

**MENTAL HEALTH AND PSYCHOLOGICAL WELLBEING AMONG PERSONS WITH
DISABILITIES IN NIGERIAN CHRISTIAN COMMUNITIES**

By

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Abstract

The relationship between Christian faith, mental health and physical disability is a very under-researched issue in the Nigerian context of theological scholarship and pastoral practice. Persons with physical disabilities (PWDs) in Nigeria are vulnerable in more ways than one as a consequence of the disability, the PWDs are structurally excluded and are worse off socio-economically. At the same time, they encounter intense psychological pressure (including identity issues, internalized shame, anxiety and depression) often exacerbated by dominating theological discourses within their local churches. Culture and the “theology of healing” that associates physical health with God's blessing, has resulted in a situation where physically ill believers are expected to endure their hardships without receiving pastoral care or psychological assistance. Based on a systematic literature review and biblical-theological evaluation, this paper introduces a constructive Theology of Wholeness as a liberating alternative. Drawing upon the biblical idea of shalom, Christ's approach of compassionate presence, Paul's strength-in-weakness theology, and contemporary psychological theories of post-traumatic growth and resilience, this study claims that a thorough understanding of human flourishing is scripturally sound and scientifically sound. The paper concludes with actionable recommendations to theological educators, pastors and church leaders to create psychologically safe and theologically enabling spaces for spiritual and mental health for PWDs in Nigeria.

Keywords: Theology of Wholeness, Mental Health, Physical Disability, Shalom, Pastoral Care, Nigerian Church, Stigma, Psychological Wellbeing.

1. Introduction

Nigeria is caught up in two powerful discourses of the human body and suffering. First, there is a long Judeo-Christian heritage that sees the whole human person spirit, mind, and body as the context in which God redeems. Secondly, there is an undercurrent of Nigerian Christianity, dominated by Pentecostal/charismatic prosperity gurus, that has a split concept of humanity. This perspective honors productive, healthy bodies while demonizing disheartened and damaged minds and bodies. The differences in this theology have dire implications for the approximately 25 to 30 million Nigerians

who are physically disabled (World Health Organization). They exist in economic marginality and structural inequality and are disproportionately affected by mental health problems. There are strong indications from global studies that PWDs are two to three times more likely to suffer from post-traumatic stress, anxiety, and depression than non-disabled persons (Adewuya and Makanjuola 489; World Health Organization). Poverty, limited mental health resources, and cultural attitudes which view psychological distress as spiritual weakness further compound the psychological vulnerability in Nigeria. The Christian Church is the most culturally dominant institution in Nigeria, and this paradoxical situation has placed the church in a position of conflict. Many Nigerians turn to their local churches as their main sources of comfort when afflicted with physical and/or mental distress. Many churches in Nigeria however don't have the pastoral and theological resources to offer real mental health care to PWDs. In many instances, dominant religious beliefs actually maintain the psychological suffering to which they refer. This study aims to address this paradox, and advocates that, instead of better counseling techniques, Nigerian churches need a paradigmatic change in theology, namely a Theology of Wholeness. The transition needs to be towards a biblical understanding of human flourishing (shalom) and to the mental health needs of physically challenged people.

Mental health problems among the physically challenged in Nigerian Christian communities is a theological and cultural and a clinical conundrum. Anxiety and depression are prevalent mental health disorders of PWDs, but there is limited access to professional psychiatric services (Gureje et al. 168). This clinical deficit puts the church in a unique position to be the country's most important resource for mental health. The Spiritualization of Psychological Distress: There are three main issues that have hindered the church in meeting this need theologically and culturally: The first is the popular Nigerian understanding of psychological stress as a demonstrated attack of the devil or a failure of the victim's spiritual strength. PWDs who are experiencing depression are repeatedly reminded to just pray and not worry ignoring the psychological effects of the situation, thereby leaving depression in the shadows and exacerbating the sense of shame. Theology of Healing as Cure: Problem: Many Nigerian Pentecostal teachings take the view that physical disability is a disease to be taken away through miraculous means. This story reveals that the unhealed are living in sin and have no faith, and that this is a destructive cycle for PWDs that involves self-blame and spiritual alienation. A problem in Nigerian Christianity is the Dualistic Anthropology which gives more value to the spiritual soul and less value to the physical body. The missing bridge here is mental health - which is neither spiritual enough to be prayed for nor physical enough to be referred to a medical site and therefore is completely ignored by the PWDs.

The purpose of this study is to address these issues by offering a biopsychosocial-spiritual approach that is grounded in the biblical understanding of shalom. The overarching aim is to develop a "Theology of Wholeness" which will enable pastoral counselors and church leaders to have a compassionate insight and response to the mental health issues which are experienced with physical disability.

In particular, this study is intended to do the following:

1. Critically examine the prevailing Nigerian theological perspectives that will be detrimental to the mental health of the PWDs.
2. Work out a biblical-theological analysis of shalom, Christ's compassionate presence, and Paul's theology of weakness to construct a Theology of Wholeness.
3. Use relevant psychological theories, such as Resilience and Post-traumatic growth, within this new theological construct.
4. Give practical solutions that can be implemented in church communities to enable PWDs to thrive spiritually and mentally in Nigeria.

This study is a novel contribution to African Disability Theology by focusing on mental health issues of disability which are sparsely discussed in theological writings in Nigeria. It provides the professional and theological resources that the priest needs to go beyond spiritualizing problems and to providing integrated care. Furthermore, it models a collaboration between psychological science and theological wisdom, which is urgently needed given Nigeria's lack of clinical resources. This theoretical paper is an interdisciplinary work, drawing on elements from systematic theology, biblical studies, clinical psychology and pastoral theology. Its psychological models are well known, and its applications are specifically Nigerian, predominantly to charismatic, Pentecostal and mainstream Protestant churches.

2. Methodology

The Research Design adopted in this research is systematic interdisciplinary literature review and biblical-theological constructive analysis. The methodology is congruent with the objectives, which are theoretical and constructive, a normative theological framework, and is based on three major disciplines: biblical scholarship and hermeneutics, systematic and pastoral theology and clinical and health psychology. The study is a representative, analytical and synthetic study of literature from each discipline to build an integrated Theology of Wholeness.

The Selection of Literature adopted the use of the peer-reviewed journals in the field of theology and disability studies, foundation monographs in disability theology, African theology and positive psychology, official report of the World Health Organization (WHO) and health bodies in Nigeria, as well as the primary scriptural texts of old and new testaments, with focus on its canonical, literary and theological context, were used in the selection.

Constructive analysis is built in three movements: (1) a critical analysis of the existing theological frameworks and their psychological implications, (2) a retrieval of under-used theological and biblical resources in the Christian tradition, and (3) a constructive integration of these resources with the psychological frameworks to arrive at the Theology of Wholeness and its implications.

The authors recognize that this study is carried out from the perspective of Christians in Nigeria and from a normative stance of the integrity of theological scholarship, and the welfare of physically challenged individuals in the churches in Nigeria. This is an asset in that it allows for sensitivity to context and pastoral realism, but it has its drawbacks which are ameliorated through careful reference to critical literature and various disciplinary lenses.

3. Findings and Discussion

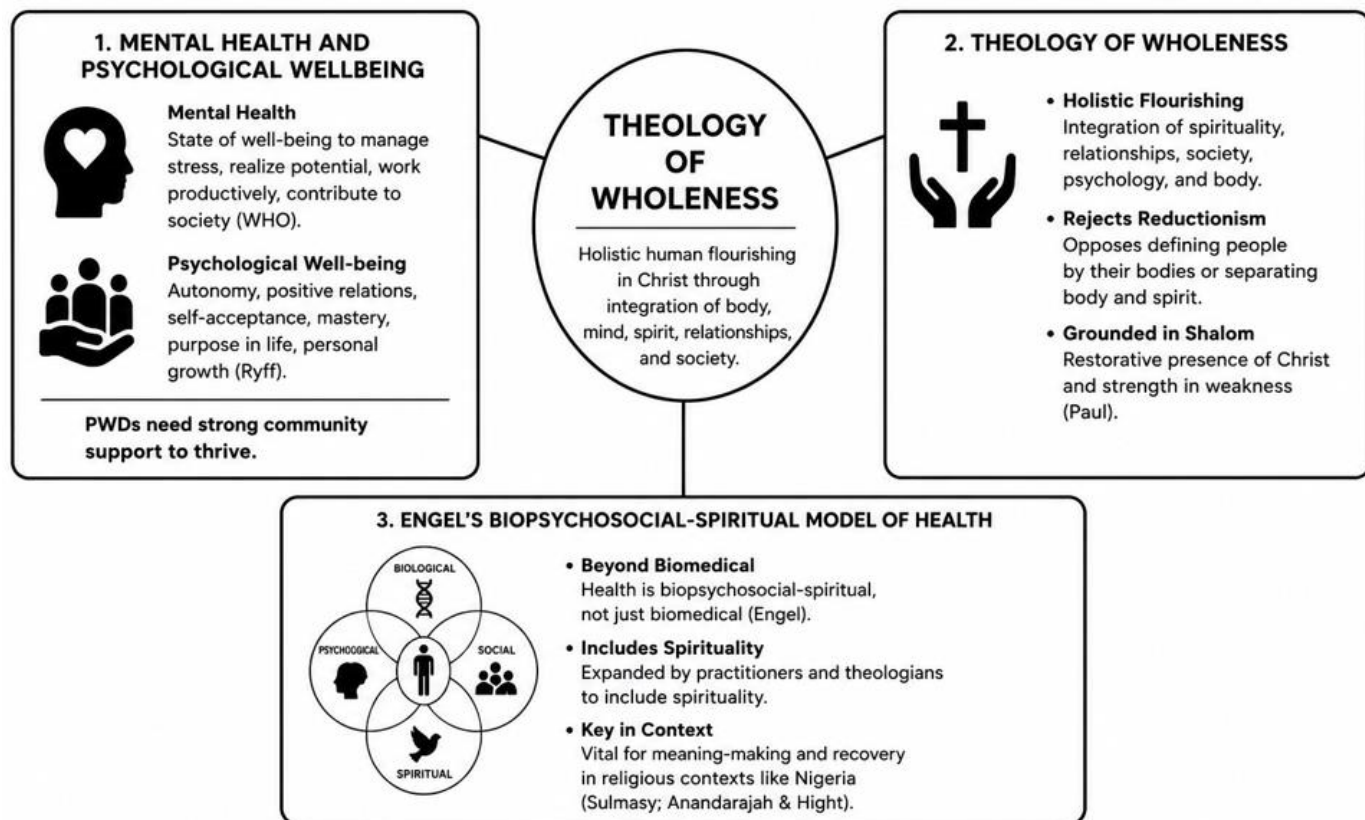
The critical investigations of this study identify three dominant theological frameworks within contemporary Nigerian Christianity that actively undermine the psychological well-being and mental health of Persons with Disabilities (PWDs): the prosperity gospel, dualistic anthropology, and the systemic stigmatization of mental health help-seeking.

When a church community insists that immediate, visible “healing as a physical cure” is the only valid proof of divine favor or authentic faith, unhealed PWDs are trapped in a highly destructive cycle of self-blame and existential despair. The prosperity gospel essentially reframes physical impairment as a spiritual deficit, which deepens internalized shame and leads to severe religious trauma (Winell 16). Within this rigid framework, disability is turned into a visible sign of an individual's spiritual inadequacy or hidden sin (Gifford).

Furthermore, an unexamined dualistic approach leaves the entire realm of mental health stranded in a dangerous pastoral void. Because the mind is neither treated as a purely spiritual entity that can be resolved via brief deliverances nor a purely physical organ requiring standard medical referral, it is entirely ignored. This cultural expectation of bodily perfection promotes a harmful “curative eschatology” and a subtle form of Christian ableism that inherently devalues the human dignity of PWDs (St Pierre).

Consequently, deep psychological distress is delegitimized. When physically challenged individuals experience intense emotional struggles or clinical depression within this religious environment, their pain is dismissed as a spiritual failure. This perspective heavily stigmatizes the utilization of professional psychiatric or psychotherapeutic services (Dada et al. 5). In its most extreme forms, this profound theological distortion contributes to severe psychological crises, identity fragmentation, and a heightened risk of suicide within vulnerable populations facing untreated psychocosmic distress (Nnaji, “Psychocosmic Analysis” 165).

Fig. 1: Conceptual Findings.



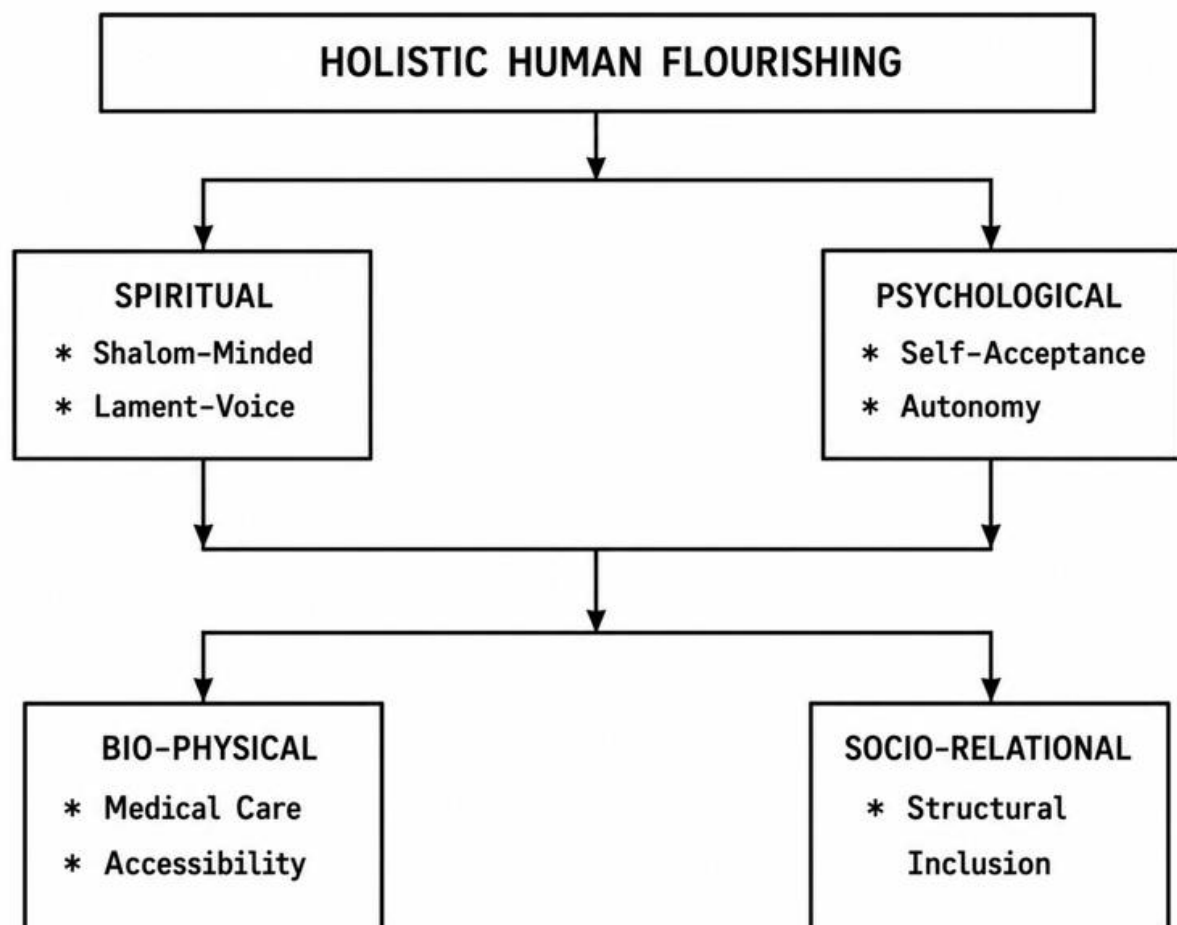
To counter these damaging narratives, we must first establish clear, rigorous definitions of mental health and psychological well-being within a holistic framework. The World Health Organization defines mental health not merely as the absence of illness, but as a dynamic state of overall well-being in which an individual can effectively manage the standard stressors of life, realize their personal potential, work productively, and contribute meaningfully to their community (World Health Organization, *World Mental Health Report*).

Furthermore, psychological well-being is defined by key dimensions that include autonomy, positive social relationships, environmental mastery, purpose in life, self-acceptance, and ongoing personal growth (Ryff 1069). For a physically challenged individual living within a highly challenging socio-economic environment like Nigeria, achieving these psychological dimensions requires deep, sustained affirmation from both their immediate community and their underlying theological worldview.

Authentic human flourishing occurs only when all facets of a person's existence the spiritual, psychological, social, relational, and biological are seamlessly integrated. This holistic paradigm strongly rejects the biological reductionism that defines a human being solely by the functional efficiency of their physical body. It likewise condemns the anthropological dualism that devalues the material flesh in favor of an abstract soul (Nnaji, "Introduction" 138).

This study utilizes an expanded version of George Engel’s classic medical model. While Engel originally formulated his model to challenge the narrow biomedical reductionism of Western medicine by insisting on the psychological and social dimensions of illness (Engel 129), contemporary healthcare practitioners and pastoral theologians have expanded it to explicitly include spirituality. In a deeply religious society like Nigeria, spirituality operates as a foundational matrix for individual meaning-making, coping mechanisms, and long-term psychological recovery (Anandarajah and Hight 81; Sulmasy 24).

Fig.2: Holistic Human Flourishing

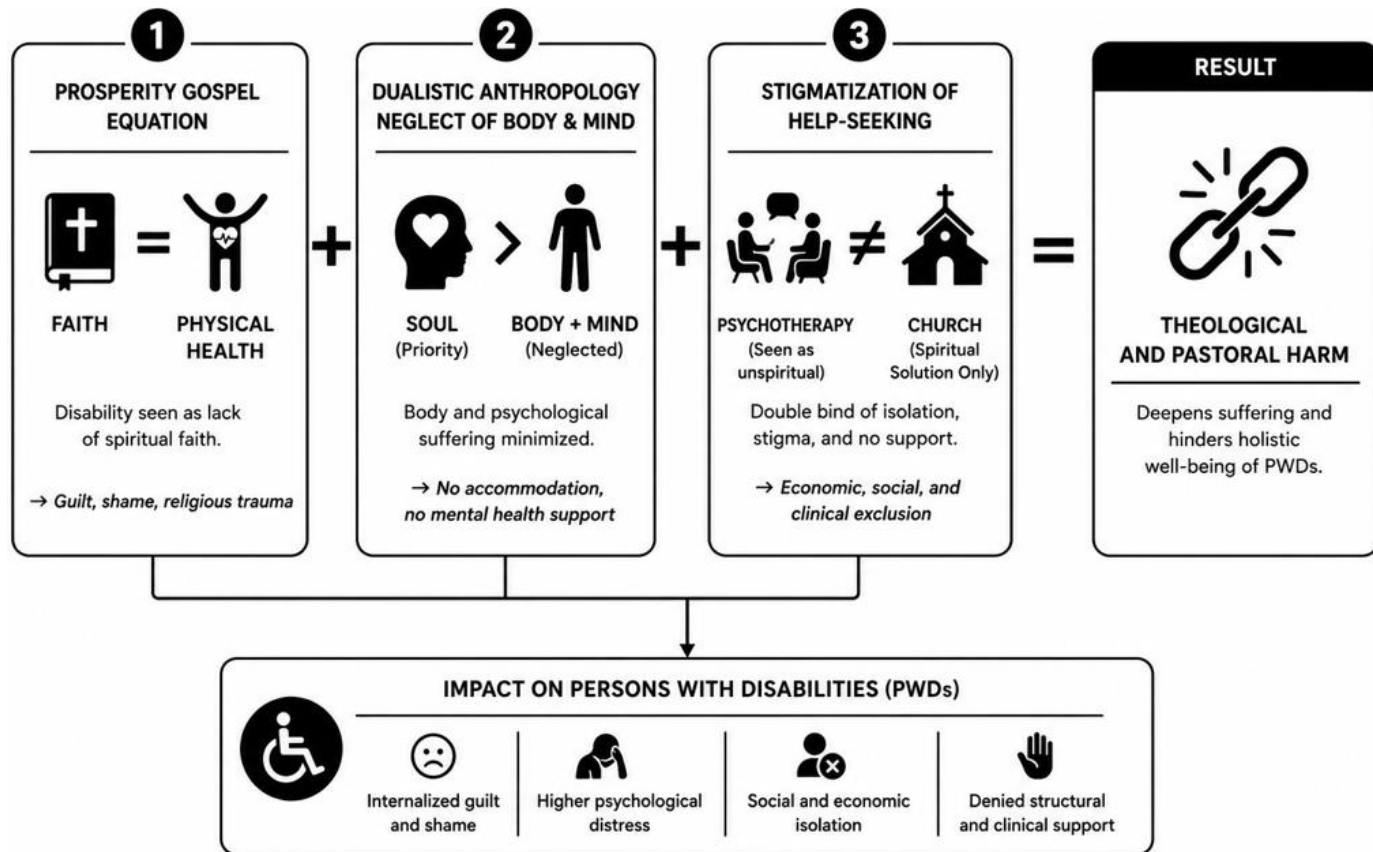


The pervasiveness of body-neglecting theologies within Nigerian Christian communities can be traced back to historical philosophical distortions that infiltrated early Western Christian thought and were subsequently imported into African ecclesiastical spaces. This perspective is deeply influenced by Platonic philosophy, which posits a radical cleavage between the material body (seen as an inferior, transient prison) and the immaterial soul (viewed as the ultimate, pure seat of human identity).

When modern churches adopt this unexamined dualism, they inadvertently devalue the physical and psychological realities of the human body (Nnaji, “Introduction” 138). This ideological framework erases the crucial distinction between bodily impairment and psychological suffering. It leads directly

to an ecclesiastical culture where no structural accommodations are made for physical access, and no emotional support systems are established for mental health care.

Fig.3: The Prosperity Gospel and the “Faith = Physical Health” Equation



As illustrated in Fig.3above, this ideological framework locks the physically challenged believer into a destructive double bind of multi-layered isolation. They are subjected to intense economic and social marginalization by the state, burdened with severe physical stigma by society, and simultaneously denied both structural accommodation and clinical psychological support by their local faith communities.

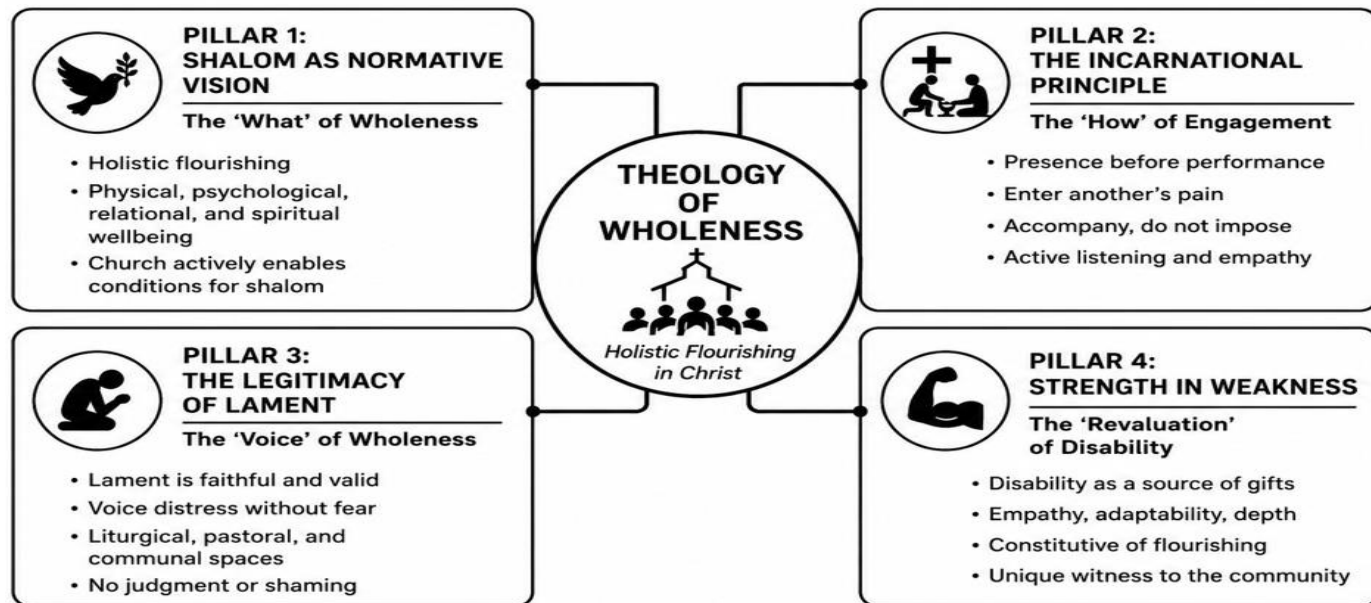
Because mental health struggles are consistently mischaracterized as spiritual failures or demonic oppressions, seeking professional psychotherapeutic help is frequently framed as a betrayal of faith in God (Dada *et al.* 1). PWDs are thus forced to choose between authentic emotional honesty and social acceptance within their churches.

To counter damaging theological narratives, the study proposes a “Theology of Wholeness” built on four interlocking biblical pillars:

1. *Shalom* as a normative vision of comprehensive flourishing.
2. The Incarnational Principle, prioritizing compassionate presence over performance.

3. The Legitimacy of Lament, granting a faithful voice to distress.
4. Strength in Weakness, revaluing disability as a site of spiritual gifting.

Fig.4: Core Pillars of the Theology of Wholeness



The first pillar, Shalom as Normative Vision ('The What' of Wholeness), makes it clear that in the study of shalom my wellbeing is not defined by the process of my healing, or even my spiritual productivity: it is comprehensive. It argues that the need for physical, psychological, relational and spiritual aspects to be incorporated is essential for achieving true flourishing. One of the church's functions is to provide conducive conditions: architectural, theological, attitudinal and pastoral; to facilitate this holistic development.

The second pillar also emphasizes the Incarnational principle 'The How of Engagement', which means that at the core of the church's engagement with PWDs is the presence of God, not performance. Allowing people to journey with them during their suffering and experiences without imposing any agenda for solutions or cures. In a pastoral care session, the question of disability and suffering ought to be addressed by active listening, empathy and learning to cope with anxieties.

The third pillar is the Legitimacy of Lament ('The Voice' of Wholeness); a declaration that expressions of faith in the form of lament are legitimate. This pillar highlights trauma and psychological distress, for example grief and anger, as something that must be recognized in the church, based on Biblical traditions. Creating learning environments where persons can safely share their real-life experiences without judgment and spiritual reproach is very important in a community that strives for wholeness.

The fourth pillar posits that; by reimagining physical disabilities less as a burden and more as a strength, it rejects the understanding of ‘The Revaluation’ of Disability as one of its major aspirations. This pillar, grounded in Pauline theology and resilience research, sees that the challenges of what it means to be touched by problems and importantly a person with a handicap can develop individual gifts, insights and strengths that bring colour to the whole community. The Theology of Wholeness, then, spurs a revaluation of disability itself, and suggests that the current traditional concept of disability be understood as one of the ways individuals and communities can flourish and contribute to spiritual life.

This proposed framework shifts the church’s focus from attempting to eradicate disability to fostering an environment where PWDs can flourish as they are. *Shalom* dictates that true well-being requires the integration of relational, psychological, spiritual, and physical health, rather than just a physical cure (Sanou 295; Wolff). Incorporating the psalms of lament normalizes psychological distress, validating grief and anger as authentic expressions of faith (Brueggemann 58). Furthermore, the incarnational model emphasizes that pastoral care must involve entering into another's pain with active listening and empathy. Ultimately, Paul's theology of weakness and Christ's resurrected, wounded body demonstrate that physical impairment is not incompatible with divine power or human wholeness (Eiesland; Yinger).

The Theology of Wholeness successfully integrates the Biopsychosocial-Spiritual model of health with psychological frameworks such as Meaning-Making Theory and Post-Traumatic Growth (PTG). This interdisciplinary integration allows the church to understand the lived experiences of PWDs without resorting to reductionism or toxic positivity.

Pairing Pauline theology with PTG validates the complex reality of living with a disability. PTG recognizes that grappling with severe adversity can catalyze profound positive changes in self-perception, relational depth, and spiritual insight (Tedeschi and Calhoun 5). Meanwhile, Meaning-Making Theory is crucial for PWDs whose existing religious assumptions (e.g., “disability is a punishment for sin”) are shattered by their physical realities. By adopting the Theology of Wholeness, the church can offer healthier meaning-making frameworks that allow PWDs to reconstruct a coherent, dignified identity and maintain their spiritual well-being (Park, “Making Sense” 260; Park, “Religion” 710). Recognizing the biopsychosocial-spiritual nature of health ensures that interventions address the whole person (Engel 130; Sulmasy 25).

To operationalize the Theology of Wholeness, the study outlines three practical steps for Nigerian church communities:

1. Developing disability-affirming liturgies (e.g., utilizing lament psalms and celebrating resilience rather than just miraculous healings).
2. Establishing psychologically safe small groups in physically accessible venues.
3. Integrating mental health literacy into the church’s pastoral care infrastructure.

Liturgy is the ordered patterns of corporate worship. It is the primary formation mechanism of the Christian community. If the church's liturgy consistently presents physical healing as the ultimate sign of divine favour, and fails to include the voices, images, and experiences of disabled persons in its prayers, sermons, and rituals, it will continue to form a community that unconsciously devalues disability.

A Theology of Wholeness calls for disability-inclusive liturgical practices: regular inclusion of lament psalms and honest prayers of lament; sermons that draw on the theology of weakness and incarnational presence; testimonies that celebrate resilience, meaning-making, and community inclusion rather than exclusively miraculous physical healing; and the active inclusion of physically challenged persons as liturgical readers, musicians, ministers, and preachers.

Psychologically Safe Small Groups and Fellowship Communities: Small group communities—home fellowships, cell groups, and Bible study groups—are the relational heart of the local church. For physically challenged members to experience genuine psychological safety within these communities, three conditions are necessary:

- i. All fellowship meetings must be held in accessible venues or relocated to accommodate physically challenged members, rather than expecting them to be carried or to remain absent.
- ii. Small group leaders must be trained to create environments in which honest emotional expression—including grief, anger, and doubt—is met with empathy rather than theological correction.
- iii. Physically challenged members must be positioned not as recipients of the group's charity but as full contributors whose insights, gifts, and experiences enrich the whole community.

Integrating Pastoral Counselling and Mental Health Literacy: A Theology of Wholeness necessitates the integration of mental health literacy into the church's pastoral care infrastructure. This does not require every pastor to become a licensed clinical psychologist. It does require that:

- i. All pastoral workers receive basic training in mental health first aid, including the ability to recognize the symptoms of depression, anxiety, grief, and spiritual injury; to listen without judgment; and to make appropriate referrals to professional services.
- ii. Seminaries and theological institutions in Nigeria integrate Disability Pastoral Theology and Mental Health and Faith as required modules in all pastoral training programmes.
- iii. Churches actively establish Mental Health Reference Panels—partnerships with qualified psychologists, social workers, and occupational therapists who can receive referrals from pastoral staff and provide professional support within a faith-affirming context.

- iv. Church leaders publicly normalize mental health help-seeking by preaching explicitly about psychological wellbeing, inviting mental health professionals to speak at church events, and affirming from the pulpit that seeking professional psychological support is an act of wisdom and self-stewardship, not a failure of faith.

Theological ideals must be translated into tangible, structural changes for PWDs to experience genuine psychological safety (Wilder). Liturgy serves as the primary formation mechanism of the church; by including disabled voices and testimonies of meaning-making, the church actively dismantles ableist narratives. Furthermore, equipping pastoral workers with Mental Health First Aid training and establishing Mental Health Reference Panels ensures that psychological distress is met with appropriate professional referrals rather than theological correction (Ajayi 105; Carnes). Leaders must publicly normalize mental health help-seeking, fostering a culture of belonging and psychological safety across all small groups and congregations (Jones; Kiener).

5. Summary, Conclusion, and Recommendations

This study examines the theological, pastoral and clinical needs of Persons with Disabilities (PWDs) in Nigerian Christian Communities. The results of the investigations are summarized here.

1. The study determined that dualistic anthropology, the prosperity gospel and stigmatization of seeking mental health help contribute to a “curative eschatology” that pathologises disability and delegates psychological pain.
2. A methodical analysis revealed four corrective theological pillars: Pauline theology of strength in weakness, the Psalmic tradition of mourning, Incarnational paradigm of loving presence, and Shalom (holistic flourishing).
3. To provide a holistic treatment of pastoral care without reduction and avoid this, the study successfully linked these theological insights with psychological models such as Post-Traumatic Growth (PTG), Meaning-Making Theory and the Biopsychosocial-Spiritual model.
4. The implementation of disability affirming liturgies, the creation of ministries of trained pastoral access and mental health, and the establishment of formal disability start-up and implementation ministries are all necessary since structural change cannot be achieved without changes in practice.

Recommendations

1. Denominational bodies need to have a policy formally embracing ‘Theology of Wholeness’ and a clear stance against ableist stories and the affirmation of the full dignity and psychological correctness of PWDs.
2. To fill the gap between science and pastoral response, lay leaders and ordained Ministers need mental health certified Mental Health First Aid training to respond competently and with information.

3. Each local congregation should create a “Wholeness Ministry Team” composed of (Lay Counselors, Mental Health Professionals and People with disabilities) that support the professional referral and ensures consistent support and follow-up from the congregation itself.
4. Closeness to destructive positivity and creation of psychological safety is understood through the use of lament psalms and the use of non-miraculous testimonies to resilience in public worship, leading by example for others.
5. Disability modules should be introduced in seminaries and theology faculty and interdisciplinary research collaborations should be made with clinical psychology faculty to institutionalize care that is biopsychosocial-spiritual.
6. The Church should resource and empower PWDs to continue to lead peer support groups, as well as to be active participants in the church's continued reformation, giving them representation.

Conclusion

The Christian Community in Nigeria has the great theological resources and cultural power to become a place of wholeness. But, with current emphasis on performance and cure theological managements that encourage triumph over the real complaints of human suffering continue to breed environments that favour the expression of success over sorrow. The church can transition from the trauma destination to the presence of dignity and by restoring the ancient biblical calls to shalom and incarnational presence. Physical beauty is not the key attribute of a successful pastor, but openness, inclusiveness, and caring-for-the-whole-person are the hallmarks of that which is successful.

Works Cited

Religion as a Meaning-Making Framework in Coping with Life Stress.” *Journal of Social Issues*, vol. 61, no. 4, 2005, pp. 707-29.

Adeola, Kehinde Adedayo, and Lawrence Ogbu Ugwuanyi. “Religion as a Cultural Heritage: African Traditional Religion, Culture and Philosophy.” *Nnamdi Azikiwe Journal of Philosophy*, 2014, pp. 1-22.

Adewuya, A. O., and R. O. A. Makanjuola. “Social Distance Towards People with Mental Illness Amongst Nigerian University Students.” *Social Psychiatry and Psychiatric Epidemiology*, vol. 44, no. 6, 2009, pp. 489-93.

Ajayi, D. E. “Pastoral Care and Mental Health Literacy.” *Wukari International Studies Journal*, vol. 9, no. 3, 2025.

Anandarajah, G., and E. Hight. “Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment.” *American Family Physician*, vol. 63, no. 1, 2001, pp. 81-89.

Bila, G. J., and U. S. Lawal. “Barrier and Access Enhancement Strategies for Disability Inclusion.” *Special Needs Education from the Lens of Interdisciplinary Dialogue*, vol. 2, no. 1, 2023, pp. 45-67.

Black, K. *A Healing Homiletic: Preaching and Disability*. Abingdon Press, 1996.

Brueggemann, W. “The Costly Loss of Lament.” *Journal for the Study of the Old Testament*, no. 36, 1986, pp. 57-71.

- Carnes, J. *The Inclusive Church: Structural and Pastoral Approaches*. Academic Press, 2022.
- Dada, M. U., et al. "Factors Associated with Identification of Mental Health as a Priority in Nigeria: A Public Health Perspective." *BMC Public Health*, vol. 21, no. 1, 2021, pp. 1-10.
- Dike, Uzoma Amos, Kehinde Adedayo Adeola, and Amos Francis Dike. "Divine Wisdom and Thinking Machines: An African Theological Perspective of AI in the Fourth Industrial Revolution." *NOUN Scholar*, 2024.
- Echeta, E. C. "The Imago Dei and the Rights of Persons with Disabilities in Nigeria: A Theological Critique." *Journal of African Christian Studies*, vol. 5, no. 2, 2019, pp. 112-30.
- Eiesland, N. L. *The Disabled God: Toward a Liberatory Theology of Disability*. Abingdon Press, 1994.
- Engel, G. L. "The Need for a New Medical Model: A Challenge for Biomedicine." *Science*, vol. 196, no. 4286, 1977, pp. 129-36.
- Federal Republic of Nigeria. *Discrimination Against Persons with Disabilities (Prohibition) Act*. Official Gazette, 2018.
- Gifford, P. *Ghana's New Christianity: Pentecostalism in a Globalizing African Economy*. Indiana University Press, 2004.
- Gureje, O., et al. "The Role of Global Traditional and Complementary Medicine in Treating Mental Health Disorders: A Systematic Review." *The Lancet Psychiatry*, vol. 2, no. 2, 2022, pp. 168-80.
- Jones, L. *Psychological Safety in Faith Communities*. Eerdmans, 2023.
- Kiener, A. *Disability and Pastoral Accompaniment*. Liturgical Press, 2021.
- Nnaji, C. O. "Introduction to Christian Philosophy." *Sophia: An African Journal of Philosophy*, vol. 15, no. 2, 2015, pp. 134-44.
- Nnaji, Charles Ogundu. "Psychocosmic Analysis of Suicide." *Open Journal of Philosophy*, vol. 5, no. 2, 2015, pp. 163-70.
- Nwachukwu, O. T. *The Prophetic Mission of the Church in Contemporary Nigeria: Advocacy, Action, and Inclusion*. Theological Publications, 2020.
- Oladoye, Mojirayo Ireoluwa, Kehinde Adedayo Adeola, and Andy-Philip Nesta. "Jesus' Concept of Gender Equity and Its Role in Nation-Building." *The NOUN Scholar*, vol. 3, no. 1, 2023, pp. 102-116.
- Park, C. L. "Making Sense of the Meaning Literature: An Integrative Review of Meaning Making and Its Effects on Adjustment to Stressful Life Events." *Psychological Bulletin*, vol. 136, no. 2, 2010, pp. 257-301.
- Ryff, C. D. "Happiness Is Everything, or Is It? Explorations on the Meaning of Psychological Well-Being." *Journal of Personality and Social Psychology*, vol. 57, no. 6, 1989, pp. 1069-81.
- Sanou, B. "On the Path to Shalom." *Wholistic Healing*, Seventh-day Adventist Theological Seminary, 2024.
- St Pierre, J. "Curative Eschatology: Christian Ableism and Religious Cripistemology." *The Journal of Philosophy of Disability*, 2024.
- Sulmasy, D. P. "A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life." *The Gerontologist*, vol. 42, no. 3, 2002, pp. 24-33.
- Tedeschi, R. G., and L. G. Calhoun. "Posttraumatic Growth: Conceptual Foundations and Empirical Evidence." *Psychological Inquiry*, vol. 15, no. 1, 2004, pp. 1-18.
- Wilder, C. *Disability, Faith, and the Church*. Bloomsbury Publishing, 2016.

Winell, M. "Religious Trauma Syndrome: How Some Organized Religion Leads to Mental Health Problems." *British Association for Behavioural and Cognitive Psychotherapies (BABCP) Magazine*, vol. 19, no. 1, 2011, pp. 16-18.

Wolff, H. W. *Anthropology of the Old Testament*. Translated by M. Kohl, Fortress Press, 1974.

World Health Organization. *Global Report on Health Equity for Persons with Disabilities*. WHO, 2022.

World Mental Health Report: Transforming Mental Health for All. WHO, 2021.