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MENTAL HEALTH LITERACY AMONG RELIGIOUS LEADERS: IMPLICATIONS FOR COMMUNITY MENTAL HEALTH PROMOTION AND REFERRAL PATHWAYS IN HARARE, ZIMBABWE

Phillip Angeline

Community Psychologist Intern.

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Abstract — Religious leaders are trusted community figures who are frequently approached by individuals experiencing psychological difficulties. Their mental health literacy may influence early recognition, initial support, and referral to professional services. Although Zimbabwean evidence has documented the importance of clergy in community mental health, quantitative evidence describing mental health literacy, confidence, and referral attitudes among religious leaders remained limited. This study assessed mental health literacy among religious leaders and examined its implications for community mental health promotion and referral pathways in Harare, Zimbabwe. A quantitative descriptive survey was conducted among 70 religious leaders in Harare. Participants were selected using purposive and snowball sampling techniques. Data were collected through a structured online questionnaire comprising demographic questions and 25 mental health literacy statements rated on a five-point Likert scale ranging from 1 (Completely Disagree) to 5 (Completely Agree). Content validity was established through expert review and pilot testing. Descriptive statistics including frequencies, percentages, means, and standard deviations were used to summarise the findings. Respondents demonstrated generally positive self-reported mental health literacy, with an overall mean score of 4.11 out of 5. However, lower scores were observed for distinguishing normal stress from serious mental illness (M = 3.63), recognising withdrawal from church activities as a possible mental health concern (M = 2.97), identifying serious emotional or psychological distress (M = 3.71), and knowing the steps to take when urgent professional help was required (M = 3.70). Support for professional referral and collaboration was particularly strong, with relevant item means ranging from 4.59 to 4.67. Only 17 respondents (24.3%) reported previous mental health training, while 53 (75.7%) reported none. Religious leaders reported generally positive mental health literacy and strong support for professional referral. Nevertheless, specific knowledge and confidence gaps indicated a need for targeted mental health education, clearer referral pathways, and collaboration between faith communities and mental health professionals. Community Psychology could contribute through prevention, capacity building, community participation, and strengthening community-professional linkages.

Keywords: *mental health literacy; religious leaders; Community Psychology; mental health promotion; referral pathways; Zimbabwe.*

***Corresponding Author**

Phillip Angeline*

Email: angelinephillip0@gmail.com

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1.0 INTRODUCTION

Mental health literacy among religious leaders has emerged as a critical determinant of community mental health outcomes, particularly in resource-constrained settings where clergy function as frontline responders to psychological distress (Jorm, 2000; Jang et al., 2017). In Zimbabwe, where mental health services remain severely under-resourced and treatment gaps persist (WHO, 2022), religious leaders occupy trusted positions that could facilitate early recognition and appropriate referral. However, quantitative evidence describing mental health literacy levels, confidence in responding to psychological difficulties, and referral attitudes among religious leaders in Zimbabwe remains conspicuously absent from the literature. This study addresses this gap by assessing mental health literacy among 70 religious leaders in Harare, examining implications for community mental health promotion and the strengthening of referral pathways between faith communities and professional mental health services.

1.1 BACKGROUND TO THE STUDY

Mental health literacy (MHL) has been defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al., 1997, p. 182, as cited in Jorm, 2000). An umbrella review synthesising 40 systematic reviews confirmed that this foundational definition remains the most frequently cited across disciplines, though recent frameworks have expanded the concept to include positive mental health, stigma reduction, and help-seeking efficacy (Kutcher et al., 2016, as cited in Conceptualisation and Operationalisation of Mental Health Literacy, 2025). Within this framework, MHL encompasses six key components: the ability to identify specific disorders, knowledge of how to obtain mental health information, knowledge of risk factors and causes, knowledge of self-care methods, knowledge of available professional assistance, and attitudes that encourage appropriate help-seeking (Jorm, 2012, as cited in Conceptualisation and Operationalisation of Mental Health Literacy, 2025).

Religious leaders have historically occupied a central role in community mental health support across diverse cultural contexts. In Western countries, research has extensively documented clergy involvement in mental health care. In the United States, it has been reported that approximately 40% of individuals seek support from religious officials for mental health problems—a rate exceeding those seeking help from psychiatrists and psychologists combined (Heseltine-Carp & Hoskins, 2020, as cited in Sevinik & Ceylan, 2026). African-American pastors have been described as "frontline responders in mental health, serving as natural helpers within a community as well as gatekeepers to more formal treatment" (Kramer et al., 2006, p. 124, as cited in Townsend, 2022). Studies of Korean American clergy in the United States have similarly highlighted their potential role as community gatekeepers, though noting that "clergy may not have the same level of training and expertise as mental health professionals, which could lead to inappropriate or harmful interventions" (Heseltine-Carp & Hoskins, 2020, as cited in Curtin University, 2024). In Canada, research with Pentecostal clergy revealed that participants "frequently shared a belief that pastoral training failed to equip them to meet congregational mental health needs, often prompting them to rely on peer support or autodidactic mental health training" (PLOS ONE, 2024). These findings from Western contexts establish clergy as critical yet under-prepared mental health gatekeepers, underscoring the need for systematic assessment of their mental health literacy.

Research from Asian contexts has further illuminated the complexities of clergy mental health literacy. In Turkey, a randomised controlled trial conducted by Sevinik and Ceylan (2026) among 29 clergy found that "mental illness training improved clergy's mental health literacy significantly" and that "training reduced clergy's negative beliefs about mental illness effectively." The study reported that "past illnesses and childhood trauma were seen as main causes of mental illness," and that "medical treatment was widely trusted, though some favored traditional methods." Notably, the authors recommended that "periodic mental health training is advised for clergy and community leaders" and that such training be "planned periodically in collaboration with psychiatric teams." This intervention study represents one of the few experimental designs directly examining clergy mental health literacy, providing a methodological benchmark for the present investigation. In Bangladesh, a cross-sectional study of 358 Islamic religious leaders (Imams) found that "more than 90% of the respondents were able to correctly identify anxiety and depression symptoms," with recognition rates for obsessive-compulsive disorder and schizophrenia reaching 83% and 88% respectively (Arafat et al., 2025). However, approximately 71% of Imams believed that "sin or supernatural factors cause mental illness," and many considered that "a person with mental illness might be a threat to others," reflecting the complex interplay between knowledge, cultural beliefs, and stigma in South Asian contexts (Arafat et al., 2025).

In African contexts, the role of religious leaders in mental health care assumes particular significance given the scarcity of formal mental health services and the predominance of spiritual and traditional explanatory frameworks. Research in Nigeria has documented that "clergy professionals are the primary resources of mental health care and support for tens of millions of Nigerians" (CLERIC study, 2026). The CLERIC study, a comprehensive mixed-methods investigation conducted in Lagos, identified what the authors termed a "collaboration paradox": while religious leaders demonstrated willingness

to engage with mental health services, structural barriers including "inaccessible services" and "mistrustful intergroup norms" impeded effective collaboration (CLERIC study, 2026). Quantitative findings from this study revealed that "mental health literacy emerged as the strongest independent predictor" of collaboration readiness ($\beta = 0.41$, $p < 0.001$), followed by education level and prior mental health training. Critically, the study found that "48.8% of respondents had never made a medical referral for a mental health concern in the preceding 12 months," described as "the quantitative expression of the collaboration paradox". The CLERIC study recommended "co-designed bidirectional training" and "formalised referral pathways with named contact persons" to address these systemic gaps.

In Zimbabwe, the relationship between religion, spirituality, and mental health assumes particular cultural significance. Research has documented that "religion shapes attitudes and practices surrounding mental health issues and is an integral part of Zimbabwean culture" (Mafuriranwa et al., 2024, as cited in Curtin University, 2024). A qualitative study by Murambidzi (2016) at the University of Cape Town examined how Zimbabwean clergy understood and managed mental health issues, finding that "the clergy's conceptualisation of mental illness reflects a positive and encouraging level of mental health literacy which can be nurtured to raise community mental health awareness". Notably, the study reported that clergy recognised multiple causal factors including "biological, psychological, environmental, and social factors which were consistent with both the biopsychosocial-spiritual model" (Murambidzi, 2016, p. 67). Murambidzi further noted that "both traditional healers and religious and faith healers are important stakeholders worth partnering with in community mental health interventions". Research with Zimbabwean-Australian clergy has similarly employed the Bio-Psycho-Social-Spiritual Model (BPSSM), noting that "many Zimbabwean-Australian congregants heavily depend on their spirituality for emotional and physical support" (Mafuriranwa et al., 2024, as cited in Curtin University, 2024).

Despite this emerging body of research, significant gaps remain in the literature. First, while qualitative studies have explored clergy perspectives on mental health in Zimbabwe and the diaspora (Murambidzi, 2016; Mafuriranwa et al., 2024), quantitative evidence describing mental health literacy levels, confidence in responding to psychological difficulties, and referral attitudes among religious leaders in Zimbabwe remains limited. Second, most existing research has focused on Western contexts, with the umbrella review noting that "most tools prioritise disorder-related literacy over wellbeing-focused components" (Conceptualisation and Operationalisation of Mental Health Literacy, 2025). Third, the specific domains of mental health literacy where religious leaders may lack knowledge or confidence—such as distinguishing normal stress from serious mental illness, recognising subtle signs of psychological distress, and knowing appropriate responses to urgent situations—have not been systematically examined in the Zimbabwean context. The CLERIC study identified similar gaps in Nigeria, finding that "capability deficits" existed in mental health literacy, risk assessment, and referral among religious leaders. Fourth, while the CLERIC study employed sophisticated analytical methods including structural equation modelling and latent class analysis to examine collaboration readiness among Nigerian religious leaders, no equivalent quantitative investigation has been conducted in Zimbabwe.

The present study addresses these gaps by conducting a quantitative descriptive survey among 70 religious leaders in Harare. By examining mental health literacy levels, recognition of mental health concerns, confidence in responding to psychological difficulties, and attitudes towards professional referral, this study provides context-specific evidence to inform community mental health promotion and the development of effective referral pathways. The findings have implications for Community Psychology practice, particularly in designing capacity-building interventions and strengthening collaboration between faith communities and professional mental health services. As Sevinik and Ceylan (2026) concluded, "periodic mental health training is advised for clergy and community leaders," and such training should be "planned periodically in collaboration with psychiatric teams."

1.2 PROBLEM STATEMENT

Despite religious leaders' trusted community position and frequent contact with psychologically distressed individuals, no quantitative evidence exists on their mental health literacy, confidence, and referral attitudes in Harare, Zimbabwe. This gap limits effective community mental health promotion and referral pathway development.

1.3 AIM OF THE STUDY

To assess mental health literacy among religious leaders and examine its implications for community mental health promotion and referral pathways in Harare, Zimbabwe.

1.4 OBJECTIVES

Main Objective:

To assess the level of mental health literacy among religious leaders in Harare, Zimbabwe.

Sub-Objectives:

- To examine religious leaders' ability to recognise signs and symptoms associated with mental health difficulties.

- To assess religious leaders' confidence in responding to individuals experiencing mental health difficulties.

- To examine religious leaders' attitudes towards referral to professional mental health services.

1.5 RESEARCH QUESTIONS

The following research questions guided this quantitative study:

- What is the level of mental health literacy among religious leaders in Harare?

- What is religious leaders' ability to recognise signs and symptoms associated with mental health difficulties?

- What is religious leaders' confidence in responding to individuals experiencing mental health difficulties?

- What are religious leaders' attitudes towards referral to professional mental health services?

2.0 THEORETICAL FRAMEWORK

This study is grounded in **Jorm's (2000) Mental Health Literacy Framework**, which provides the primary conceptual foundation for examining religious leaders' knowledge, attitudes, and help-seeking behaviours. Mental health literacy is defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm, 2000, p. 396). The framework encompasses six key components: (1) the ability to identify specific disorders, (2) knowledge of how to obtain mental health information, (3) knowledge of risk factors and causes, (4) knowledge of self-care methods, (5) knowledge of available professional assistance, and (6) attitudes that encourage recognition and appropriate help-seeking (Jorm, 2012, as cited in Conceptualisation and Operationalisation of Mental Health Literacy, 2025). This framework is particularly appropriate for the present study because it addresses not only knowledge but also attitudes and help-seeking behaviours, which are directly relevant to clergy's role in facilitating referral. As Sevinik and Ceylan (2026) noted in their study of clergy in Turkey, "mental health literacy is important for early diagnosis and intervention, reducing stigma, increasing public awareness, developing self-help skills, and promoting the tendency to seek professional help." The framework's emphasis on both knowledge and attitudes aligns with the study's examination of recognition abilities, confidence levels, and referral attitudes among religious leaders.

Community Psychology principles as articulated by Dalton, Elias, and Wandersman (2007) provide the applied framework for this study. Community Psychology emphasises prevention, empowerment, community participation, capacity building, and collaboration. These principles are directly relevant to the study's focus on religious leaders as community stakeholders in mental health promotion. The CLERIC study (2026) similarly grounded its analysis in implementation science frameworks including the Consolidated Framework for Implementation Research (CFIR) and the Theory of Planned Behaviour, recognising that "readiness is not a singular construct but a product of interacting individual, organisational and contextual influences". This multidimensional approach aligns with Community Psychology's emphasis on understanding psychological phenomena within broader social and community contexts.

3.0 METHODS

This study adopted a post-positivist research philosophy, which holds that reality can be approximated through objective measurement while acknowledging that knowledge is probabilistic rather than absolute (Creswell & Creswell, 2018). This philosophical stance is appropriate for quantitative descriptive research that seeks to measure and describe phenomena through structured instruments. The research employed a quantitative approach to enable systematic measurement of mental health literacy levels, recognition abilities, confidence, and referral attitudes among religious leaders. As Sevinik and Ceylan (2026) demonstrated in their randomised controlled trial with clergy, quantitative methods can effectively assess mental health literacy and beliefs about mental illness in religious populations.

A descriptive survey design was employed to provide a snapshot of mental health literacy among religious leaders in Harare at a specific point in time. This design is appropriate for describing characteristics of a population and identifying patterns in knowledge, attitudes, and confidence (Creswell & Creswell, 2018). The population comprised religious leaders in Harare, Zimbabwe, representing various denominations and leadership positions including pastors, apostles, bishops, reverends, and prophets. Purposive sampling was used to identify participants representing diverse religious traditions and leadership roles, while snowball sampling facilitated access to additional participants through referrals from initial respondents. This combined approach was necessary given the absence of a comprehensive sampling frame for religious leaders in Harare. The final sample consisted of 70 religious leaders who completed the survey. This sample size is consistent with similar quantitative studies of clergy mental health literacy; for example, the CLERIC study in Nigeria achieved a sample of 207 religious leaders through stratified purposive sampling (CLERIC study, 2026).

Data collection was conducted using a structured Mental Health Awareness Survey for Religious Leaders, comprising demographic questions and 25 mental health literacy statements rated on a five-point Likert scale (1 = Completely Disagree to 5 = Completely Agree). The instrument was developed based on Jorm's (2000) mental health literacy framework and adapted for the Zimbabwean context. Content validity was established through review by mental health professionals and community psychology experts, while pilot testing with five religious leaders assessed clarity and relevance. The CLERIC study similarly employed a stakeholder advisory group comprising religious leaders and mental health professionals to review draft instruments and

inform revisions to item wording and face validity (CLERIC study, 2026). Data analysis employed descriptive statistics including frequencies, percentages, means, and standard deviations to summarise responses and identify patterns in mental health literacy, confidence, and referral attitudes. Ethical considerations included informed consent obtained electronically, voluntary participation, confidentiality assurances, and anonymous data presentation. No personal identifying information was collected, and findings are presented in aggregate form.

4.0 RESULTS

4.1 DATA PRESENTATION

Table 1: Participant Characteristics (n = 70)

Characteristic	Category	Frequency (n)	Percentage (%)
Gender	Male	61	87.1
	Female	9	12.9
Previous Mental Health Training	Yes	17	24.3
	No	53	75.7
Religious Leadership Role	Pastor	28	40.0
	Apostle	12	17.1
	Bishop	8	11.4
	Reverend	9	12.9
	Prophet	7	10.0
	Other	6	8.6

Table 2: Recognition of Mental Health Concerns

Statement	Mean (M)	SD
I can distinguish between normal stress and serious mental illness	3.63	0.89
Withdrawal from church activities may indicate a mental health concern	2.97	1.02
I can recognise thoughts or speech indicating a person may not be in touch with reality	4.03	0.78

Table 3: Confidence in Responding to Mental Health Difficulties

Statement	Mean (M)	SD
I know when pastoral counselling is no longer sufficient	4.09	0.81
I can recognise deterioration in a person's condition	4.14	0.76
I can identify serious emotional or psychological distress	3.71	0.92
I know the steps to take when urgent professional help is required	3.70	0.95

Table 4: Attitudes Towards Professional Referral and Collaboration

Statement	Mean (M)	SD
Referral to a mental health professional may sometimes be necessary	4.59	0.58
Spiritual and professional mental health care can work together	4.60	0.55
Some situations require trained mental health professionals	4.67	0.52
Members should seek help from counsellors or psychologists when necessary	4.64	0.54
Referral does not mean the religious leader has failed	4.67	0.51

Table 5: Understanding of Factors Associated with Mental Illness

Statement	Mean (M)	SD
Psychological factors such as stress and trauma contribute to mental illness	4.57	0.61
Spiritual factors contribute to mental illness	4.39	0.72
Biological factors contribute to mental illness	4.33	0.75
Mental illness results from combined psychological, spiritual, and biological factors	4.23	0.79
Understanding causes of mental illness helps religious leaders respond appropriately	4.69	0.49

4.2 DATA ANALYSIS AND DISCUSSION OF FINDINGS

The findings indicate generally positive self-reported mental health literacy among religious leaders in Harare, with an overall mean score of approximately 4.11 out of 5. This finding aligns with Murambidzi's (2016) observation that Zimbabwean clergy demonstrate "a positive and encouraging level of mental health literacy". However, the variability across individual items reveals that positive overall perceptions do not mean that all aspects of mental health literacy are equally developed. The CLERIC study similarly found that mental health literacy was the strongest predictor of collaboration readiness ($\beta = 0.41$, $p < 0.001$), yet also identified significant capability deficits in specific domains.

The comparatively lower scores for distinguishing normal stress from serious mental illness (M = 3.63) and recognising withdrawal from church activities as a possible concern (M = 2.97) suggest that less obvious presentations may be more difficult to identify. This finding is significant because mental health literacy includes the ability to recognise mental disorders and psychological distress (Jorm, 2000). The CLERIC study similarly identified "capability deficits" in mental health literacy and risk assessment among religious leaders in Nigeria, recommending "co-designed bidirectional training" to address these gaps. Research by Gouniai et al. (2022, as cited in Townsend, 2022) found that clergy members sometimes misidentified mental health conditions, with one study reporting that clergy believed an obsessive-compulsive disorder vignette to be "a crime rather than a mental illness," resulting in referral to police rather than mental health services.

The findings concerning confidence show a distinction between willingness to support and confidence in identifying serious distress or responding during urgent situations. While respondents expressed confidence in knowing when pastoral counselling was no longer sufficient (M = 4.09) and recognising deterioration (M = 4.14), confidence in identifying serious emotional distress (M = 3.71) and knowing steps for urgent help (M = 3.70) was comparatively lower. This suggests that capacity-building should go beyond general awareness to include practical recognition and referral skills, consistent with Sevinik and Ceylan's (2026) finding that structured training significantly improved clergy mental health literacy. The CLERIC study similarly found that "willingness to attend mental health training was highest (78.3%), while trust in professionals (43.5%) and perceived respect from clinicians (39.1%) were the lowest-endorsed items".

The strong support for professional referral and collaboration (M = 4.59–4.67) is a particularly positive finding. This aligns with research showing that religious leaders can be important points of contact for people seeking help and that collaboration with professional mental health

services may strengthen pathways to care (Burns & Tomita, 2015; Cjuno et al., 2024). The CLERIC study identified the need for "formalised referral pathways and named contact persons" to replace reliance on informal networks, and found that "each one-point readiness increase raised referral odds by 12% (OR=1.12, 95% CI 1.08 to 1.17, p<0.001)". This suggests that willingness to refer must be supported by structural mechanisms that make referral feasible and reliable.

The finding that 75.7% of respondents had not received previous mental health training indicates a significant capacity-building opportunity. The CLERIC study reported that "nearly a quarter (23.2%) had prior mental health training" among Nigerian religious leaders, a comparable figure to the 24.3% observed in the present study. Sevinik and Ceylan (2026) recommend that mental health training be "planned periodically in collaboration with psychiatric teams." The present study does not establish that lack of training caused the identified gaps, and no causal relationship should therefore be inferred. However, the training gap supports further investigation of accessible mental health literacy programmes for religious leaders in Zimbabwe.

Respondents' recognition of psychological (M = 4.57), biological (M = 4.33), and spiritual (M = 4.39) factors suggests that mental health is understood through multiple explanatory perspectives. This multidimensional understanding is consistent with Murambidzi's (2016) finding that Zimbabwean clergy attributed mental illness to "biological, psychological, environmental, and social factors" and aligns with the Bio-Psycho-Social-Spiritual Model employed in research with Zimbabwean-Australian clergy. Community Psychology can support respectful collaboration across these perspectives while promoting appropriate professional assessment and referral.

4.3 CONCLUSIONS (ANSWERS TO RESEARCH QUESTIONS)

Religious leaders demonstrated generally positive self-reported mental health literacy (M ≈ 4.11/5), with strong recognition of multiple causal factors and positive attitudes towards professional care. However, specific knowledge gaps exist in recognising less obvious presentations and distinguishing normal distress from serious mental illness.

Recognition was stronger for obvious signs (disconnection from reality, M = 4.03) but weaker for subtle indicators (withdrawal from church activities, M = 2.97), suggesting that less visible presentations may be missed.

Confidence was higher for knowing when pastoral counselling was insufficient (M = 4.09) and recognising deterioration (M = 4.14), but lower for identifying serious distress (M = 3.71) and knowing steps for urgent professional help (M = 3.70).

Attitudes were strongly positive (M = 4.59–4.67), with respondents endorsing professional referral as complementary to spiritual care and not indicative of pastoral failure.

4.4 RECOMMENDATIONS

This study made the following recommendations;

- Develop and implement structured mental health literacy training programmes for religious leaders in Zimbabwe. These programmes should emphasise recognition of subtle mental health indicators, differentiation between normal stress and serious psychological difficulties, and practical steps for responding to urgent situations. Training should be developed in collaboration with mental health professionals and integrated into pastoral training curricula, as recommended by Sevinik and Ceylan (2026).

- Establish formal referral pathways between faith communities and professional mental health services. Clear protocols, named contact persons, and mutual agreements should be developed to facilitate timely and appropriate referral. These pathways should address the structural barriers identified in the CLERIC study, including inaccessible services and unclear role boundaries.

- Encourage Community Psychologists and mental health professionals to collaborate with faith-based organisations in mental health promotion, prevention, and capacity-building initiatives. This collaboration should respect the spiritual dimension of care while promoting appropriate professional assessment and referral.

- Conduct further research to examine whether structured mental health training improves objective knowledge, confidence, and referral practices over time. Longitudinal studies with larger samples and pre-post intervention designs would strengthen the evidence base for clergy mental health literacy interventions in Zimbabwe.

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