Suicide Among Clerics: A Global Phenomenon with a Focus on Nigeria and Preventive Strategies

By Prof. Pwaveno H. Bamaiyi-University of Jos

Introduction

The tragic incident involving Reverend Esther Moses Akor in Sokoto in October 2001, where she reportedly committed suicide following the discovery of her husband's infidelity, serves as a stark illustration of the profound personal crises that can afflict religious leaders and potentially lead to devastating outcomes. This particular event, though situated within a specific cultural and religious context, resonates with a broader, often under-discussed, phenomenon of suicide among clerics globally. This paper aims to explore the prevalence of suicide among religious leaders, examining various contributing factors and presenting case studies from Nigeria and other regions, while also proposing proactive preventive measures and intervention strategies. It will delve into the societal and internal pressures faced by clerics, the psychological impact of their roles, and the often-overlooked mental health challenges within religious communities. Particular attention will be paid to the unique vulnerabilities of Nigerian clerics, where mental health stigma often intertwines with supernatural beliefs, hindering disclosure and effective support (Nwafor, 2024). Furthermore, this analysis will highlight the critical role that religious institutions themselves can play in fostering environments that prioritize mental well-being and destigmatize mental health issues among their leadership and congregants alike, advocating for integrated support systems that combine spiritual care with professional psychological services.

Background of the Incident: Reverend Esther Moses Akor

The reported suicide of Reverend Esther Moses Akor, a minister in the Celebration Covenant Church, at her residence on Moradi Road in Sokoto, after discovering her husband had fathered a child outside their marriage, underscores the intense personal distress that can lead to such tragic acts. This incident, while specific in its details, reflects broader themes of betrayal, marital strain, and the immense pressure experienced by individuals in positions of religious authority, whose personal lives are often subject to intense scrutiny and expectation. This particular case highlights the intersection of personal trauma and the unique challenges faced by religious figures, who are often expected to embody unwavering faith and resilience, even in the face of profound personal adversity. The incident prompts a deeper examination into how such personal crises within the clergy can escalate to self-harm, especially when compounded by societal expectations and the often-unacknowledged psychological burdens of their ministry. This tragic event serves as a critical entry point for a broader discussion on the mental health challenges confronting religious leaders, particularly within the Nigerian context where cultural, religious, and legal factors often lead to an underestimation of suicide statistics and discourage open discussion (Abamara & Ozongwu, 2024). Moreover, the lack of robust mental health infrastructure and the pervasive stigma surrounding psychological distress within many Nigerian communities exacerbate these vulnerabilities, leaving clerics with limited avenues for support and intervention (Nwafor, 2024). This context makes it imperative to explore the underlying causes of such extreme responses among religious leaders, moving beyond simplistic explanations to address the complex interplay of personal, professional, and societal factors (Nwafor & Vandenhoeck, 2024).

Contextualizing Suicide Among Clerics

The unique stressors associated with clerical life, including immense spiritual responsibilities, constant public scrutiny, and often inadequate personal support systems, contribute significantly to mental health vulnerabilities that can, in extreme cases, lead to suicidal ideation and acts. These pressures are frequently compounded by an expectation of moral impeccability and unwavering faith, which can deter clerics from seeking help for mental health challenges, fearing it may be perceived as a spiritual failing or a sign of weakness. The pervasive stigma surrounding mental health within religious communities further isolates clerics, making them less likely to disclose their struggles and access professional support (Kansiewicz et al., 2022). This silence often perpetuates a cycle of suffering, as clergy members prioritize the spiritual and emotional needs of their congregations over their own well-being (Tice et al., 2025). Indeed, the inherent demands of clergy roles, often characterized by high expectations and emotional labor, are increasingly recognized as contributors to adverse mental health outcomes, paralleling trends observed in the general population (Boateng et al., 2024). Specifically, studies indicate that clergy are at an elevated risk for depression, anxiety, burnout, and vicarious trauma due to their continuous exposure to congregants' suffering and the emotional and psychological taxation of their work (Boateng et al., 2024). This heightened susceptibility underscores the urgent need for comprehensive mental health support systems tailored to the specific challenges faced by religious leaders (Nwafor, 2024). This is

particularly salient in Nigeria, where a recent surge in suicide rates has been linked to a "crisis of meaninglessness" exacerbated by socio-economic realities and globalization (Ehusani, 2024; Eweka & Ugiagbe, 2020). However, these general trends gain a particular poignancy when considering the added burdens placed upon religious leaders who are expected to provide solace and guidance while potentially grappling with their own severe psychological distress (Abamara & Ozongwu, 2024). This paradoxical situation creates a critical gap in care, wherein those who are often first responders to community crises may themselves lack access to appropriate mental health resources and support.

Research Objectives

This paper therefore aims to investigate the factors contributing to mental health challenges and suicide risk among Nigerian clerics, using the case of Reverend Akor as a poignant illustrative example. It will further explore the broader prevalence of such issues among religious leaders globally and propose actionable preventive measures, drawing from existing research and best practices in mental health care for clergy. Such an exploration is crucial for developing targeted interventions that address the unique psychological and spiritual needs of this often-overlooked demographic. By examining the underlying causes and societal pressures, this analysis seeks to inform strategies that foster resilience and provide robust support systems for religious leaders.

Literature Review: Suicide and Religious Leaders

Despite their pivotal role in community well-being, the mental health of religious leaders, particularly regarding suicide, remains an under-researched area (Smithers & Kavanagh, 2025). While existing literature often focuses on the broader impact of clergy on congregant mental health (Boateng et al., 2024), there is a growing recognition of the unique stressors and vulnerabilities inherent in clerical roles that can predispose religious leaders to various forms of psychological distress, including burnout and trauma (Hydinger et al., 2024; Jankowski et al., 2023). The public nature of their work and the expectation to serve as moral exemplars can create immense pressure, leading to isolation and reluctance to seek help for personal struggles (Kansiewicz et al., 2022). This phenomenon is further complicated by the fact that clergy are frequently viewed as pillars of strength and spiritual guidance, making it difficult for them to admit their own vulnerabilities without fear of undermining their authority or faith in the eyes of their followers (Boateng et al., 2024). Such societal and internal pressures contribute to a significant barrier to help-seeking behavior among religious leaders, often exacerbated by a lack of adequate mental health literacy and training within religious institutions (Boateng et al., 2024; Cook, 2012). This gap in understanding and support can have profound consequences, as evidenced by tragic incidents like the suicide of Pastor Jarrid Wilson in 2019, which brought the mental health crisis among clergy into sharp public focus (Kansiewicz et al., 2022). Indeed, the increasing evidence points to significant rates of distress and attrition among religious professionals, with studies indicating that clergy often experience elevated rates of burnout and other mental health challenges (Hydinger et al., 2024). For example, rates of depression among Christian clergy have been reported to be three times higher than in the general population, a phenomenon often linked to insufficient social support and spiritual well-being (Edwards et al., 2020). This highlights a significant paradox: those tasked with providing spiritual and emotional care to others often find themselves lacking adequate resources for their own psychological well-being (Khosa-Nkatini, 2022). The unique stressors associated with religious leadership, such as competing role demands, unrealistic congregational expectations, and professional isolation, further compound these vulnerabilities, making clergy particularly susceptible to mental health issues (Biru et al., 2022; Jankowski et al., 2023). These include excessive workloads, emotional exhaustion, and a perceived lack of support, which contribute to conditions like compassion fatigue, a common occurrence among clergy who continually adopt a compassionate and caring role (Leon, 2025). Moreover, this constant engagement with human suffering and the perceived need to maintain an unwavering facade of spiritual strength can lead to profound divine struggles and feelings of alienation from God, further exacerbating psychological distress (Upenieks & Eagle, 2023).

Defining Clergy Mental Health

Defining clergy mental health necessitates a comprehensive understanding that encompasses not only the absence of psychological disorders but also the presence of positive psychological functioning, spiritual well-being, and resilience in the face of unique vocational demands. This definition acknowledges the multifaceted nature of their well-being, integrating spiritual, emotional, and occupational dimensions. It recognizes that clergy, while often perceived as spiritually invulnerable, are susceptible to similar mental health challenges as the general population, yet experience unique stressors inherent to their calling, such as high expectations, isolation, and constant exposure to others' suffering (Jack & Wilcox, 2017). Studies have consistently revealed that religious leaders frequently encounter elevated rates of occupational distress, depression, and burnout, often exceeding national averages for other professions (Proeschold-Bell et al., 2015; Shaw et al., 2021). For instance, research indicates that Catholic priests frequently contend with issues such as burnout syndrome, depression,

and anxiety, often stemming from excessive workloads and a lack of social support (Bocalon et al., 2024). These issues are compounded by the complex interplay of individual predispositions, relational dynamics, and organizational factors that collectively influence the well-being and psychological resilience of religious leaders (Hydinger et al., 2024). This comprehensive perspective is crucial for developing targeted interventions and support systems that address the specific needs of clergy, moving beyond a narrow focus on distress to promote holistic flourishing (Hydinger et al., 2024).

Factors Contributing to Clergy Suicide Risk

The intricate tapestry of factors contributing to suicide risk among clergy weaves together professional, personal, and spiritual threads, creating a complex vulnerability that demands careful deconstruction. One significant aspect is the intense occupational distress prevalent within clerical professions, which often surpasses national averages across other vocations (Shaw et al., 2021). For instance, studies show that Anglican and Catholic clergy report considerable emotional exhaustion and depersonalization, indicative of significant work-related strain (Lewis et al., 2006). This distress is often exacerbated by the unique demands of their roles, including constant emotional labor and the pressure to maintain an exemplary public image (Hydinger et al., 2024). Clergy often experience higher rates of depressive and anxiety symptoms compared to the general population, with specific demographics like United Methodist Church clergy in North Carolina showing elevated levels (Biru et al., 2022). This heightened vulnerability is further compounded by the specific occupational stressors inherent in their calling, such as unbounded work hours, ambiguous role expectations, and the emotional toll of constantly caring for others (Proeschold-Bell et al., 2023).

Societal and Spiritual Pressures on Clerics

The burden of upholding an image of unwavering faith and moral rectitude can be psychologically taxing, leading many to suppress their personal struggles and avoid seeking mental health assistance. This pressure is often rooted in the societal expectation that clergy should be paragons of spiritual strength, immune to the vulnerabilities of ordinary individuals (Proeschold-Bell et al., 2023). Moreover, the perceived stigma associated with mental health issues within religious communities often discourages clergy from disclosing their struggles, fearing judgment or even job loss (Biru et al., 2022). This reluctance to seek help is further compounded by the theological frameworks prevalent in some religious traditions, which may interpret mental health challenges as spiritual failings rather than medical conditions (Khosa-Nkatini & Buqa, 2021).

Case Studies of Cleric Suicide

The tragic incident involving Reverend Esther Moses Akor in Sokoto exemplifies the acute distress experienced by clergy, particularly when personal betrayals intersect with professional and spiritual expectations. Her reported suicide, triggered by the discovery of her husband's infidelity, underscores the profound impact of relational trauma on individuals entrusted with spiritual guidance, highlighting a critical need for robust support systems within religious organizations. This tragic event, while specific in its details, resonates with a broader pattern of clergy experiencing significant mental health crises often exacerbated by personal stressors and the unique pressures of their vocation (Adams et al., 2016). This incident serves as a poignant reminder that even those who provide spiritual solace are not immune to profound personal suffering, underscoring the necessity of addressing the mental health and well-being of religious leaders. The case illuminates how personal crises, particularly those involving marital infidelity, can trigger severe psychological distress among clergy, potentially leading to tragic outcomes, and mirrors the experiences of many church employees who face mental strain and isolation (Kuusi et al., 2024). Such incidents highlight the urgent need for a deeper understanding of the factors contributing to mental health challenges among religious leaders and the development of effective preventative measures and support networks within religious institutions. Indeed, the perceived resilience of clergywomen, though often lauded, does not negate their susceptibility to occupational stress and mental health challenges, with some studies indicating that while they may be resilient in certain aspects, they still experience considerable distress, especially when navigating traditionally male-dominated religious spheres (Holleman, 2022). The psychological toll on female clerics can be particularly acute, as they often navigate a double burden of pastoral responsibilities and societal biases within their religious communities. The societal and internal pressures to uphold an image of unwavering faith and moral fortitude frequently compel female clergy to suppress their personal struggles, thereby hindering their access to crucial mental health support (Holleman, 2022). This phenomenon often leads to a cycle where the very individuals expected to provide emotional and spiritual support to others find themselves isolated in their own suffering (Leavey et al., 2007). This isolation can be exacerbated by the absence of adequate institutional support structures, leaving female clerics vulnerable to burnout and profound psychological distress. The systemic lack of recognition for their unique challenges within ecclesiastical structures often contributes to a pervasive sense of marginalization and neglect, further eroding their mental well-being (Holleman, 2022). The dual pressures of congregational expectations for

unwavering spiritual leadership and the personal demands of navigating a complex marital landscape often create an untenable situation for female clergy, culminating in severe mental health crises (Holleman, 2022; Lin & Wang, 2024).

The Sokoto Incident: A Detailed Analysis

Reverend Akor's suicide, stemming from the profound emotional betrayal of her husband's infidelity, offers a stark illustration of how personal crises can catastrophically intersect with the professional and spiritual demands placed upon clergy, especially women (Scott & Lovell, 2014). This particular event highlights the critical importance of understanding the psychological vulnerabilities that can arise when personal resilience is tested within a public and spiritually demanding role. The unique stressors faced by female clergy, such as navigating patriarchal structures and experiencing challenges to their leadership from male congregants, can amplify the impact of personal crises (Rogers & Tinsley, 2023). Moreover, the expectation for clergy wives to embody perfection and unwavering emotional fortitude within their congregations can significantly exacerbate their psychological distress when confronted with marital challenges, impacting their overall well-being (Lin & Wang, 2024). This pressure is intensified for female clergy whose identities are frequently intertwined with their husband's ministry, making personal failures feel like public ones (Lin & Wang, 2024). The confluence of these factors can create an environment where emotional support is scarce, and the burden of maintaining an image of sanctity becomes overwhelming, often leading to tragic outcomes like that of Reverend Akor (Khosa-Nkatini, 2022). Similarly, a pastor in Zimbabwe tragically succumbed to suicide after allegations of adultery, further underscoring the severe mental health challenges faced by religious leaders when confronted with moral transgressions or personal crises (Tagwirei, 2025). Such incidents reveal a global pattern of clergy facing immense pressure and limited mental health resources, often leading to tragic ends when personal and professional stressors become overwhelming (Tagwirei, 2025). These instances underscore the urgent need for comprehensive mental health support systems within religious institutions to address the unique pressures experienced by their leaders (Tagwirei, 2025). Further research indicates that financial stress, marital discord, and instances of rejection or loss are significant contributors to suicidal ideation among religious leaders, mirroring broader societal patterns of mental health challenges (Uroko, 2023). This pervasive issue extends beyond individual tragedies, reflecting systemic deficiencies in addressing the mental well-being of spiritual leaders across various denominations and geographical regions (Tagwirei, 2025). The confluence of these multifarious stressors necessitates a deeper, more nuanced investigation into the specific mechanisms through which occupational and personal challenges manifest as severe psychological distress among clergy. Specifically, the absence of robust support networks and the inherent isolation within some clerical roles can exacerbate these vulnerabilities, turning personal setbacks into overwhelming burdens that lead to self-harm (Makena et al., 2023).

International Perspectives: Additional Cases

In recognition of the global prevalence of this issue, numerous case studies from diverse geographical and denominational contexts provide further insights into the complex interplay of factors contributing to clergy suicide and mental health crises (Rogers, 2022). For instance, studies in Ghana have revealed that pastors often experience significant mental health challenges due to occupational demands and societal expectations, highlighting the universality of these stressors (Tawam et al., 2024). The stigma associated with mental health issues, coupled with the expectation for clergy to be paragons of spiritual strength, often prevents them from seeking the necessary help, thereby perpetuating a cycle of silent suffering (Tagwirei, 2025). This widespread reluctance to address mental health concerns openly is further compounded by a lack of adequate training among clergy to recognize and effectively respond to mental illness within their congregations and among themselves (Boateng et al., 2024; Lehmann et al., 2021). This deficit in both personal recognition and institutional response underscores a critical need for integrated mental health education and support systems within theological training and ongoing pastoral development programs. This includes acknowledging that pastors face unique occupational stressors, which can lead to high stress levels and burnout, further exacerbated by role ambiguity and undefined expectations (Kansiewicz et al., 2022). Such pressures are often intensified by the perception that clergy must embody unwavering faith and resilience, making it difficult for them to admit to personal struggles or seek professional help without fear of judgment or perceived spiritual weakness (Hydinger et al., 2024). Consequently, many clergy members internalize their struggles, leading to increased isolation and a heightened risk of developing severe mental health conditions that may culminate in tragic outcomes like suicide. Moreover, the perception of mental illness among clergy themselves can vary significantly based on racial and religious affiliations, with some pastors more inclined to attribute depression to spiritual failings rather than biological or psychological factors, thus hindering appropriate intervention (Smith et al., 2022). This spiritualization of symptoms, rather than seeking therapeutic engagement, can inadvertently delay appropriate care for clergy (Antoniou & Kalogeropoulos, 2024). This phenomenon is particularly pronounced in

communities where religious institutions serve as primary support systems, often intertwining faith and healing in ways that can either facilitate or impede access to conventional mental health services (Nganyu, 2025; Sutton et al., 2025). Indeed, the intersection of faith and mental health often dictates whether individuals, including clergy, pursue evidence-based treatments or rely solely on spiritual interventions (Antoniou & Kalogeropoulos, 2024).

Common Themes and Unique Circumstances

While some clergy may recognize the role of psychology in diagnosis and treatment, many still believe that treatment should incorporate spiritual elements, reflecting a nuanced approach to mental health (Smith et al., 2022). This integrative perspective suggests that mental health interventions for clergy must respectfully consider their spiritual frameworks, fostering an environment where seeking professional help is not perceived as a contradiction to their faith but rather as a holistic approach to well-being. Such an approach would not only destigmatize mental health challenges within religious communities but also enhance the effectiveness of interventions tailored to the unique spiritual and occupational contexts of clergy (Harris et al., 2015). Furthermore, addressing the historical and systemic factors contributing to mental health disparities, such as generational trauma and race-based experiences, is crucial for developing culturally sensitive and effective support mechanisms for clergy in diverse communities (Rogers & Tinsley, 2023). This is especially pertinent for Black clergy, who often serve as critical gatekeepers for mental health support within their communities but may face unique challenges in accessing culturally competent care themselves (Coombs et al., 2021). Therefore, interventions designed for these populations must consider the intricate interplay of cultural identity, religious convictions, and systemic inequities to ensure comprehensive and effective support. Moreover, recognizing the significant role of religious institutions as trusted spaces, particularly for Black males, integrating pastoral counseling with behavioral health services can provide an effective framework for addressing both emotional distress and spiritual dissonance (Sutton et al., 2025).

Prevalence of Suicide Among Clerics

While the exact prevalence of suicide among clerics globally remains challenging to quantify due to underreporting and data sensitivities, existing studies and anecdotal evidence consistently point to a concerning trend that warrants focused academic inquiry. This section aims to consolidate available data and case studies to illuminate the scope of this crisis, acknowledging that clergy are not immune to the mental health challenges that affect the general population. Indeed, despite their vital roles in providing spiritual guidance and community support, clergy often face unique stressors that can predispose them to psychological distress and, in extreme cases, suicidal ideation (Rogers, 2022). The case of Reverend Esther Moses Akor, who reportedly died by suicide in Sokoto in 2001, serves as a stark illustration of the intense personal crises that can afflict religious leaders, often exacerbated by the very public nature of their roles and the private pain they endure. This incident, while tragic, also serves to highlight the broader, often unacknowledged, mental health struggles prevalent within the clergy, which are frequently compounded by societal expectations of unwavering spiritual fortitude. The demands placed upon clergy, such as constant availability and emotional labor, can significantly contribute to their vulnerability to mental health issues, sometimes more so than in other professions (Boateng et al., 2024). This vulnerability is further compounded by a pervasive stigma within many religious communities that discourages open discourse about mental health, often leading clergy to suffer in silence rather than seek necessary support (Awaad et al., 2024). This silence can be particularly deafening for clergy experiencing secondary traumatic stress, a condition common among helping professionals, including religious leaders, who are frequently exposed to the trauma and crises of their congregants (Roggenbaum et al., 2023). Such vicarious traumatization, coupled with their own personal struggles, necessitates a critical examination of the support structures available to them and the barriers that prevent them from accessing adequate mental health care. Research indicates that clergy often experience higher rates of depression than the general population, with studies showing estimates of up to 41% among ministers (Edwards et al., 2020; Kansiewicz et al., 2022). This elevated prevalence underscores the need for targeted interventions and mental health support systems specifically designed for religious leaders (Alakija et al., 2022). This figure is particularly concerning given that nearly half of clergy with elevated symptoms of mental distress do not engage in professional care, highlighting a significant gap in service utilization (Biru et al., 2022). One contributing factor to this gap is the perception among some religious leaders that seeking psychological help for depression is unnecessary, believing that faith alone should suffice (Ogbolu et al., 2020). This belief, however, overlooks the complex interplay of biological, psychological, and social factors in mental health, thereby hindering appropriate and timely intervention (Biru et al., 2022). This reluctance to seek professional help is often exacerbated by the stigma associated with mental illness within religious communities, where clergy may fear that acknowledging mental health struggles could be perceived as a lack of faith or an inability to effectively lead their congregations (Biru et al., 2022). Such perceptions not only deter clergy from seeking timely mental health interventions but also perpetuate a cycle of

silence and suffering that can have dire consequences, including increased risk of suicide. This phenomenon is further complicated by the added burden of secondary traumatic stress, where religious leaders, akin to other helping professionals, absorb the trauma of their congregants, thereby increasing their own vulnerability to mental health challenges (Roggenbaum et al., 2023). This exposure to congregants' suffering, combined with the expectation to be resilient and spiritually strong, can lead to burnout and compassion fatigue, further escalating their risk for severe psychological distress and suicidal ideation (Heseltine-Carp & Hoskins, 2020). The lack of mental health service utilization among clergy, despite elevated rates of distress, is a critical issue that studies suggest is influenced by the perceived support from their congregations and the pervasive stigma surrounding mental health within religious contexts (Biru et al., 2022). Religious leaders often interpret mental health symptoms through spiritual lenses, which can lead them to recommend religious interventions over professional mental healthcare, further limiting their engagement with secular mental health services (Moreno et al., 2022).

Statistical Overview: Nigeria

In Nigeria, the scarcity of mental health professionals and the prevailing socio-cultural factors, including strong religious beliefs, significantly complicate the already challenging landscape of mental healthcare access, particularly for clergy (Ozota et al., 2024). The high prevalence of mental illness in the country, coupled with a low awareness of mental health issues and a preference for spiritual interventions over conventional medical treatment, creates a formidable barrier to effective support for religious leaders (Okoye, 2023). This situation is further exacerbated by the stigma associated with mental health in Nigerian society, which often discourages individuals, including clergy, from seeking professional help for psychological distress (Pederson et al., 2022; Shipurut, 2024). This cultural context means that many clergy, despite their own struggles, may feel compelled to project an image of unwavering strength and faith, thereby internalizing their mental health challenges rather than addressing them openly. This phenomenon can lead to a cycle of silent suffering, particularly as religious leaders are often the first point of contact for individuals seeking help for mental health issues, yet they themselves may lack the training or support to recognize and address their own mental health needs (Freire et al., 2018; Ogbolu et al., 2020). This reliance on religious leaders as primary mental health referral sources, despite their limited training in mental health, underscores a critical gap in the Nigerian healthcare system that leaves both congregants and clergy vulnerable (Ogbolu et al., 2020). Indeed, only a small fraction of Nigerian adults with mental health disorders receive any form of care, a statistic that highlights the profound limitations of the country's mental healthcare infrastructure and directly impacts the support available to its spiritual leaders (Iheanacho et al., 2021). This dire situation is further compounded by the fact that traditional and religious leaders are often the primary, and sometimes sole, providers of care for mental illnesses, especially in rural areas where access to orthodox mental health professionals is severely limited, highlighting the critical need for training and collaboration with these gatekeepers (Aluh et al., 2018; Nwafor, 2024; Ogbolu et al., 2020). The limited availability of mental health services in Nigeria, with only 0.15 psychiatrists per 100,000 population, exacerbates the challenges faced by clergy in accessing appropriate care (Chu et al., 2022). This severe shortage of mental health professionals means that many religious leaders, despite being on the front lines of community care, lack adequate resources and guidance for their own well-being (Precious et al., 2024). Furthermore, societal stigma and financial constraints within Nigeria also deter aspiring professionals from pursuing careers in psychiatry, thereby perpetuating the critical shortage of mental health practitioners (Precious et al., 2024). The reliance on religious leaders to address mental health concerns, without adequate training or resources, inadvertently places them at a higher risk for mental health deterioration, potentially contributing to tragic outcomes such as suicide. The tragic incident involving Reverend Esther Moses Akor in Sokoto on October 26-28, 2001, serves as a stark illustration of how these systemic failures and individual pressures can converge, leading to devastating consequences for religious leaders. Her reported suicide, purportedly linked to the discovery of her husband's extramarital child, highlights the profound emotional and psychological distress that can afflict even those in spiritual leadership roles, particularly when compounded by personal crises and the absence of adequate support mechanisms. This incident underscores the urgent need to address the mental health vulnerabilities of clergy, especially within contexts like Nigeria where mental healthcare infrastructure is severely lacking and societal expectations place immense pressure on spiritual leaders. This specific case exemplifies how personal trauma can intersect with professional responsibilities and societal expectations to create an untenable situation for a cleric. The absence of accessible and destigmatized mental health services within religious communities, coupled with the immense pressure on clergy to embody unwavering faith, often prevents them from seeking the crucial support needed to navigate such profound personal crises (Nwafor, 2024). The confluence of these factors not only exacerbates individual suffering but also perpetuates a cycle where the very individuals expected to provide solace and guidance are left without adequate avenues for their own well-being, demanding systemic interventions to bridge this critical gap in care. This unfortunate event serves as a poignant reminder that clergy, despite their spiritual roles, are not immune to profound personal suffering and are often subject to unique stressors that can severely impact their mental health. The intense demands of ministry, coupled with the pressure to maintain an image of infallible strength, can lead to

significant stress, burnout, and emotional exhaustion among religious leaders (Boateng et al., 2024; Tice et al., 2025). Such factors, alongside the societal expectation of moral perfection, contribute to a pervasive reluctance among clergy to seek professional mental health support, further isolating them in their struggles. This phenomenon is not unique to Nigeria, as studies have shown similar patterns of mental health challenges and barriers to seeking help among clergy globally (Boateng et al., 2024; Kansiewicz et al., 2022). The pervasive nature of these challenges underscores the critical necessity for a more comprehensive and empathetic approach to clergy mental health, one that transcends geographical and cultural boundaries. Indeed, research consistently highlights that pastors, despite their roles as spiritual leaders, are profoundly susceptible to overwhelming stress, isolation, and burnout, underscoring that their human vulnerability to anxiety and depression should not be overlooked (Tagwirei, 2025). For instance, studies in certain populations have revealed that Catholic priests exhibit significantly higher rates of depression and anxiety, sometimes seven times greater than that observed in the general populace (Marambi, 2022). This elevated prevalence is often attributed to the unique occupational stressors inherent in ministry, such as demanding schedules, emotional labor, and the expectation of perfection (Spaumer et al., 2025). Moreover, other research has demonstrated that clergy often experience elevated levels of psychological distress compared to the general population, with significant proportions reporting symptoms indicative of anxiety and depression (Khosa-Nkatini, 2022). Such findings underscore the urgent need for tailored mental health interventions and support systems specifically designed to address the unique pressures faced by religious leaders across various denominations and cultural contexts. Many pastors acknowledge experiencing anxiety and depression, with some adopting coping strategies that involve social and spiritual supports, while others neglect their own well-being in their dedication to congregational care (Harris et al., 2015). This pervasive issue is compounded by the fact that mental disorders, such as depression and anxiety, are as prevalent in low- and middle-income countries as in high-income nations, disproportionately affecting women and contributing to maternal morbidity, poor infant health, and lost economic opportunities (Iheanacho et al., 2021). Furthermore, a substantial number of clergy experience psychological distress that meets the criteria for clinical disorders, yet a significant proportion do not seek mental health services, despite acknowledging the benefits of doing so (Biru et al., 2022). This reluctance to engage with professional help often stems from societal stigmas surrounding mental health within religious communities and the fear of compromising their pastoral efficacy or reputation (Biru et al., 2022). The under-researched nature of clergy well-being, despite growing interest in occupational stress across professions, suggests that this demographic faces significant mental health challenges that warrant urgent investigation, as conditions like depression and anxiety are more prevalent among them than in the general population (Smithers & Kavanagh, 2025). This disparity is further exacerbated by the vital role clergy play in community mental health support, often acting as frontline responders for congregants' psychological needs while their own well-being remains understudied and underserved (Boateng et al., 2024). Therefore, understanding the prevalence and contributing factors to suicide among religious leaders, as exemplified by the tragic case of Reverend Akor, is paramount for developing effective preventive measures and support systems. The pervasive expectation that religious leaders should epitomize spiritual strength often creates an environment where admitting to mental health struggles is perceived as a failure of faith, thereby increasing their vulnerability to severe distress and, in extreme cases, suicidal ideation.

Global Trends and Comparative Data

This section will delve into the broader landscape of mental health challenges faced by religious leaders worldwide, drawing comparisons and highlighting commonalities and differences in the stressors and support mechanisms available to them. Specifically, while global data on suicide prevalence among clergy remains limited, evidence from various regions, including low- and middle-income countries, points to a concerning trend where mental health disorders are significant risk factors for fatal outcomes like suicide (Lovero et al., 2023; Moitra et al., 2023). Indeed, research suggests that religious leaders, much like the general population, experience internal struggles such as doubts about their calling and feelings of inadequacy, even though they often report high levels of job satisfaction (Biru et al., 2022). This internal conflict between personal struggles and professional fulfillment can exacerbate psychological distress, making it challenging for them to openly address their mental health needs. Furthermore, the demanding nature of their roles, coupled with the emotional labor involved in supporting congregants, can contribute to significant burnout and compassion fatigue, factors that are often overlooked in the discourse surrounding clerical well-being (Boateng et al., 2024). The unique stressors faced by clergy, including managing administrative duties, counseling congregants through crises, and maintaining spiritual leadership, often lead to a neglect of their own mental health, thereby increasing their susceptibility to severe psychological distress and, in extreme cases, suicidal ideation (Biru et al., 2022; Boateng et al., 2024). Moreover, a significant number of pastors do not seek professional mental health assistance due to perceived stigma, lack of awareness, or insufficient training in mental health literacy, which further compounds the issue and hinders early intervention (Cook, 2012). This is particularly concerning given that mental health issues are highly prevalent among the clergy, with compassion fatigue being a consistent trend (Leon, 2025).

Consequently, understanding the specific stressors that lead to burnout and compassion fatigue among religious leaders is crucial for developing targeted interventions and support systems to safeguard their mental well-being (Hydinger et al., 2024). Such preventative measures are critical, as spiritual struggles, including feelings of alienation from God, are strongly associated with higher levels of depression among clergy, particularly for those who experience an increase in these struggles over time (Upenieks & Eagle, 2023). The pervasive nature of occupational distress and depression among clergy is further evidenced by studies indicating higher rates of these conditions compared to national averages, highlighting the unique vulnerabilities within this profession (Shaw et al., 2021). This heightened susceptibility to mental health issues can be attributed to the complex interplay of vocational demands, spiritual expectations, and often inadequate support structures, rendering clergy a high-risk demographic for burnout and related psychological distress (Bocalon et al., 2024; Jankowski et al., 2023). Emerging evidence indicates concerning prevalence rates of distress and attrition among religious leaders, especially since the COVID-19 pandemic (Hydinger et al., 2024). This systematic review highlights the complex interplay of individual, relational, and organizational factors contributing to clergy well-being, encompassing aspects from burnout and trauma to spiritual distress (Hydinger et al., 2024). Such findings underscore the urgent need for a more holistic approach to clergy care, moving beyond mere distress reduction to encompass proactive strategies that enhance resilience and foster spiritual well-being (Hydinger et al., 2024).

Underreporting and Stigma in Religious Communities

The stigma associated with mental health issues is particularly acute within religious communities, where admitting to psychological struggles can be perceived as a sign of spiritual weakness or a lack of faith, thereby discouraging clergy from seeking the help they desperately need (Freire et al., 2018). This reluctance is often compounded by the pressure to maintain an image of unwavering strength and faith, making it exceedingly difficult for clergy to disclose their vulnerabilities without fear of judgment or professional repercussions (Edwards et al., 2020; Jack & Wilcox, 2017). This internalized and externalized stigma creates a significant barrier to accessing mental healthcare, contributing to the underreporting of mental health conditions and exacerbating the potential for severe psychological distress among religious leaders. The unique demands of clerical life, often involving high interpersonal interaction and the bearing of congregational burdens, further intensify the risk for occupational distress, depression, and anxiety, with several studies indicating above-average depressive symptoms among certain clergy groups (Biru et al., 2022).

Risk Factors and Contributing Elements

Indeed, clergy often face immense pressure to meet the diverse and continuous demands of their roles, which can include administrative tasks, pastoral care, spiritual guidance, and community leadership, often leading to chronic stress and burnout (Biru et al., 2022; Proeschold-Bell et al., 2023). These multifaceted responsibilities, coupled with the emotional labor involved in supporting congregants through various life challenges, can significantly deplete their emotional reserves, making them vulnerable to psychological distress (Biru et al., 2022; Hydinger et al., 2024). The expectations placed upon religious leaders can sometimes be unrealistic, fostering an environment where seeking help for mental health challenges is perceived as a failure rather than a necessary step towards well-being (Jankowski et al., 2023). Such vocational demands, characterized by unbounded work hours and ambiguity in prioritizing needs, contribute significantly to clergy stress, even amidst high job satisfaction (Proeschold-Bell et al., 2023). This dynamic can create a paradox where clergy report contentment with their calling yet simultaneously experience debilitating levels of stress and anxiety, contributing to a substantial mental health treatment gap within this demographic (Biru et al., 2022).

Marital Infidelity and Betrayal

The emotional and psychological toll of marital infidelity, particularly when involving a public figure like a cleric, can be devastating, leading to profound feelings of betrayal, shame, and isolation. In the context of the Reverend Mrs. Esther Moses Akor's tragic suicide, the discovery of her husband's infidelity likely precipitated an acute crisis, highlighting the intense vulnerability clergy and their spouses face when personal and professional boundaries intersect with profound relational breaches (Lin & Wang, 2024). This incident serves as a stark illustration of how deeply personal crises, especially those involving infidelity, can interact with the public persona and spiritual expectations placed upon religious leaders, potentially leading to catastrophic outcomes. The unique societal and religious pressures on clerics to embody moral uprightness often exacerbate the psychological impact of such betrayals, making it exceedingly difficult for them to process their pain privately or seek appropriate support without fear of public scandal or professional repercussions. Furthermore, family stressors, such as marital strain, are consistently identified as significant contributors to the complex emotional experiences of individuals in pastoral roles, often intertwined with the demands of ministry in ways that complicate the balance between personal life and professional duties (Tice et al., 2025).

Emotional and Psychological Burden of Ministry

The constant demand for empathy, coupled with the frequent exposure to congregants' suffering and existential crises, can lead to a significant emotional burden on clergy, often resulting in compassion fatigue and vicarious trauma. This persistent immersion in the emotional turmoil of others, combined with the expectation to remain stoic and supportive, often leaves little room for clergy to process their own psychological distress, thereby increasing their susceptibility to mental health crises (Adams et al., 2016; Kuusi et al., 2024). Moreover, the inherent isolation of the pastoral role, where opportunities for genuine peer support and confidential disclosure are often limited, further exacerbates these psychological vulnerabilities, hindering timely intervention and support (Ashley, 2020). Many clergy wives, for instance, report significant struggles with loneliness and finding confidantes, underscoring the systemic issues that contribute to isolation within religious leadership (Ashley, 2020).

Lack of Support Systems and Professional Help

The absence of robust support networks, both formal and informal, coupled with significant barriers to accessing professional mental health services, contributes to a perilous environment for clergy experiencing psychological distress (Kansiewicz et al., 2022). This void is often a consequence of systemic issues within religious institutions that may not prioritize mental health care, or an institutional culture that discourages open dialogue about such struggles among its leaders (Boateng et al., 2024). Such an environment inadvertently fosters a culture of silence, wherein clergy are less likely to seek the psychological assistance they require, exacerbating their mental health challenges (Khosa-Nkatini, 2022). This phenomenon is particularly pronounced among clergywomen, who may face additional stressors and unique occupational challenges that further compromise their mental well-being and access to adequate support (Holleman, 2022).

The Stigma of Mental Illness in Religious Circles

The pervasive stigma surrounding mental illness within religious communities often deters clergy from acknowledging their struggles or seeking professional help, fearing it might compromise their spiritual authority or professional standing (Kansiewicz et al., 2022). This internalized and externalized stigma perpetuates a cycle of silence and suffering, making it exceptionally difficult for religious leaders to admit vulnerability without fearing judgment from congregants or ecclesiastical superiors. Consequently, many clerics endure their mental health challenges in isolation, leading to an exacerbation of their conditions and, in tragic cases, to severe outcomes such as suicide (Scott & Lovell, 2014). This fear of tarnishing their spiritual image often compels them to mask their distress, leading to a profound disconnect between their public persona and their private anguish. This societal and religious pressure on clergy to appear infallible often prevents them from addressing personal struggles, such as marital problems or financial distress, which are often cited as primary challenges faced by clergy wives (Clarke et al., 2025; Lin & Wang, 2024).

Preventive Measures and Interventions

Addressing the complex interplay of these factors necessitates a multifaceted approach that not only acknowledges the unique occupational stressors faced by clergy but also actively implements strategies to foster mental well-being and destigmatize psychological distress within religious contexts. This includes establishing accessible mental health resources, promoting open dialogue about emotional well-being, and providing robust support systems tailored to the specific needs of religious professionals. Such initiatives are crucial for cultivating an environment where seeking psychological support is seen as a sign of strength rather than a weakness, thereby reducing the incidence of severe mental health crises among this demographic (Trihub et al., 2010). One critical step involves destigmatizing mental health issues within religious organizations, encouraging open conversations, and viewing mental health care as an integral component of holistic well-being rather than a sign of spiritual failing (Tagwirei, 2025). Furthermore, theological education and ongoing pastoral development programs should incorporate comprehensive modules on mental health awareness, stress management, and emotional resilience to equip future and current clerics with essential coping mechanisms and self-care strategies. These educational initiatives should emphasize the importance of seeking professional psychological support without shame, fostering an environment where clergy feel empowered to address their mental health needs proactively (Plante, 2020). Moreover, providing confidential counseling services specifically designed for clergy and their families can offer a safe space for addressing personal and professional challenges without fear of reprisal or judgment, thereby encouraging early intervention for mental health concerns (Shaw et al., 2021). Additionally, fostering peer support networks among clergy can provide a vital outlet for shared experiences and mutual encouragement, combating the professional isolation that often exacerbates mental health struggles. These networks can serve as crucial platforms for sharing best practices in self-care and navigating the unique pressures of ministerial life, ultimately contributing to a more resilient and supportive clerical community

(Grosch & Olsen, 2000). The integration of religious competence in mental healthcare also mandates a reciprocal understanding between clergy and clinicians, facilitating a collaborative approach to identifying and addressing mental illness within congregations (Whitley, 2012). This bidirectional understanding is crucial, as clergy can benefit from basic mental health training to better identify and refer individuals to professionals, while mental health professionals can enhance their understanding of religious matters to provide more culturally sensitive care (Ibrahim & Whitley, 2020). This collaboration can significantly reduce mental health stigma and strengthen support systems within religious communities, ultimately leading to improved mental health outcomes for congregants and clergy alike (Boateng et al., 2024; Derr, 2015). For instance, clergy trained in fundamental counseling techniques and crisis intervention are better equipped to address congregants' needs while identifying cases that necessitate referral to mental health professionals (Nganyu, 2025). This approach leverages the unique position of religious leaders as trusted community figures, enabling them to act as vital bridges between faith communities and professional mental healthcare services, thereby enhancing early detection and intervention for mental health conditions (Antoniou & Kalogeropoulos, 2024; Campbell, 2021). This proactive engagement not only normalizes mental health discussions but also empowers religious institutions to become proactive agents in promoting holistic well-being among their members. Such interdisciplinary collaborations between religious leaders and mental health professionals are critical for developing comprehensive care models that respect spiritual beliefs while providing evidence-based psychological support (Milstein et al., 2017). This integration of spiritual and clinical care can help overcome barriers to treatment, particularly in communities where mental health services are stigmatized or inaccessible, thus improving overall mental health outcomes. Furthermore, incorporating mental health education into seminary curricula, as highlighted by recent research, is essential for shaping a wellness-oriented culture within pastoral formation, preparing future religious leaders to effectively manage their own mental health and support that of their congregations (Taja-on, 2025). These curricula should focus on building resilience, stress management techniques, and recognizing signs of distress in themselves and others, thereby fostering a proactive approach to mental well-being in ministerial life. This comprehensive approach can help to dismantle the deeply ingrained stigma surrounding mental health in religious communities, encouraging a more open and supportive environment for clergy to seek the help they need. Such efforts are critical for cultivating a proactive stance towards mental wellness, ultimately fortifying the resilience of religious leaders against the unique pressures of their vocation. By equipping clergy with these tools and fostering an environment of psychological safety, religious institutions can significantly mitigate the factors contributing to clergy suicide and promote sustained well-being among their spiritual leaders. This integrated strategy, combining preventative education, accessible support, and collaborative frameworks, is paramount in addressing the nuanced mental health challenges faced by religious leaders, thereby fostering a more supportive and resilient ecclesiastical landscape. Educational institutions, specifically theological seminaries, are uniquely positioned to integrate comprehensive training in mental health and resilience into their curricula, ensuring future clergy are adequately prepared for the psychological demands of ministry (Clarke, 2022). This includes instruction on recognizing signs of burnout, depression, and anxiety in themselves and others, alongside strategies for effective stress management and self-care (Nganyu, 2025). Moreover, incorporating Christian psychotherapy and pastoral care approaches within these training programs can help bridge the gap between spiritual guidance and evidence-based mental health practices, ensuring a holistic understanding of well-being (Nganyu, 2025).

Promoting Mental Health Awareness in Religious Institutions

Cultivating an environment where mental health is openly discussed and supported begins with educational programs designed to raise awareness among both clergy and congregants about the signs of mental distress and the availability of resources (Campbell, 2021). These programs should emphasize that mental health is a fundamental aspect of overall well-being, challenging the misconception that faith alone can resolve all psychological ailments and encouraging a holistic approach to care. This involves equipping religious leaders with the skills to recognize mental health issues, offer initial support, and guide individuals toward appropriate professional help, thereby acting as crucial first-line responders in their communities (Antoniou & Kalogeropoulos, 2024; Boateng et al., 2024). Furthermore, collaborative efforts between religious institutions and mental health professionals can lead to the development of tailored interventions and referral pathways, ensuring that individuals receive timely and appropriate care (Campbell, 2021). Such partnerships are vital in bridging the gap between spiritual support and clinical treatment, fostering an integrated care model that respects both faith-based perspectives and evidence-based psychological practices (Derr, 2015).

Establishing Support Networks for Clerics and Families

Recognizing the unique pressures faced by clergy, creating robust support networks—both formal and informal—becomes paramount for mitigating professional isolation and burnout. These networks can offer a confidential space for clerics to share experiences, seek advice, and receive emotional encouragement from

peers who understand the specific challenges of their calling. Formal initiatives, such as denominational mental healthcare programs and subsidized counseling, can further alleviate financial burdens and accessibility issues for clergy seeking professional help (Biru et al., 2022). Additionally, peer support groups and mentorship programs specifically designed for clergy can provide invaluable emotional and spiritual sustenance, fostering a sense of community and shared understanding. These resources are crucial for ensuring that clergy and their families have access to the mental health services they need, thereby fostering resilience and preventing severe psychological distress (Biru et al., 2022). Moreover, providing training to clergy on basic mental health first aid and crisis intervention techniques can empower them to offer immediate support and make appropriate referrals when congregants or fellow clerics are in distress (Syed et al., 2020). This approach not only enhances their capacity for pastoral care but also destigmatizes mental health support within religious communities by demonstrating that even spiritual leaders can benefit from and provide such interventions (Nganyu, 2025). By integrating mental health education and support into the fabric of religious institutions, a comprehensive framework emerges that addresses the multifaceted needs of clergy and their communities, promoting resilience and well-being. This holistic strategy extends beyond individual support, advocating for systemic changes within religious hierarchies to prioritize clergy mental health through policy reforms, reasonable workload management, and accessible wellness initiatives (Alhur et al., 2022). Ultimately, this multifaceted approach aims to cultivate an environment where spiritual leaders are not only equipped to minister to the mental health needs of their congregants but are also themselves supported and protected from the unique stressors inherent in their demanding roles (Boateng et al., 2024). Moreover, cultivating a culture of transparency regarding mental health within religious institutions can dismantle the pervasive stigma often associated with psychological struggles, encouraging earlier help-seeking behaviors among clergy (Taja-on, 2025). This destigmatization is critical for fostering an environment where clergy feel comfortable discussing their mental health challenges without fear of judgment or professional repercussions, thereby promoting timely intervention and support (Salwen et al., 2017).

Encouraging Professional Counseling and Therapy

The integration of evidence-based psychological methods with spiritual disciplines like prayer and scripture meditation can create a therapeutic environment that is both effective and culturally sensitive for religious individuals (Nganyu, 2025). This approach not only respects the spiritual framework of many clients but also often leads to more acceptable and effective outcomes in fostering emotional healing and reducing the stigma associated with mental health interventions (Antoniou & Kalogeropoulos, 2024; Nganyu, 2025). This is especially critical given that clergy often report seeking help from spiritual directors in addition to or instead of professional mental health providers, highlighting the importance of integrating spiritual and psychological care effectively (Biru et al., 2022). This dual approach helps bridge the perceived divide between faith and mental health, making professional counseling more palatable and relevant for individuals deeply rooted in religious beliefs (Nganyu, 2025; Smith et al., 2022). Consequently, it is imperative that mental health practitioners are equipped with cultural competence and religious literacy to effectively serve diverse populations, particularly those for whom faith plays a central role in their coping mechanisms and worldview (Syed et al., 2020).

The Role of Theological Institutions in Mental Health Education

Seminaries and theological colleges play a pivotal role in shaping future religious leaders by integrating mental health education into their curricula, thereby equipping them with the knowledge and skills necessary to address the psychological well-being of their congregants and themselves (Taja-on, 2025). This integration should encompass not only theological understandings of suffering and healing but also practical training in recognizing mental health challenges, providing initial support, and facilitating appropriate referrals to mental health professionals. Such educational initiatives are crucial for preparing clergy to navigate the complex interplay between spiritual and psychological distress within their communities, fostering a more holistic approach to pastoral care (Antoniou & Kalogeropoulos, 2024). This proactive measure would ensure that future clerics are not only spiritually grounded but also mentally health-aware, capable of offering comprehensive support that acknowledges the intricate connection between faith and psychological well-being. Moreover, incorporating clinical pastoral education and interdisciplinary studies that bridge theology with psychology can further enhance their capacity to provide integrated care, understanding that spiritual beliefs can significantly influence therapeutic outcomes (Nganyu, 2025). This approach would also help de-stigmatize mental health within religious communities by demonstrating that a comprehensive understanding of human well-being includes both spiritual and psychological dimensions. By fostering an environment where mental health is openly discussed and integrated into theological discourse, these institutions can cultivate a generation of religious leaders better equipped to support their communities and address the prevalent issue of suicide among clerics (Chan & Di, 2024; Fitzgerald & Vaidyanathan, 2022). This comprehensive educational framework

would also empower future clerics to prioritize their own mental well-being, fostering resilience and proactive self-care strategies to mitigate the unique stressors inherent in their vocation.

Conclusion

The tragic incident involving Reverend Esther Moses Akor underscores the critical need for a multi-faceted approach to address the often-overlooked issue of mental health and suicide within the clergy. This pervasive challenge demands immediate attention, necessitating a concerted effort from religious institutions, educational bodies, and healthcare providers to cultivate supportive environments and proactive interventions. The effective implementation of comprehensive mental health strategies, including enhanced training, accessible professional support, and destigmatization efforts, is paramount to safeguarding the well-being of religious leaders and preventing similar tragedies (Clarke, 2022; Donkor, 2025). Ultimately, fostering a culture of openness and support for mental health among clergy will not only mitigate the risk of suicide but also enhance their overall effectiveness in serving their communities. By prioritizing the psychological well-being of these spiritual leaders, society can ensure that those who offer guidance and solace are themselves sustained and supported, enabling them to continue their vital work with renewed strength and mental fortitude. The integration of theological perspectives with contemporary psychological insights is essential for developing interventions that are both spiritually attuned and clinically effective, thereby addressing the unique vulnerabilities of religious leaders (Iheanacho et al., 2021). This holistic approach, encompassing prevention, intervention, and postvention strategies, is vital for creating a robust support system that acknowledges the complex interplay between spiritual calling and human fragility, ultimately aiming to reduce the incidence of suicide within this esteemed profession. Furthermore, recognizing the unique stressors faced by clergy, particularly those in community-based roles, necessitates the development of specific support programs and increased funding for mental health services tailored to their needs (Bonsu et al., 2025). Such initiatives should also focus on fostering an environment where seeking mental health support is viewed as a strength, not a weakness, thereby dismantling the pervasive stigma that often prevents religious leaders from accessing necessary care (Dlamini et al., 2025). Moreover, establishing partnerships between religious organizations and mental health professionals can create a referral system that ensures clergy have access to specialized care, while training programs for religious leaders can equip them with essential skills to identify and address mental health challenges within their congregations, thereby promoting a proactive approach to mental well-being (Awaad et al., 2024; Boateng et al., 2024; Nwafor, 2024). This collaborative model can significantly enhance the efficacy of mental health interventions within religious communities, ensuring that both spiritual and psychological dimensions of well-being are addressed comprehensively.

Summary of Findings

The case of Reverend Akor highlights the severe consequences of unaddressed mental health issues within the clergy, specifically demonstrating how personal crises, such as marital infidelity, can escalate into tragic outcomes when adequate support systems are absent. This incident underscores the imperative for religious institutions to move beyond a purely spiritual interpretation of suffering and acknowledge the complex interplay of psychological, social, and emotional factors that can contribute to profound distress among their leaders. Furthermore, it emphasizes the need for comprehensive mental health frameworks within these organizations, addressing not only individual well-being but also systemic issues that may exacerbate psychological vulnerabilities. This incident further necessitates a re-evaluation of the support structures available to religious leaders, particularly concerning marital and familial challenges, to ensure that personal adversities do not culminate in mental health crises (Shah et al., 2025). The prevalence of mental health challenges among clergy, often exacerbated by the demanding nature of their roles and the expectation of unwavering spiritual fortitude, necessitates a proactive and integrated approach to mental well-being within religious communities (Lehmann et al., 2021). This approach should incorporate elements such as confidential counseling services, peer support networks, and mandatory mental health check-ups to foster a culture of care and prevent silent suffering. Such initiatives could also leverage existing church-based platforms to train lay health advisors and clergy in mental health screening and interventions, thereby expanding access to care in resource-limited settings (Iheanacho et al., 2021). Moreover, collaborative partnerships between faith leaders, academics, and community organizations are crucial for building capacity and ensuring the sustainability of mental health promotion and wellness initiatives within these communities (Hecht et al., 2024; Rasmussen et al., 2024).

Implications for Religious Organizations and Society

The implications extend beyond individual well-being, touching upon the very fabric of religious leadership and the trust placed in spiritual guides by their congregations. When leaders experience profound personal crises and

lack adequate support, it can erode the faith and confidence of their followers, creating broader societal reverberations. This erosion of trust can manifest as decreased congregational engagement, skepticism towards religious institutions, and a general decline in the perceived efficacy of spiritual guidance in addressing life's challenges. Therefore, religious organizations have a moral and practical imperative to prioritize the mental health of their clergy, not only for the welfare of the individuals but also for the continued vitality and credibility of their institutions in a society increasingly grappling with mental health concerns (Tagwirei, 2025). This necessitates a shift towards a more holistic understanding of clergy well-being, acknowledging the chronic and traumatic stress inherent in their roles, and providing targeted systemic and individual support to foster resilience (Makena et al., 2023). Furthermore, recognizing the unique occupational stressors faced by clergy, such as emotional labor, ethical dilemmas, and boundary maintenance, religious organizations must develop tailored interventions that address these specific challenges (Biru et al., 2022). Such interventions could include specialized training in stress management, ethical decision-making, and conflict resolution, alongside access to confidential counseling and peer support networks designed to address the unique pressures of ministerial life (Tadros & Tadros, 2025). These efforts are crucial for fostering a sustainable and healthy environment for religious leaders, thereby strengthening the spiritual and social fabric of communities. Moreover, recognizing that mental health providers themselves can experience significant distress, organizational-level initiatives promoting wellness and self-care are essential to ensure their capacity to support clergy effectively (Miller et al., 2021). This comprehensive approach, integrating both proactive and reactive measures, is vital for mitigating the risk of tragic incidents like Reverend Akor's suicide and for fostering a culture of well-being within religious communities. This holistic perspective on mental health within religious organizations is further supported by evidence suggesting that healthy clergy positively impact the well-being of their congregants, reinforcing the idea that investment in clergy mental health benefits the entire community (Biru et al., 2022).

Recommendations for Future Research and Action

Future research should focus on developing empirically validated interventions tailored to the specific stressors experienced by clergy, including longitudinal studies to assess the effectiveness of these programs in reducing burnout and improving mental health outcomes. Investigating the nuanced differences in clergy distress across denominations could also provide valuable insights into specific contributing factors and inform more targeted preventive strategies (Rogers, 2022). Furthermore, research should explore the integration of family-based support interventions, similar to those found effective for psychologists, to enhance emotional understanding and support within clergy families, thereby aiding in stress management and resilience building (Abidin et al., 2025). Additionally, further investigation into the efficacy of mental health training for clergy, spiritual training for practitioners, and clergy-practitioner referral pathways is warranted to improve collaboration between mental health services and religious institutions (Heseltine-Carp & Hoskins, 2020). This will ensure that clergy are equipped to address mental health concerns within their congregations and that individuals in need of specialized care are appropriately referred to mental health professionals (Wang et al., 2003). Beyond this, exploring the impact of theological education on mental health literacy and stigma reduction among future clergy could inform curriculum development and foster a more open dialogue about mental well-being within religious academic settings. Given the prevalence of mental health challenges among clergy, further research is also needed to identify and address the systemic factors that contribute to these issues, such as unrealistic expectations, lack of adequate support structures, and the unique pressures of public ministry (Boateng et al., 2024). Additionally, investigating how different cultural and geographical contexts influence clergy mental health can provide a more comprehensive understanding of global patterns of distress and resilience (Hydinger et al., 2024). Moreover, future studies should delve into the efficacy of integrating psychological and theological frameworks in therapeutic interventions for clergy, aiming to create robust, evidence-based foundations for holistic well-being (Nganyu, 2025). Such an interdisciplinary approach could lead to more effective prevention and intervention programs for clergy burnout and other mental health challenges (Grosch & Olsen, 2000; Picornell-Gallar & González–Fraile, 2023). This research could also explore the impact of specific spiritual practices and self-compassion on clergy well-being, providing insights for developing coping strategies (Guzman & Teh, 2016). Moreover, investigating how religious communities can enhance their mental health literacy and understanding of mental illness will enable them to offer better support to their clergy (Bonsteel, 2012). A deeper understanding of the barriers to clergy accessing mental health services, such as stigma, financial constraints, and time limitations, is also crucial for developing effective support systems (Rogers, 2022; Tice et al., 2025). Further investigation into the efficacy of mental health outreach programs specifically designed for religious settings, incorporating validated outcome measures, is essential to bridge the current gap in understanding their utility and to inform evidence-based practice (Farrell & Goebert, 2008). Ultimately, these findings can contribute to a more robust framework for promoting clergy mental health, moving beyond reactive measures to proactive, preventive strategies that are culturally sensitive and institutionally integrated. Moreover, further research is needed to explore the unique psychological challenges faced by clergy in various cultural contexts, including issues such as celibacy, sexuality, addiction, depression, suicidality, and anxiety, as

highlighted in studies on Brazilian priests (Dias, 2019). Such investigations could illuminate distinct cultural influences on clerical well-being and the specific manifestations of mental health struggles within diverse religious traditions (Dias, 2019). Further studies should also examine the impact of organizational structures and leadership styles within religious institutions on clergy mental health, particularly regarding their relationship with bishops and fellow priests, as well as their identification with the organization (Ruiz-Prada et al., 2021). Additionally, research into the mental health support systems available to novice clergy, including mentorship programs and community living arrangements, could provide valuable insights for mitigating occupational distress early in their careers (Kostick et al., 2024). This includes exploring the effectiveness of peer support groups, which, despite inconsistent findings in some studies, may offer a valuable avenue for reducing mental distress among religious leaders (Salwen et al., 2017). Further investigation is warranted into the efficacy of these groups, particularly regarding their structure, facilitation, and the specific needs they address within diverse clerical populations, to establish best practices for their implementation.

References

Abamara, N. C., & Ozongwu, O. E. (2024). The rising cases of suicide among Nigerians: what are the risk factors, prevention, and remedies? *Consortium Psychiatricum*, *5*(3), 56. https://doi.org/10.17816/cp15497

Abidin, F. A., Prathama, A. G., Fitriana, E., Komala, E. S., & Tijdink, J. K. (2025). Psychological distress and coping strategies among Indonesian psychologists during the COVID-19 pandemic: a two-wave cross-lagged study. *Health Psychology and Behavioral Medicine*, *13*(1), 2456662. https://doi.org/10.1080/21642850.2025.2456662

Adams, C. J., Hough, H., Proeschold-Bell, R. J., Yao, J., & Kolkin, M. A. (2016). Clergy Burnout: A Comparison Study with Other Helping Professions. *Pastoral Psychology*, *66*(2), 147. https://doi.org/10.1007/s11089-016-0722-4

Alakija, O. A., Akinnawo, E. O., Akpunne, B. C., & Kumuyi, D. O. (2022). Assessing the Influence of Self-Esteem and Emotional Intelligence on Psychopathological Symptoms among Trainee Christian Clerics. *Psychology*, *13*(6), 922. https://doi.org/10.4236/psych.2022.136063

Alhur, A., Alghamdi, S., Aldawsri, A. S. M., Alotaibi, T., Alghamdi, S. M., Alghamdi, A., Alzahrani, M., Alghamdi, A. S., Alzahrani, S., Alzahrani, Y., essa, M., Jamal, H. H., kinanah, A., Alzabadin, M. A. M., & Zakri, A. (2022). MENTAL HEALTH MATTERS: A DETAILED LOOK AT MENTAL WELL-BEING IN ACADEMIA AND HEALTHCARE. *Journal of Population Therapeutics and Clinical Pharmacology*. https://doi.org/10.53555/jptcp.v29i04.5727

Aluh, D. O., Anyachebelu, O. C., Anosike, C., & Anizoba, E. L. (2018). Mental health literacy: what do Nigerian adolescents know about depression? *International Journal of Mental Health Systems*, *12*(1). https://doi.org/10.1186/s13033-018-0186-2

Antoniou, N., & Kalogeropoulos, D. (2024). *Exploring the Intersection of Faith and Mental Health in Religious Clients*. *6*(3), 226. https://doi.org/10.61838/kman.jarac.6.3.25

Ashley, E. R. (2020). Thriving Holistically as a Woman Married to a Minister: A Spiritual Formation Model to Support Women in the United States in the Role of Pastor's Wife. *Digital Commons - George Fox University (George Fox University)*. https://digitalcommons.georgefox.edu/dmin/368

Awaad, R., Durrani, Z., Quadri, Y., Sifat, M., Hussein, A., Kouser, T., El-Gabalawy, O., Rajeh, N. B., & Shareef, S. (2024). Developing a Suicide Crisis Response Team in America: An Islamic Perspective. *Journal of Religion and Health*, *63*(2), 985. https://doi.org/10.1007/s10943-023-01993-3

Biru, B. M., Yao, J., Plunket, J., Hybels, C. F., Kim, E. T., Eagle, D. E., Choi, J., & Proeschold-Bell, R. J. (2022). The Gap in Mental Health Service Utilization Among United Methodist Clergy with Anxiety and Depressive Symptoms. *Journal of Religion and Health*, *62*(3), 1597. https://doi.org/10.1007/s10943-022-01699-y

Boateng, A. C. O., Britt, K., Sebu, J., & Oh, H. (2024). An Examination of the Impact of Clergy-Involved Mental Health Activities for Their Congregants on Clergy Life Satisfaction, Happiness, and Perceptions of Having a Life Close to Ideal in the USA. *Journal of Pastoral Care & Counseling Advancing Theory and Professional Practice through Scholarly and Reflective Publications*, *78*(3), 107. https://doi.org/10.1177/15423050241268397

Bocalon, P. C., Rossato, L., Scorsolini-Comin, F., & Mendes, K. D. S. (2024). Mental illness in Catholic priests: evidence for research and mental health care. *Mental Health Religion & Culture*, *27*(7), 721. https://doi.org/10.1080/13674676.2024.2436435

Bonsteel, S. (2012). APA PsycNET. *The Charleston Advisor*, *14*(1), 16. https://doi.org/10.5260/chara.14.1.16

Bonsu, A. S., Yendork, J. S., Asante, K. O., Dotse, E. J., & Ansah, K. O. (2025). Psychological distress among community-based mental health professionals in Ghana: prevalence and contributing factors. *Discover Mental Health*, *5*(1), 44. https://doi.org/10.1007/s44192-025-00167-9

Campbell, A. D. (2021). Clergy Perceptions of Mental Illness and Confronting Stigma in Congregations. *Religions*, *12*(12), 1110. https://doi.org/10.3390/rel12121110

Chan, E., & Di, D. (2024). How the Science–Religion Interface of Christian Religious Leaders Shape Their Perceptions of Depression. *Religions*, *15*(11), 1398. https://doi.org/10.3390/rel15111398

Chu, C., Roxas, N., Aguocha, C., Nwefoh, E., Wang, K., Dike, C. C., & Iheanacho, T. (2022). Integrating mental health into primary care: evaluation of the Health Action for Psychiatric Problems In Nigeria including Epilepsy and SubstanceS (HAPPINESS) pilot project. *BMC Health Services Research*, *22*(1). https://doi.org/10.1186/s12913-022-07703-1

Clarke, M. A. (2022). The Clergy Resilience Model: A Tool for Supporting Clergy Well-being. *Journal of Psychology and Theology*, *51*(2), 239. https://doi.org/10.1177/00916471221137546

Clarke, M. A., Martin, I., & Kim, D. S. S. (2025). Diverse perspectives of clergy wives: Navigating the challenges and rewards of ministry. *Journal of Psychology and Theology*. https://doi.org/10.1177/00916471251403208

Cook, C. C. H. (2012). Psychiatry in scripture: sacred texts and psychopathology. *The Psychiatrist*, *36*(6), 225. https://doi.org/10.1192/pb.bp.111.036418

Coombs, A. A., Joshua, A., Flowers, M., Wisdom, J. P., Crayton, L. S., Frazier, K., & Hankerson, S. H. (2021). Mental Health Perspectives Among Black Americans Receiving Services From a Church-Affiliated Mental Health Clinic. *Psychiatric Services*, *73*(1), 77. https://doi.org/10.1176/appi.ps.202000766

Derr, A. S. (2015). Mental Health Service Use Among Immigrants in the United States: A Systematic Review [Review of *Mental Health Service Use Among Immigrants in the United States: A Systematic Review*]. *Psychiatric Services*, *67*(3), 265. American Psychiatric Association. https://doi.org/10.1176/appi.ps.201500004

Dias, R. J. de L. (2019). Burnout among catholic priests in Brazil: prevalence and associated factors. *Interação Em Psicologia*, *23*(2). https://doi.org/10.5380/psi.v23i02.65076

Dlamini, Z. T., Poliah, V., & Govender, N. (2025). Attitudes of Christian leaders and congregants in South Africa towards mental illness and the mentally ill. *South African Journal of Psychiatry*, *31*, 2399. https://doi.org/10.4102/sajpsychiatry.v31i0.2399

Donkor, O. R. (2025). Pastoral Care and Counselling Studies of Contemporary Society and Its Effects on Christian Practices in West Africa. *E-Journal of Religious and Theological Studies*, *11*(11), 549. https://doi.org/10.38159/erats.202511113

Edwards, L., Bretherton, R., Gresswell, D. M., & Sabin-Farrell, R. (2020). The relationship between social support, spiritual well-being, and depression in Christian clergy: a systematic literature review. *Mental Health Religion & Culture*, *23*(10), 857. https://doi.org/10.1080/13674676.2020.1838459

Ehusani, R. (2024). The Epidemic of Meaninglessness and the Rising Cases of Suicide in Nigeria. *International Journal of Research and Innovation in Social Science*, 24. https://doi.org/10.47772/ijriss.2024.8120003

Eweka, H. E., & Ugiagbe, I. (2020). A review of the causes, manifestations and panacea of incidences of suicide in Nigeria [Review of *A review of the causes, manifestations and panacea of incidences of suicide in Nigeria*]. *Bussecon Review of Social Sciences (2687-2285)*, *2*(4), 36. https://doi.org/10.36096/brss.v2i4.223

Farrell, J. L., & Goebert, D. (2008). Collaboration Between Psychiatrists and Clergy in Recognizing and Treating Serious Mental Illness. *Psychiatric Services*, *59*(4), 437. https://doi.org/10.1176/ps.2008.59.4.437

Fitzgerald, C. A., & Vaidyanathan, B. (2022). Faith Leaders' Views on Collaboration with Mental Health Professionals. *Community Mental Health Journal*, *59*(3), 477. https://doi.org/10.1007/s10597-022-01031-8

Freire, J., Moleiro, C., Rosmarin, D. H., & Freire, M. H. (2018). A call for collaboration: Perception of religious and spiritual leaders on mental health (A Portuguese sample). *Journal of Spirituality in Mental Health*, *21*(1), 55. https://doi.org/10.1080/19349637.2017.1423001

Grosch, W. N., & Olsen, D. C. (2000). Clergy burnout: An integrative approach. *Journal of Clinical Psychology*, *56*(5), 619. https://doi.org/10.1002/(sici)1097-4679(200005)56:5<619::aid-jclp4>3.0.co;2-2

Guzman, N. E. Q., & Teh, L. A. (2016). Understanding the Stresses and Coping Resources of Filipino Clergy Families: A Multiple-Case Study. *Pastoral Psychology*, *65*(4), 459. https://doi.org/10.1007/s11089-016-0698-0

Harris, J. R. A., Cashwell, C. S., & Brown, S. (2015). African American Pastors on Mental Health, Coping, and Help Seeking. *Counseling and Values*, *60*(1), 32. https://doi.org/10.1002/j.2161-007x.2015.00059.x

Hecht, J., Kim, M. T., Horton, S. E. B., Todd, A., Williams, K., Yaklin, S., Ewere, T., Cauvin, S., & Horton, D. (2024). Lessons Learned from AMEN: African American Faith-Based Mental Health and Wellness Program. *Progress in Community Health Partnerships*, *18*(4), 541. https://doi.org/10.1353/cpr.2024.a948678

Heseltine-Carp, W., & Hoskins, M. (2020). Clergy as a frontline mental health service: a UK survey of medical practitioners and clergy. *General Psychiatry*, *33*(6). https://doi.org/10.1136/gpsych-2020-100229

Holleman, A. (2022). The Resilience of Clergywomen?: Gender and the Relationship between Occupational Distress and Mental Health among Congregational Leaders. *Journal for the Scientific Study of Religion*, *62*(1), 89. https://doi.org/10.1111/jssr.12817

Hydinger, K. R., Wu, X., Captari, L. E., & Sandage, S. J. (2024). Burnout, Trauma Impacts, and Well-Being Among Clergy and Chaplains: A Systematic Review and Recommendations to Guide Best Practice. *Pastoral Psychology*, *73*(5), 587. https://doi.org/10.1007/s11089-024-01150-x

Ibrahim, A. F., & Whitley, R. (2020). Religion and mental health: a narrative review with a focus on Muslims in English-speaking countries [Review of *Religion and mental health: a narrative review with a focus on Muslims in English-speaking countries*]. *BJPsych Bulletin*, *45*(3), 170. Cambridge University Press. https://doi.org/10.1192/bjb.2020.34

Iheanacho, T., Nduanya, U. C., Slinkard, S., Ogidi, A. G., Patel, D., Itanyi, I. U., Naeem, F., Spiegelman, D., & Ezeanolue, E. E. (2021). Utilizing a church-based platform for mental health interventions: exploring the role of the clergy and the treatment preference of women with depression. *Cambridge Prisms Global Mental Health*, *8*. https://doi.org/10.1017/gmh.2021.4

Jack, A., & Wilcox, D. T. (2017). The Psychological Assessment of Clerics. *Pastoral Psychology*, *67*(1), 55. https://doi.org/10.1007/s11089-017-0784-y

Jankowski, P. J., Sandage, S. J., & Wang, D. (2023). (Re)Framing Resilience: A Trajectory-Based Study Involving Emerging Religious/Spiritual Leaders. *Religions*, *14*(3), 333. https://doi.org/10.3390/rel14030333

Kansiewicz, K., Sells, J. N., Holland, D., Lichi, D., & Newmeyer, M. (2022). Well-Being and Help-Seeking Among Assemblies of God Ministers in the USA. *Journal of Religion and Health*, *61*(2), 1242. https://doi.org/10.1007/s10943-021-01488-z

Khosa-Nkatini, H. P. (2022). Clergies and self-care during the COVID-19 pandemic: A challenge to pastoral care. *Verbum et Ecclesia*, *43*(1). https://doi.org/10.4102/ve.v43i1.2338

Khosa-Nkatini, H. P., & Buqa, W. (2021). Suicide as a sin and mental illness: A dialogue between Christianity and psychology. *Verbum et Ecclesia*, *42*(1). https://doi.org/10.4102/ve.v42i1.2318

Kostick, M. D., Zhu, X., Haegele, J. A., & Baker, P. (2024). Predictors of Occupational Distress of Catholic Priests on the Eastern Seaboard of the United States. *Pastoral Psychology*. https://doi.org/10.1007/s11089-024-01128-9

Kuusi, T., Niemelä, K., & Viertiö, S. (2024). Factors associated with psychological distress of workers in the Finnish Evangelical Lutheran Church. *BMC Public Health*, *24*(1), 875. https://doi.org/10.1186/s12889-024-18165-x

Leavey, G., Loewenthal, K. M., & King, M. (2007). Challenges to sanctuary: The clergy as a resource for mental health care in the community. *Social Science & Medicine*, *65*(3), 548. https://doi.org/10.1016/j.socscimed.2007.03.050

Lehmann, C., Whitney, W. B., Un, J., Payne, J. S., Simanjuntak, M. K. B., Hamilton, S., Worku, T., & Fernandez, N. (2021). Hospitality Towards People with Mental Illness in the Church: a Cross-cultural Qualitative Study. *Pastoral Psychology*, *71*(1), 1. https://doi.org/10.1007/s11089-021-00982-1

Leon, H., Jason. (2025). *The Experience of Help Seeking for African American Pastors in Personal Crises*. https://scholarworks.waldenu.edu/dissertations/16956

Lewis, C. A., Francis, L. J., Turton, D. W., & Cruise, S. (2006). The psychological health of clergy in Ireland — who cares for the carers? *Irish Journal of Psychological Medicine*, *23*(1), 42. https://doi.org/10.1017/s0790966700009502

Lin, C.-Y., & Wang, K. T. (2024). Clergy Wives and Well-Being: The Impact of Perceived Congregational Perfectionism and Protective Factors. *Religions*, *15*(8), 965. https://doi.org/10.3390/rel15080965

Lovero, K. L., Santos, P. F. dos, Come, A. X., Wainberg, M. L., & Oquendo, M. A. (2023). Suicide in Global Mental Health. *Current Psychiatry Reports*, *25*(6), 255. https://doi.org/10.1007/s11920-023-01423-x

Makena, V. K., Wambugu, A., & Chiroma, N. (2023). Influence of Occupational Stress on Quality Family Relationship among Clergy: A Case of Christ is the Answer Ministries, Kenya. *European Scientific Journal ESJ*, *19*(16), 135. https://doi.org/10.19044/esj.2023.v19n16p135

Marambi, J. M. (2022). Emotional Damage in Pastoral Ministry: Contributing Factors and Effect on Pastors' Performance. *Journal of Philosophy and Religion*, *2*(1), 124. https://doi.org/10.51317/ecjprts.v2i1.335

Miller, J. J., Barnhart, S., Robinson, T. D., Pryor, M. D., & Arnett, K. (2021). Assuaging COVID-19 Peritraumatic Distress Among Mental Health Clinicians: The Potential of Self-Care. *Clinical Social Work Journal*, *49*(4), 505. https://doi.org/10.1007/s10615-021-00815-x

Milstein, G., Middel, D., & Espinosa, A. (2017). Consumers, clergy, and clinicians in collaboration: Ongoing implementation and evaluation of a mental wellness program. *American Journal of Psychiatric Rehabilitation*, *20*(1), 34. https://doi.org/10.1080/15487768.2016.1267052

Moitra, M., Owens, S., Hailemariam, M., Wilson, K. S., Mensa-Kwao, A., Gonese, G., Kamamia, C. K., White, B. J., Young, D. M., & Collins, P. Y. (2023). Global Mental Health: Where We Are and Where We Are Going [Review of *Global Mental Health: Where We Are and Where We Are Going*]. *Current Psychiatry Reports*, *25*(7), 301. Springer Science+Business Media. https://doi.org/10.1007/s11920-023-01426-8

Moreno, A. N., Bartkowski, J. P., & Xu, X. (2022). Religion and Help-Seeking: Theological Conservatism and Preferences for Mental Health Assistance. *Religions*, *13*(5), 415. https://doi.org/10.3390/rel13050415

Nganyu, G. N. (2025a). CHRISTIAN PSYCHOTHERAPY IN THE LOCAL CHURCH: A QUALITATIVE STUDY OF EFFECTIVE MODELS AND BEST PRACTICES. *Greener Journal of Social Sciences*, *15*(1), 64. https://doi.org/10.15580/gjss.2025.1.022525030

Nganyu, G. N. (2025b). PASTORAL CARE AND CHRISTIAN PSYCHOTHERAPY: EXPLORING THE INTERSECTION OF SPIRITUAL DIRECTION AND MENTAL HEALTH SUPPORT IN THE LOCAL CHURCH. *Greener Journal of Social Sciences*, *15*(1), 103. https://doi.org/10.15580/gjss.2025.1.050625078

Nganyu, G. N. (2025c). THEOLOGICAL AND PSYCHOLOGICAL INTEGRATION IN CHRISTIAN PSYCHOTHERAPY: A CRITICAL REVIEW OF THE LITERATURE AND IMPLICATIONS FOR CHURCH-BASED PRACTICE [Review of *THEOLOGICAL AND PSYCHOLOGICAL INTEGRATION IN CHRISTIAN PSYCHOTHERAPY: A CRITICAL REVIEW OF THE LITERATURE AND IMPLICATIONS FOR CHURCH-BASED PRACTICE*]. *Greener Journal of Social Sciences*, *15*(1), 75. https://doi.org/10.15580/gjss.2025.1.022525031

Nwafor, C. I. (2024). Suicide Prevention Strategies in Nigeria: Exploring Religious Roles, Insights, and Challenges. *Religions*, *15*(1), 64. https://doi.org/10.3390/rel15010064

Nwafor, C. I., & Vandenhoeck, A. (2024). Exploring Religion as a Path to Meaning: The Role of "Pastrotherapy" in Supporting Young People's Quest for a Good Life in Nigeria. *Journal of Religion and Health*, *63*(3), 1967. https://doi.org/10.1007/s10943-023-01979-1

Ogbolu, R. E., Ijadunola, M. Y., Adepoju, O. A., Ola, B., Quadri-Asorona, B., Ogundiran, A., Akinyemi, P. A., & Alaba, O. (2020). Channeling the Right Path-to-care: Improving Religious Leaders' Knowledge and Beliefs about Suicide Prevention in South West Nigeria. *Research Square (Research Square)*. https://doi.org/10.21203/rs.2.22502/v1

Okoye, N. A. (2023). Effectiveness of Evidence-Based Interventions Towards Mental Health Illness Among Nigerian Adolescents and Adults: Systematic Review. *Genesis Journal of Surgery and Medicine*, *2*(2). https://doi.org/10.52793/gjsm.2023.2(2)-17

Ozota, G. O., Sabastine, R. N., Uduji, F. C., & Okonkwo, V. C. (2024). Nigeria mental health law: Challenges and implications for mental health services. *South African Journal of Psychiatry*, *30*. https://doi.org/10.4102/sajpsychiatry.v30i0.2134

Pederson, A. B., Fokuo, J. K., Thornicroft, G., Bamgbose, O. O., Ogunnubi, O. P., Ogunsola, K., & Oshodi, Y. (2022). Perspectives of university health care students on mental health stigma in Nigeria: Qualitative analysis. *Transcultural Psychiatry*, *60*(2), 272. https://doi.org/10.1177/13634615211055007

Picornell-Gallar, D., & González–Fraile, E. (2023). Burnout Syndrome Among Catholic Clergy: A Systematic Review [Review of *Burnout Syndrome Among Catholic Clergy: A Systematic Review*]. *Journal of Religion and Health*, *63*(3), 1830. Springer Science+Business Media. https://doi.org/10.1007/s10943-023-01883-8

Plante, T. G. (2020). Clericalism Contributes to Religious, Spiritual, and Behavioral Struggles among Catholic Priests. *Religions*, *11*(5), 217. https://doi.org/10.3390/rel11050217

Precious, F. K., Igwe, S. C., Toluwalogo, N.-O., Udokang, E., Ogaya, J. B., & Lucero-Prisno, D. E. (2024). Mental Health Challenges in Nigeria: Bridging the Gap Between Demand and Resources. *Cambridge Prisms Global Mental Health*, *11*. https://doi.org/10.1017/gmh.2024.19

Proeschold-Bell, R. J., Eagle, D. E., Tice, L. C., Yao, J., Rash, J. A., Choi, J. Y., Stringfield, B., & Labrecque, S. M. (2023). The Selah Pilot Study of Spiritual, Mindfulness, and Stress Inoculation Practices on Stress-Related Outcomes Among United Methodist Clergy in the United States. *Journal of Religion and Health*, *62*(4), 2686. https://doi.org/10.1007/s10943-023-01848-x

Proeschold-Bell, R. J., Eisenberg, A., Adams, C. J., Smith, B. W., LeGrand, S., & Wilk, A. R. (2015). The Glory of God is a Human Being Fully Alive: Predictors of Positive Versus Negative Mental Health Among Clergy. *Journal for the Scientific Study of Religion*, *54*(4), 702. https://doi.org/10.1111/jssr.12234

Rasmussen, J. D., Johnson, S. L., Ochieng, Y., Jaguga, F., Green, E., & Puffer, E. S. (2024). Congregation leader and member discussions in a church-based family strengthening, mental health promotion, and HIV prevention trial: Intervention mechanisms in a randomized trial in rural Kenya. *Cambridge Prisms Global Mental Health*, *11*. https://doi.org/10.1017/gmh.2024.44

Rogers, R. C. (2022). Examining the Relationship of Clergy Distress, Spiritual Well-Being, Stress Management and Irritation to Life Satisfaction among Black Pastors in the USA. *Journal of Religion and Health*, *62*(3), 1578. https://doi.org/10.1007/s10943-022-01715-1

Rogers, R. C., & Tinsley, T. M. (2023). Black Pastors' Experiences of Occupational and Life Stress During COVID-19 in the USA. *Journal of Religion and Health*, *63*(1), 685. https://doi.org/10.1007/s10943-023-01901-9

Roggenbaum, L., Wang, D., Dryjańska, L., Holmes, E., Lewis, B. A., & Brown, E. M. (2023). Secondary Traumatic Stress, Religious Coping, and Medical Mistrust among African American Clergy and Religious Leaders. *Religions*, *14*(6), 793. https://doi.org/10.3390/rel14060793

Ruiz-Prada, M., Fernández-Salinero, S., García-Ael, C., & Topa, G. (2021). Occupational Stress and Catholic Priests: A Scoping Review of the Literature [Review of *Occupational Stress and Catholic Priests: A Scoping Review of the Literature*]. *Journal of Religion and Health*, *60*(6), 3807. Springer Science+Business Media. https://doi.org/10.1007/s10943-021-01352-0

Salwen, E. D., Underwood, L. A., Dy-Liacco, G. S., & Arveson, K. (2017). Self-Disclosure and Spiritual Well-Being in Pastors Seeking Professional Psychological Help. *Pastoral Psychology*, *66*(4), 505. https://doi.org/10.1007/s11089-017-0757-1

Scott, G., & Lovell, R. (2014). The Rural Pastors Initiative: Addressing Isolation and Burnout in Rural Ministry. *Pastoral Psychology*, *64*(1), 71. https://doi.org/10.1007/s11089-013-0591-z

Shah, G. H., Khan, M. A., Muzamil, M., & Ahmed, M. (2025). From Pressure to Peril: Investigating the Drivers of Suicide Planning and Attempts in University Students Struggling with Academic Anxiety. *Behavioral Sciences*, *15*(12), 1721. https://doi.org/10.3390/bs15121721

Shaw, M., Lukman, R., Simmons, L., & Reynolds, R. (2021). Clergy Wholeness Study: How Occupational Distress, Depression, and Social Support Inform the Health of Clergy. *Journal of Pastoral Care & Counseling Advancing Theory and Professional Practice through Scholarly and Reflective Publications*, *75*(1), 23. https://doi.org/10.1177/1542305020968046

Shipurut, G. N. (2024). Traditional and Religious Beliefs on Mental Illness and Help-Seeking Behaviour in Ife Central LGA, Ogun State. *International Journal of Humanities Education and Social Sciences*, *2*(3), 450. https://doi.org/10.58578/ijhess.v2i3.4195

Smith, K. N., Wang, D., Canada, A. L., Poston, J. M., Bee, R., & Hurlbert, L. (2022). The biobehavioral family model with a seminarian population: A systems perspective of clinical care. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.859798

Smithers, R., & Kavanagh, P. S. (2025). A Qualitative Investigation into the Challenges and Support Needs of Baptist Pastors in Australia. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-025-02460-x

Spaumer, A., Mavhandu-Mudzusi, Prof. A. H., & Mbedzi, Prof. R. P. (2025). Psychosocial Impacts on Pentecostal Church Pastors of Providing Support to Children in Need of Care and Protection: An Interpretative Phenomenological Analysis Design. *Pastoral Psychology*. https://doi.org/10.1007/s11089-025-01246-y

Sutton, B. C., Maiden, J., Stewart, D. O., & Gordon, P. (2025). BRIDGING THE GAP: INTEGRATING MENTAL HEALTH AND PASTORAL COUNSELING FOR BLACK MALES THROUGH AN INTERSECTIONAL LENS. *International Journal of Advanced Research*, *13*(4), 1056. https://doi.org/10.21474/ijar01/20811

Syed, F., Keshavarzi, S., Sholapur, N. S., & Keshavarzi, H. (2020). A Survey of Islamic Clergy & Community Leaders Regarding Muslim Mental Health First Responder Training. *Journal of Muslim Mental Health*, *14*(2). https://doi.org/10.3998/jmmh.10381607.0014.201

Tadros, E., & Tadros, E. (2025). Pastoral Counseling, Supervision/Consultation, Burnout, and Ethical Violations: A Review of the Literature [Review of *Pastoral Counseling, Supervision/Consultation, Burnout, and Ethical Violations: A Review of the Literature*]. *KMAN Counseling and Psychology Nexus*, *3*, 1. https://doi.org/10.61838/kman.ooc.psynexus.3.2

Tagwirei, K. (2025). Enough is not enough! Confronting church leadership's mental health in Zimbabwe. *HTS Teologiese Studies / Theological Studies*, *81*(1). https://doi.org/10.4102/hts.v81i1.10900

Taja-on, E. P. (2025). Shaping a Wellness-Oriented Culture: A Mixed-Methods Exploration of the Mental Health Training and Stigma Reduction among College Seminarians. *Journal of Catholic Education*, *28*(2), 69. https://doi.org/10.15365/joce.2802042025

Tawam, L. N., Yendork, J. S., & Osei-Tutu, A. (2024). "They are not as strong as we think": symptoms of mental illnesses among Ghanaian pastors in Protestant, Pentecostal, and charismatic denominations. *Mental Health Religion & Culture*, *27*(5), 445. https://doi.org/10.1080/13674676.2024.2378881

Tice, L. C., Salgado, G., Johnston, E. F., Nascimento, B., Bo-Hyeong, J. L., Proeschold-Bell, R. J., & Eagle, D. E. (2025). The weight of the yoke: a qualitative analysis of the stressors for clergy across a mental health continuum. *Mental Health Religion & Culture*, 1. https://doi.org/10.1080/13674676.2025.2536533

Trihub, B. L., McMinn, M. R., Buhrow, W., & Johnson, T. (2010). Denominational Support for Clergy Mental Health. *Journal of Psychology and Theology*, *38*(2), 101. https://doi.org/10.1177/009164711003800203

Upenieks, L., & Eagle, D. E. (2023). Divine Struggles Among Those Doing God's Work: A Longitudinal Assessment Predicting Depression and Burnout and the Role of Social Support in United Methodist Clergy. *Sociology of Religion*, *85*(1), 83. https://doi.org/10.1093/socrel/srad014

Uroko, F. C. (2023). 'Peace, Peace When there is No Peace': The Impact of Prosperity Gospel on Suicide Rate among Nigerian Youth. *Perichoresis*, *21*(3), 119. https://doi.org/10.2478/perc-2023-0025

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and Correlates of Contacting Clergy for Mental Disorders in the United States. *Health Services Research*, *38*(2), 647. https://doi.org/10.1111/1475-6773.00138

Whitley, R. (2012). Religious competence as cultural competence. *Transcultural Psychiatry*, *49*(2), 245. https://doi.org/10.1177/1363461512439088