) |
| The mentally ill should not be treated as outcasts of society (Strongly Disagree / Disagree) | 22 | (14.9) |
| Mental hospitals are outdated means of treating the mentally ill (Strongly Disagree / Disagree) | 88 | (59.5) |
| Virtually anyone can be mentally ill. (Strongly Disagree / Disagree) | 35 | (23.6) |

**Table 3. Benevolence subscale**

| Questions | N | % |
|---|---|---|
| More tax money should be spent on the care and treatment of the mentally ill (Strongly Disagree / Disagree) | 35 | (23.6) |
| The mentally ill have for too long been the subject of ridicule (Strongly Disagree / Disagree) | 31 | (20.9) |
| We need to adopt a far more tolerant attitude towards the mentally ill in our society (Strongly Disagree / Disagree) | 27 | (18.2) |
| Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for (Strongly Agree / Agree) | 85 | (57.4) |
| We have a responsibility to provide the best possible care for the mentally ill ( Strongly Disagree / Disagree) | 7 | (4.7) |
| The mentally ill are a burden on society (Strongly Agree / Agree) | 49 | (33.1) |
| Increased spending on mental health services is a waste of tax dollars ( Strongly Agree / Agree ) | 13 | (8.8) |
| There are sufficient existing services for the mentally ill (Strongly Agree / Agree ) | 49 | (33.1) |
| The mentally ill do not deserve our sympathy ( Strongly Agree / Agree ) | 12 | (8.1) |
| It is best to avoid anyone who has mental problems (Strongly Agree / Agree ) | 51 | (34.5) |

**Table 4. Social restrictiveness**

| Questions | N | % |
|---|---|---|
| The mentally ill should be isolated from the rest of the community (Strongly Agree / Agree) | 56 | (37.8) |
| A woman would be foolish to marry a man who has suffered from mental illness even though he seems fully recovered (Strongly Agree / Agree) | 38 | (25.7) |
| I would not want to live next door to someone who has been mentally ill (Strongly Agree / Agree) | 55 | (37.2) |
| Anyone with a history of mental problems should be excluded from taking public office. (Strongly Agree / Agree) | 51 | (34.5) |
| The mentally ill should not be given any responsibility. (Strongly Agree / Agree) | 42 | (28.4) |
| The mentally ill are far less of a danger than most people suppose. (Strongly Disagree/ Disagree) | 56 | (37.8) |
| No one has the right to exclude the mentally ill from their Neighborhood. (Strongly Disagree / Disagree) | 47 | (31.8) |
| Mental patients should be encouraged to assume the responsibilities of normal life. (Strongly Disagree / Disagree) | 35 | (23.6) |
| The mentally ill should be denied their rights (Strongly Agree / Agree) | 14 | (9.5) |
| Most women who were once patients in a mental hospital can be trusted as babysitters (strongly Disagree/ Disagree) | 69 | (46.6) |

The result from the interviews; Key Informant Interview (KII) and Focus Group Discussion (FGD) on identified themes from the literature concerning mental illness are as reported:

1. **Description of mental illness:** The respondents both at KII and FGD describe mental illness as abnormal behaviour and employed social norms as benchmarks for identification. Mental illness is viewed as very obvious and noticeable while only a few recognize the fact that some mental illnesses may not be immediately noticeable and can only be picked when an individual fails to meet social and psychological obligations. Most could not give specific categories of mental illness apart from the PhD students in pastoral care and counselling who could categorize mental illnesses.

One of the respondents in the FGDs made this point; *Any behaviour that an individual comes up with that causes embarrassment for the*

*immediate family, and church congregation and the individual does not see as bad and fails to control constitutes symptoms of mental illness.*

2. **Causes of Mental Illness:** Findings from the KII and FGD show that the respondents are aware that psychosocial stressors like financial problems, marital problems, business failures and others can cause mental illness. They also believe that mental illness can be due to genetic causes, direct physical injuries to the head and other physical illnesses. Some also believe that it could develop as a result of abusing substances like marijuana which is a reflection of their education and awareness. However, all the respondents believe that mental illness is often caused by spiritual factors. They corroborated this by referring to the madman of Gadarene whom Jesus Christ cast out demons out of to regain his sanity [9].

One respondent said; *Mental illness does not just occur; it is usually a product of gross violation of natural laws like abuse of psychoactive substances or emotional upheavals through life challenges in marriage or work and violation of spiritual principles like sin and engaging in spiritual warfare without fortification.*

However, all the respondents in FGDs and KII believe that all mental illnesses are traceable directly or indirectly to spiritual factors including those due to genetic causes, direct physical injuries to the head and abuse of substances.

The summary of their position is in three parts:

1. Spirits attack the mind directly either through sin or by providing an inroad to destabilize the mind. They corroborated this by referring to the madman of Gadarene whom Jesus Christ cast out demons out of him to regain his sanity.
2. A spiritual attack can upturn the thought processes by generating anxiety and stress through social and economic mishaps which invariably predisposes to mental illness.
3. Spiritual attacks along ancestral lineage manifesting as genetic factors or certain spiritual forces inducing an addiction to substances.

This belief has been established by previous studies in this environment and elsewhere in this cohort.

3. **Treatment Modalities:** The respondents subscribe to a holistic approach involving the spiritual, psychological and medical. They think that those that are due to spiritual causes can only be discerned spiritually and the attempt of the researcher to get them to come up with distinctive criteria emanating from the discernment of this group was difficult. They claim that such spirit must be cast out as Jesus did to the madman at Gadarene through spiritual authority and prayers.

However, they don't believe in beating or starving to get rid of those spirits.

They also believe that pastoral counselling through sermons or dedicated prayer sessions can prevent as well as cure mental illness while they all agreed that patients can be referred to doctors to take medications that do not invalidate the effectiveness of the spiritual intervention. One of the respondents claimed that; *it is advisable that once someone has a behavioural challenge he is referred to the medical doctors for some intervention through our training and practice while the spiritual dimension is handled through prayers. However, there are no known indicators to differentiate those that will need exorcism or ordinary prayers.*

4. **The Concept of Cure:** They all believe that mental illness can be completely cured when the three approaches are applied in a way that the patient resumes normal functioning of his life and that those who don't get well oftentimes have spiritual undertones that may require special spiritual intervention through exorcism. This is a potential asset in the involvement of the clergymen in the care of the mentally ill. They all believe that mental illness can only be completely cured when the three approaches of possible spiritual exorcism, ordinary prayers of faith, pastoral counselling and medications are applied in a way that the patient resumes the normal functioning of his life.

5. **The Role of clergymen in the care of the mentally ill:** The respondents believe that they have a very crucial role in the care of

the mentally ill, especially because as spiritual leaders they are equipped to address dysfunction in the spiritual life of congregants which they believe is the root of most mental illnesses. They strongly believe that for the mentally ill to be completely healed; there is a need for the involvement of the clergymen for prayers to cast out harmful spirits, to sustain a strong and confident mind through sermons and to help them comply with medications when prescribed by giving support to the family. They averred that taking medications does not eliminate faith by citing examples in the life of Jesus Christ and instructions given by Paul to Timothy for seeking a physical remedy.

One of the respondents in the FGDs said; *Pastors are the leaders even in the congregations and by extension in the community such that most cases of illnesses especially of mental nature are mostly reported first to us so that we can guide the process of healing.* This position is a little different from a study of the clergy done in Nigeria but of a syncretic group who do not believe in the referral because of the demonic etiology theory.

6. **Opinion about orthodox medical intervention for mental illness:** All the respondents recognize the role of medical intervention in the treatment of the mentally ill and see it as part of the spiritual intervention by drawing strongly from the medical mission of the Baptist denomination. They espoused that medications were discovered through spiritual inspiration and hence should be encouraged. They claim that they will easily refer patients to orthodox practitioners who do not work against their faith as they continue to pray with the patients and ensure that doctors' instructions are complied with. One of the respondents in the FGDs said, *Drugs are manufactured through the guidance and wisdom of God and there is a biblical basis for the use of medications for treatment only that the spiritual intervention through prayers and sermons is very important.* This is a great asset for future collaboration between psychiatry and theology as it is being proposed.

7. **Opinions about seminary training and mental health intervention:** Apart from the postgraduate students in the department of pastoral care and counselling who have adequate exposure to mental health training as part of their curriculum prerequisites, the other cadres of students claim they have limited knowledge in the actual handling of the mentally ill patient. They think that their training should be expanded to include mental health training. In one of the FGDs, a respondent thinks that; *There is virtually no serious education about mental illness apart from the spiritual perspective being taught in the pastoral care and counselling classes.* This becomes important since the pastors are usually the first to be called when a patient gets violent and most times, they may not know what to do practically in such situations.

8. **The Role of Clergymen in Community Mental Health:** In one of the key informant interviews; a former president of the convention is actually of the opinion that the church is a clinic, particularly for mental health and that with the increasing incidence of mental illnesses in our society and by extension in our congregations; it may be inevitable for pastors who will be very effective in the ministry to be equipped with basic mental health training not only for his congregation but for the community. This is how he put it; 'the *church is a clinic, particularly for mental health and that with the increasing incidence of mental illnesses in our society and by extension in our congregations; it may be inevitable for pastors who will be very effective in the ministry to be equipped with basic mental health training not only for his congregation but for the community'*.

One of the faculty members, the Dean of Student Affairs and the lecturer at the department of church music think that Christian music can be deployed especially at the preventive phase as well as when the illness has developed citing practical and scriptural basis for this assertion. The respondents also claim that through the tenets of redemption; discrimination in terms of marriage, work placement and other social dimensions can be abolished as they offer support for those who are ill and their families.

**Table 5. Community mental health ideology**

| Questions | N | % |
|---|---|---|
| The best therapy for many mental patients is to be part of a normal community. (Strongly Disagree/ Disagree) | 56 | (37.8) |
| There is something about the mentally ill that makes it easy to tell them from normal people | 122 | (82.4) |
| Residents should accept the location of mental health facilities in their neighbourhood to serve the need of the local community (Strongly Disagree / Disagree) | 37 | (25.0) |
| Locating mental health services in residential neighbourhoods does not endanger residents (Strongly Disagree/ Disagree) | 72 | (48.6) |
| Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services (Strongly Disagree/ Disagree) | 44 | (29.7) |
| Locating mental health facilities in a residential area downgrades the neighbourhood (Strongly Agree/ Agree) | 61 | (41.2) |
| Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great. (Strongly Agree/ Agree) | 21 | (14.2) |
| Residents have good reason to resist the location of mental health services in their neighbourhood. (Strongly Agree / Agree) | 65 | (43.9) |
| Mental health facilities should be kept out of residential neighbourhoods (Strongly Agree / Agree) | 78 | (52.7) |
| It is frightening to think of people with mental problems living in residential neighbourhoods (Strongly Agree/ Agree) | 91 | (68.2) |

## 4. DISCUSSION

It was observed that the majority of respondents were educated with about 63.5% having tertiary education and another 33.1% in the postgraduate program although very few of them 8.8% have ever had some form of mental health training. However, this quality of education and exposure in this cohort may invariably serve as a template for training in mental health. Certain studies had implicated poor training in mental health among the clergy as a form of handicap in intervention in mental health cases [10].

From the FGD and KII on the description and concept of the cause of mental illness; the value of this level of literacy shines through in the definition of mental illness which was quite illustrative. Their definition was closely linked to deviations from psychosocial benchmarks although not sufficient to detect less dramatic cases. This inability to be able to recognize the less dramatic mental illnesses is related to the lack of training in mental health rather than a discriminatory attitude as other studies have illustrated even in developed countries [11]. All the respondents in FGDs and KII believe that all mental illnesses are traceable directly or indirectly to spiritual factors including those due to genetic causes, direct physical injuries to the head and abuse of substances. “This aligns with themes permeating studies on religious and faith healers’ perception of mental illness in low and middle-income countries that while mental illness and emotional problems may have both natural and supernatural causes, they primarily require spiritual solutions. This line of thought resonates with African traditional healers’ belief that even the seemingly physical causes of mental illness always have a supernatural undercurrent and thus, require spiritual healing over and above biological treatment” [12–14].

On the clergy attitudes about the authoritarianism, scale elicited negative attitudes where about 70.3% feel that the mentally ill need the same kind of control and discipline as a child and another 73% claim that there is something about them that is easy to tell. These findings may not be unconnected with the prevailing African viewpoint concerning mental illness. Only a few of them 15.5% agree they should be kept behind closed doors.

From the FGD and KII; the respondents hold a spiritual paradigm encompassing a holistic intervention for the mentally ill. This they share in common with the traditional healers deriving from the African culture which may reflect the finding on the authoritarian scale as negative while their

holistic approach and compassionate calling as clergymen may explain why they don't want them locked up on the same subscale.

Harmful methods such as beating have been reported to be used by traditional healers to make the patient controllable; the spiritual healers seem to beat the patients to "drive out the evil spirits" responsible for the illness [10] "Practices of apostolic faith healers in mental health care in Zimbabwe were studied and they were reported being consulted on various problems including mental illness, physical ailments and social problems, such as bad luck, unemployment and failure to get married. Witchcraft and avenging spirits were cited as the most common causes treated mainly through prayer, holy water to drink and bathe, exorcism, holy stones, and string band tied around wrists and ankles" [15].

"The Celestial Church of Christ (CCC), a syncretic church in Nigeria shares a concept of mental illness very similar to the notion held by the community. The belief in spirit possession, malicious spirit, ancestral spirit, and curses from enemies as causative agents for mental illness are prevalent in the CCC. Means of healing or what may appear as their pharmacopoeia includes; holy water (this is water that has been imbued with divine power to heal by prayer), amulets, prayer and fasting, sacrifices (this comes in form of fruits, clothing materials, candle), and very occasionally physical restraint on a bare ground which symbolically represents where Jesus Christ was born and found as a constant feature in all the parishes of the church. It is believed by members that all prayers offered on this spot would be granted" [10].

Moreso, the clergy attitudes on the benevolence subscale showed that the majority of the respondents score very high on issues of advocacy like 76.4% of them canvassing that more tax money should be spent for their treatment. About 95.3% insist that we have a responsibility to provide the best possible care for the mentally ill. While about 57.4% of them feel that our mental hospitals seem more like prisons may reveal their benevolent orientations to the care of the mentally ill.

This may explain the reason for the high positive scores on the benevolence subscale. They also believe that apart from prayers and counselling which can be therapeutic; referrals to medical doctors are also important. This is not unconnected with the associated rich pedigree of medical ministry associated with their theological training. However, this is in contrast to practices in the syncretic churches which have healing centres that constitute a significant aspect of patients' pathway to mental health care with about 13-68% of patients having visited them before presenting to a psychiatric hospital [3,16].

"However, a particular study among apostolic faith healers indicated being in favour of some form of collaboration between themselves and orthodox medical practitioners. The perceived benefits of collaboration included getting more referrals from the formal health centre as well as opportunities to access both material resources and health training to enhance their practices" [15] "Research has consistently shown that clergy, not psychologists or other mental health professionals, are the most common source of help sought in times of psychological distress" [17]. "Recognizing their position on the frontlines of intervention, psychologists have tended to view clergy as mental health gatekeepers" [18]. "In this role, clergy are thought to function as a referral source for psychologists, who then provide direct mental health services to the client" [19].

The social restrictiveness subscale showed that the mentally ill are perceived to be dangerous and should be avoided through their unpredictable behaviour. Less than half of them (46.6%) did not agree to engage women with a previous history of mental illness as babysitters and only 37.2% agreed not to live next door to someone who has been mentally ill. These findings are in some contrast to the scores on the benevolence subscale but could be understood in the context of the African cultural viewpoint that prescribes certain social restrictions on those who are mentally ill.

From the KII and FGD; it appears the respondents (especially on the fields and the trainers) are aware of certain sociocultural prescriptions against the mentally ill when they were interviewed on their role in community mental health. They invoked the tenets of redemption as reconciliatory rather than discriminatory to banish the observed social distance in terms of marriage and job placement orientations against the mentally ill. They hinged their argument on the premise of achievable total cure from the holistic approach to management. This position is reflected on the subscale having only 9.5% agreeing to they losing their rights

while the majority believe that their rights should be respected with humane treatment.

There is a meeting point between orthodox care and religious care which can be synergistically explored. Some recent evidence suggests that Religious/ Spiritual interventions could lead to a reduction of clinical symptoms [20]. The volume of Americans for instance turning to the clergy for assistance with mental health issues is staggering. Even if individuals identified themselves as "not religiously active" and "seldom attending religious services," In a particular study, 16% reported seeking help from clergy members for personal problems. Studies have shown that women, people who have been widowed and elderly persons all tend to turn to a religious clergy member rather than to a mental health specialist [21].

In addition, surveys of psychiatry and psychology training programs indicate that both psychiatrists and psychologists are not given adequate training to deal with the religious and spiritual issues that arise in clinical practice.

The community mental health ideology findings in this study show that the respondents show an impressive understanding of their role in community health advocacy. About 70.3% of them agree that residents have nothing to fear from people coming into their neighbourhood to obtain mental health services and another 75% agree to the fact that residents should accept the location of mental health facilities in their neighbourhood to serve the need of the local community. Although 82.4% of them agree that there is something about the mentally ill that makes it easy to tell them from normal people. This statement like in the authoritarian subscale connotes more recognition rather than discrimination because other statements that should establish it as discriminatory were not agreed to.

From the FGD and KII on the role of the clergymen in community mental health; the respondents hold the view as expressed by a former president of the Nigerian Baptist Convention that the church is a healing community, particularly for mental health problems and that with the increasing incidence of mental illness in our congregations it may be inevitable for pastors who will succeed to be equipped with basic mental health training not only for his congregation but for the community. Invoking the tenets of redemption, the respondents believe that discrimination in terms of marriage, work placement and other social discriminations can be abolished as they offer support for those who are ill and their families. All the respondents referred to the holistic nature of the Baptist ministry which came with a formidable medical ministry. This is reinforced by the thrust and emphasis of the theological training that spills to the community beyond the congregation. By invoking and interpreting the doctrine of redemption in the social context; the positive findings of community mental health ideology are not surprising.

“Studies have shown that improved knowledge positively influences attitudes towards mentally ill persons, especially about authoritarianism, discriminatory beliefs and social integration. Surveys conducted in the United States consistently show that both the general public and psychiatric patients report that they attend church more frequently than do mental health professionals, believe in God at a significantly higher rate, and consider religion to have a more significant role in their life” [22]. “The domain of spirituality is a vital concern for the majority of service users. Nevertheless, participants felt that spiritual needs are not a priority for medical staff relative to more tangible issues of care. It was therefore suggested that training programs addressing spiritual awareness be introduced and that these should be multi-disciplinary. Collaborations between psychiatry and faith-based organizations pose unique problems” [23]. “The psychiatric establishment and religious organizations have historically viewed one another with suspicion and at times direct hostility” [24]. Religious organizations and clergy may be at odds with the medical establishment as to causes and proper treatment of such illnesses as depression and anxiety. In some religious groups, these maladies may be seen as stemming from a spiritual source rather than brain pathology.

“This fact raises the natural question of whether members of the clergy are adequately trained to counsel persons with major psychiatric illnesses. A survey of nearly 2,000 Methodist pastors revealed that although 95% believed that incorporating counselling training into seminary was important, 25% felt that their seminary training had significantly contributed to their competence as pastoral counsellors" [25]. “The clergy has reported referring less than 10% of those counselled to mental health specialists, yet 50% to 80% of clergy members have reported that counselling training in seminary and post-

seminary continuing education was inadequate and 45% stated that they received no training on referral criteria" [26].

Specific anti-stigma interventions should also examine the factors that promote social distancing and design strategies to minimize them. In addition, the input of patients (service users) in the anti-stigma program would prove invaluable.

## 5. CONCLUSION

This study has been able to inform the readers about the effects of pastoral response to the care and stigmatization of mental illness in this environment. The findings will be very crucial in preventing mental illness from occurring and also help the pastors to be of relevant support to the mentally ill and their families. With improved knowledge and their holistic approach to care, the clergymen in the Baptist denomination will be able to effectively work with the orthodox medical practitioners in a wholesome way through an effective referral system, ensuring compliance, rehabilitation and banishing discrimination against the mentally ill apart from offering support. This peculiarity may invariably serve as a template for the scaling up program of the WHO, especially in a low-income country like Nigeria where spiritual healers are prominent on the pathways of care and prevent patients from having access to orthodox care.

## COMPETING INTERESTS

Author has declared that no competing interests exist.

## REFERENCES


1. DeFleur ML. Stigma: Notes on the management of spoiled identity. By Erving Goffman. Englewood Cliffs, New Jersey: Prentice-Hall, 1963. 147 pp. Cloth, $4.50; paper, $1.95. Social Forces [Internet]. 1964;43(1):127–8.
   DOI: 10.1093/SF/43.1.127
   Access on 2023 Feb 19
2. Corrigan PW, Penn DL. Lessons from social psychology on discrediting psychiatric stigma. 1999;
3. Makanjuola RO. Yoruba traditional healers in psychiatry. I. Healers' concepts of the nature and aetiology of mental disorders. Afr J Med Med Sci. 1987;16(2):53–9.
4. Odejide OA. "Traditional (native) psychiatric practice: Its role in modern psychiatry in a developing country." The Psychiatry Journal of the University of Ottawa. 1979;4(4):297–401. Google Search [Internet].
   Access on 2023 Feb 19
5. Appiah-Poku J, Laugharne R, Mensah E, Osei Y, Burns T. Previous help sought by patients presenting to mental health services in Kumasi, Ghana. Soc Psychiatry Psychiatr Epidemiol. 2004;39(3):208–11.
6. Sadock BJ, Sadock VA. Pastoral counselling. Kaplan and Sadock's Synopsis of Psychiatry; 2003. - Google Search [Internet].
   Access on 2023 Feb 19
7. James BO, Thomas FI, Seb-Akahomen OJ, Igbinomwanhia NG, Inogbo CF, Thornicroft G. Barriers to care among people with schizophrenia attending a tertiary psychiatric hospital in Nigeria. South African Journal of Psychiatry. 2019;25.
8. Taylor SE. Positive illusions craeative self-deception and the healthy mind. New York Basic Books. - References - Scientific Research Publishing; 1989. [Internet]
   Available:https://www.scirp.org/(S(czeh2tfqyw2orz553k1w0r45))/reference/referencespapers. asp?referenceid=255079
   Access on 2023 Feb 19
9. Ryan B. The church and mental health: Theological and practical responses. Zygon [Internet]. 2018;53(2):409–26.
   Available:https://onlinelibrary.wiley.com/doi/full/10.1111/zygo.12417
   Access on 2023 Feb 19
10. Agara A, Makanjuola A, Morakinyo O. Management of perceived mental health problems by spiritual healers: A Nigerian study. Afr J Psychiatry (Johannesburg) [Internet]. 2008;11(2):113–8.
    Available:https://europepmc.org/article/med/19582328
    Access on 2023 Feb 19
11. Farrell JL, Goebert DA. Collaboration between psychiatrists and clergy in recognizing and treating serious mental illness. Psychiatr Serv [Internet]. 2008;59(4):437–40.
    Available:https://pubmed.ncbi.nlm.nih.gov/18378845/
    Access on 2023 Feb 19
12. Religion, Health, and Healing in the Traditional Shona Culture of Zimbabwe | Practical Matters Journal [Internet].

Available:http://practicalmattersjournal.org/2011/03/01/religion-health-healing/
Access on 2023 Feb 19

13. Omonzejele PF. African concepts of health, disease, and treatment: an ethical inquiry. Explore (NY) [Internet]. 2008;4(2): 120–6.
Available:https://pubmed.ncbi.nlm.nih.gov/18316055/
Access on 2023 Feb 19
14. Teuton J, Bentall R, Dowrick C. Conceptualizing psychosis in Uganda. [Internet]. 2016;44(1):79–114.
Available:https://journals.sagepub.com/doi/10.1177/1363461507074976
Available:http://dx.doi.org/101177/1363461507074976
Access on 2023 Feb 19
15. January J, Sodi T. The practices of apostolic faith healers in mental health care in Zimbabwe. Journal of Psychology in Africa. 2006;16(2):315–9.
16. Erinosho Olayiwola A. "Pathways to mental health delivery systems in Nigeria." Int J Soc Psych. 1977;23:55–59. - Google Search [Internet].
Access on 2023 Feb 19
17. Chalfant HP, Heller PL, Roberts A, Briones D, Aguirre-Hochbaum S, Farr W. The Clergy as a Resource for Those Encountering Psychological Distress. Rev Relig Res. 1990;31(3):305–13.
18. Hartog K, Gow KM. Religious attributions about the causes and cures of mental illness. [Internet]. 2007;8(4):263–76.
Available:https://www.tandfonline.com/doi/abs/10.1080/13674670412331304339
Available:https://doi.org/101080/13674670412331304339
Access on 2023 Feb 19
19. Benes K, Welsh J, McMinn M, Dominguez A, Aikins D. Psychology and the church: An exemplar of psychologist-clergy collaboration. Faculty Publications - Doctor of Psychology (PsyD) Program [Internet]; 2000.
Available:https://digitalcommons.georgefox.edu/gscp_fac/161
Access on 2023 Feb 19
20. Goncąlves JPB, Lucchetti G, Menezes PR, Vallada H. Religious and spiritual interventions in mental health care: a systematic review and meta-analysis of randomized controlled clinical trials. Psychol Med [Internet]. 2015;45(14):2937–49.
Available:https://pubmed.ncbi.nlm.nih.gov/26200715/
Access on 2023 Feb 19
21. Psychiatric factors predicting the use of the clergy. [Internet].
Available:https://psycnet.apa.org/record/1993-97489-002
Access on 2023 Feb 19
22. Kroll J, Sheehan W. Religious beliefs and practices among 52 psychiatric inpatients in Minnesota. Am J Psychiatry [Internet]. 1989;146(1):67–72.
Available:https://pubmed.ncbi.nlm.nih.gov/2912252/
Access on 2023 Feb 19
23. Leavey G. The appreciation of the spiritual in mental illness: A qualitative study of beliefs among clergy in the UK. Transcult Psychiatry [Internet]. 2010;47(4):571–90.
Available:https://pubmed.ncbi.nlm.nih.gov/20940269/
Access on 2023 Feb 19
24. Koenig HG. Religion and medicine I: Historical background and reasons for separation. Int J Psychiatry Med [Internet]. 2000;30(4):385–98.
Available:https://pubmed.ncbi.nlm.nih.gov/11308040/
Access on 2023 Feb 19
25. Orthner DK. Pastoral counseling: Caring and caregivers in the United Methodist Church. Nashville, Tenn, General Board of the Higher Education and Ministry of the United Methodist Church; 1986.- Google Search [Internet].
Access on 2023 Feb 19
26. Virkler HA. Counseling demands, procedures, and preparation of parish ministers: A descriptive study. Journal of Psychology and Theology. 1979;7:271–80. - Google Search [Internet].
Access on 2023 Feb 19



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