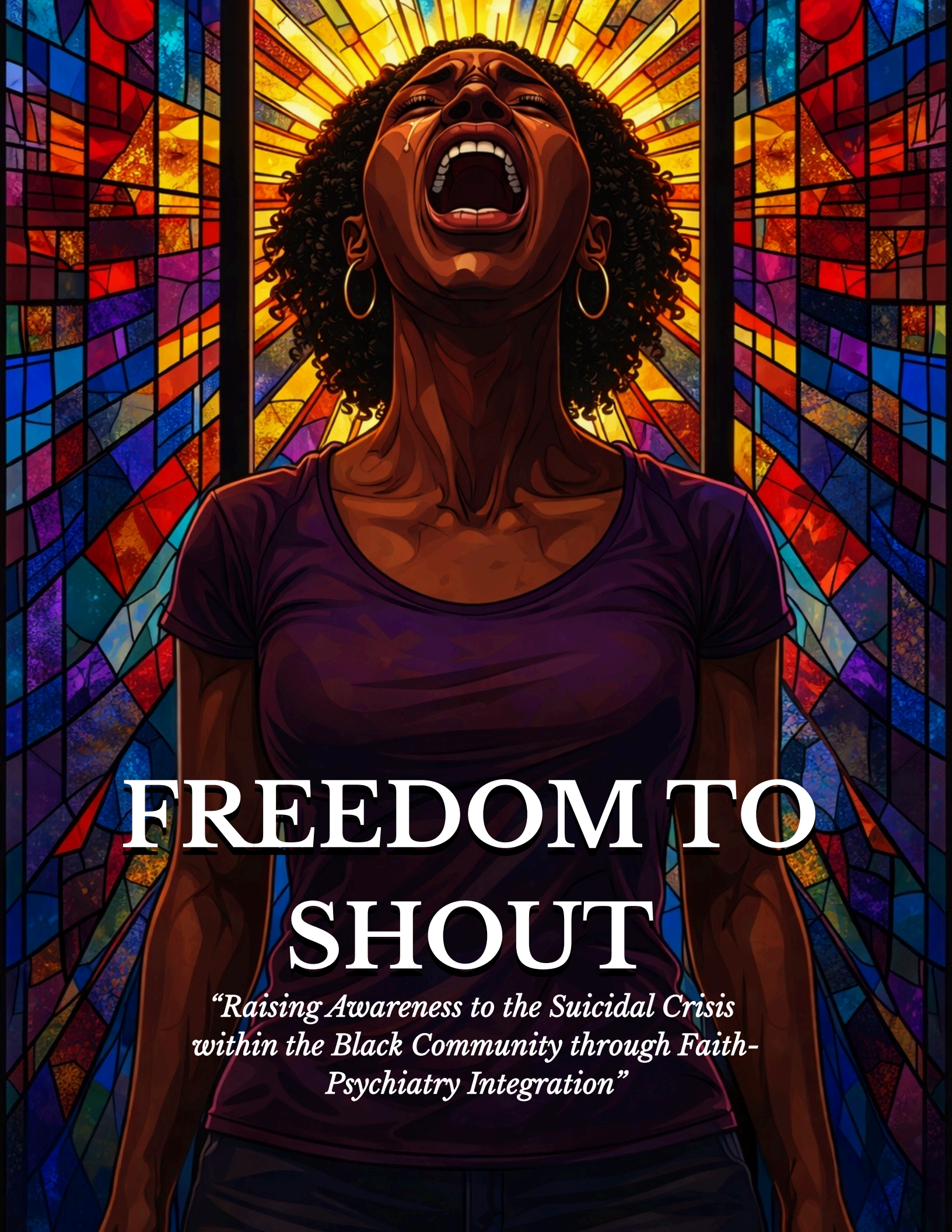


A woman with dark skin and curly hair is shown from the chest up, wearing a purple t-shirt and large hoop earrings. She has her mouth wide open in a shout or cry, with a tear visible on her cheek. Behind her is a large, colorful stained glass window with a central panel featuring a sunburst design. The overall style is that of a comic book or graphic novel illustration.

# FREEDOM TO SHOUT

*“Raising Awareness to the Suicidal Crisis  
within the Black Community through Faith-  
Psychiatry Integration”*

### **Acknowledgements**

**This presentation was supported in part by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (HHS) as part of the American Psychiatric Association's SAMHSA Fellowship Program. The contents of this presentation are solely the responsibility of the speaker and do not necessarily represent the official views of the Substance Abuse and Mental Health Services Administration (SAMHSA) or American Psychiatric Association. Mention of any trade names, commercial practices, or organizations within this presentation does not imply endorsement by the U.S. Government.**

**This Page is Left Blank on Purpose.**

# Table of Contents

9

Understanding  
Depression &  
Suicide in Our  
Communities

*Exploring the prevalence, impact, and urgent realities of depression and suicide affecting our communities.*

18

Recognizing the  
Signs of Depression

*Identifying symptoms of depression while understanding the biological, psychological, social, and spiritual factors that shape mental health.*

27

Responding in  
Times of Crisis

*Learning Psychological First Aid and practical, evidence-based strategies to support congregants experiencing emotional or suicidal crisis.*

43

Confronting Mental  
Health Stigma in the  
Church

*Reflecting on personal and faith-based perspectives to build greater compassion, understanding, and supportive church communities.*

# hey there!

## SPOTLIGHT SPEAKER



Dr. Brittany Taylor is a psychiatrist (residency class of 2027) and American Psychiatric Association Substance Abuse and Mental Health Services Administration (SAMHSA) Fellow with a dedication to community medicine. Originally from Monticello, Arkansas, her work is grounded in a deep commitment to addressing mental health disparities and improving access to care within underserved communities. Growing up in a small town, Dr. Taylor saw firsthand how limited healthcare resources could profoundly impact community well-being, often leading to significant disparities in health outcomes. These experiences ignited her passion for medicine and a deep commitment to serving underserved communities. As her journey in medicine unfolded, she felt called to address the intersection of faith and mental health—working to equip faith communities with the understanding and tools needed to support those struggling with emotional and psychological distress.

Dr. Taylor earned her degree from New York Institute of Technology College of Osteopathic Medicine in Jonesboro, Arkansas and has developed a special interest in faith-integrated mental health education, suicide prevention, and community-based mental health advocacy. Through clinical training, research, and community engagement, she works to foster meaningful partnerships between medical institutions and faith communities.

Dr. Taylor's desire is to raise awareness to the rising death rates by suicide within her community while dismantling mental health stigma. Her faith shapes her calling to serve her patients holistically. She approaches mental health through a biopsychosocial-spiritual framework, recognizing the vital role that faith, community, and cultural context play in healing.

# FREEDOM TO SHOUT

Throughout history, the Black Church has served as a cornerstone of healing and resilience for African Americans, especially in the face of systemic racism and segregation within medical institutions. Long excluded from equitable healthcare, Black communities turned to the Church not only for spiritual guidance but also for emotional, physical, and social support. Stigma surrounding mental health in the Black community can be traced back to the post-slavery era, where societal expectations often denied the reality of Black suffering. Though the Black Church has remained a safe haven for expression, open conversations about emotional well-being have too often been silenced or overlooked—creating a hidden crisis within a trusted solution.

The U.S. Department of Health and Human Services **Office of Minority Health** recognizes suicide as the third leading cause of death for Black or African Americans ages 10 to 24.

The alarm is being sounded. Suicide is becoming one of the leading causes of death while resources and culturally competent support remain limited—particularly for people of faith. This is due in part to a lack of awareness around the signs of mental illness and limited training for medical professionals to recognize help-seeking behaviors within the Black community.

Equipping the Black Church to respond to mental health challenges through a biopsychosocial-spiritual lens holds transformative potential. When religious leaders are empowered with the tools and knowledge to recognize and respond to mental health needs, lives can be saved and stigma diminished. SAMHSA has a longstanding history of partnering with faith-based and community organizations to foster resilience and break down barriers to care. Through the integration of faith-psychiatry, this workshop aims to equip faith leaders with a deeper understanding of the prevalence and impact of depression and suicide within the community, emphasizing awareness, prevention, and meaningful support. Participants will learn to recognize the signs and symptoms of depression while exploring the biological, psychological, social, and spiritual factors that contribute to its development. The workshop will also address mental health stigma within the church and provide practical, evidence-based strategies—including psychological first aid—to help leaders respond compassionately and effectively to individuals experiencing emotional or suicidal crisis. Ultimately, dialogue will lead to a new kind of liberation: one marked by healing, hope, and true praise.

Suicide is the third leading cause  
of death for Black or African  
Americans between the ages of

**10 - 24**

# MY ROLE AS A BELIEVER & PSYCHIATRIST

A psychiatrist's role is to evaluate, diagnose, and treat mental health disorders through a comprehensive and evidence-based approach. This work involves understanding the neurobiological and neurochemical factors that contribute to psychiatric illness while also carefully considering the psychological, social, cultural, and environmental influences that shape a person's experience. My training integrates multiple clinical frameworks, recognizing that the roots of mental illness are complex and multifaceted, yet responsive to thoughtful, individualized treatment. In clinical practice, I use the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a standardized guide to inform accurate diagnosis and treatment planning.

According to the DSM-5, Major Depressive Disorder (MDD) is diagnosed when a person experiences at least five symptoms over a two-week period that represent a clear change from prior functioning, with at least one symptom being either persistent depressed mood or a marked loss of interest or pleasure. Other symptoms may include significant changes in sleep or appetite, fatigue, difficulty concentrating, feelings of worthlessness or excessive guilt, slowed or agitated movement, or recurrent thoughts of death or suicide. These symptoms must cause meaningful distress or impairment in daily life and cannot be better explained by substance use, another medical condition, psychotic disorders, or a history of manic or hypomanic episodes.

The DSM-5 also notes that while grief and major loss can produce similar feelings, clinicians must carefully distinguish normal bereavement from a major depressive episode based on severity, duration, and overall impact on functioning.

Treatment for depression is tailored to the severity of symptoms and the individual's unique needs. For some, structured psychotherapy may be most appropriate to help challenge negative thinking patterns, strengthen coping skills, and improve emotional regulation. For others—particularly those experiencing severe symptoms such as persistent suicidal thoughts—antidepressant medication may be necessary as part of a comprehensive treatment plan. In both cases, integrating spiritual considerations is essential, as research consistently demonstrates that faith and spirituality can serve as protective factors against suicide and can foster resilience in the face of adversity.

*In Gospel of Luke 4:18 (KJV), Jesus declares,  
“The Spirit of the Lord is upon me... he hath sent me to heal the brokenhearted.”*

Restoration through the power of God can lead to deliverance and recovery. As a Christian, I am called to follow Christ's example of compassionate care and holistic healing. As both a psychiatrist and a product of the Black Church, my goal is to help individuals and families affected by mental illness understand the value of integrating biopsychosocial-spiritual treatment approaches—enhancing overall well-being while reducing emotional suffering and stigma within our faith communities.

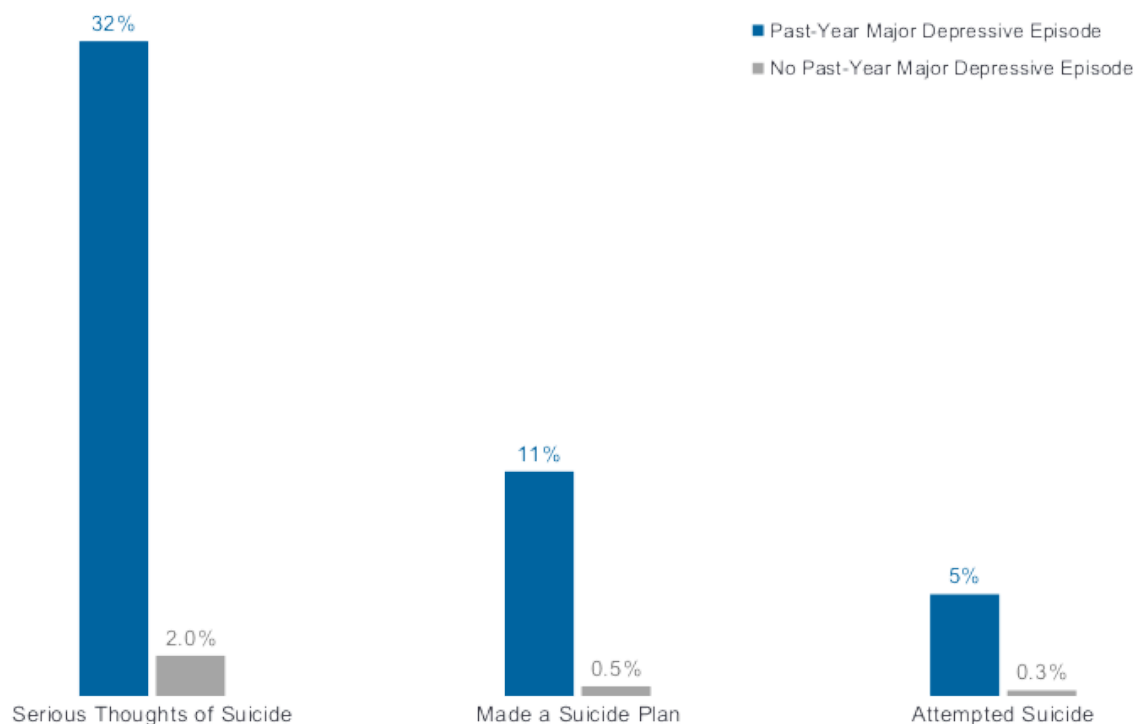
# SUICIDE DEFINED

Suicide is defined as the deliberate act of causing one's own death. It is a preventable, yet significant public health concern. Suicidal behavior is frequently associated with profound psychological distress, psychiatric conditions such as major depressive disorder, substance use disorders, or trauma-related disorders, as well as acute or chronic psychosocial stressors.

## *The Link Between Suicide & Depression*

Studies and statistics correlate an increased risk of suicidality in those with a history of suffering from current or recent major depressive episodes.

### Suicidal Behavior and Past-Year Major Depressive Episode (U.S., 2021)



# Understanding Depression & Suicide in Our Communities

ONE

*Exploring the prevalence, impact, and urgent realities of depression and suicide affecting our communities.*

# The Data on Suicide & Depression

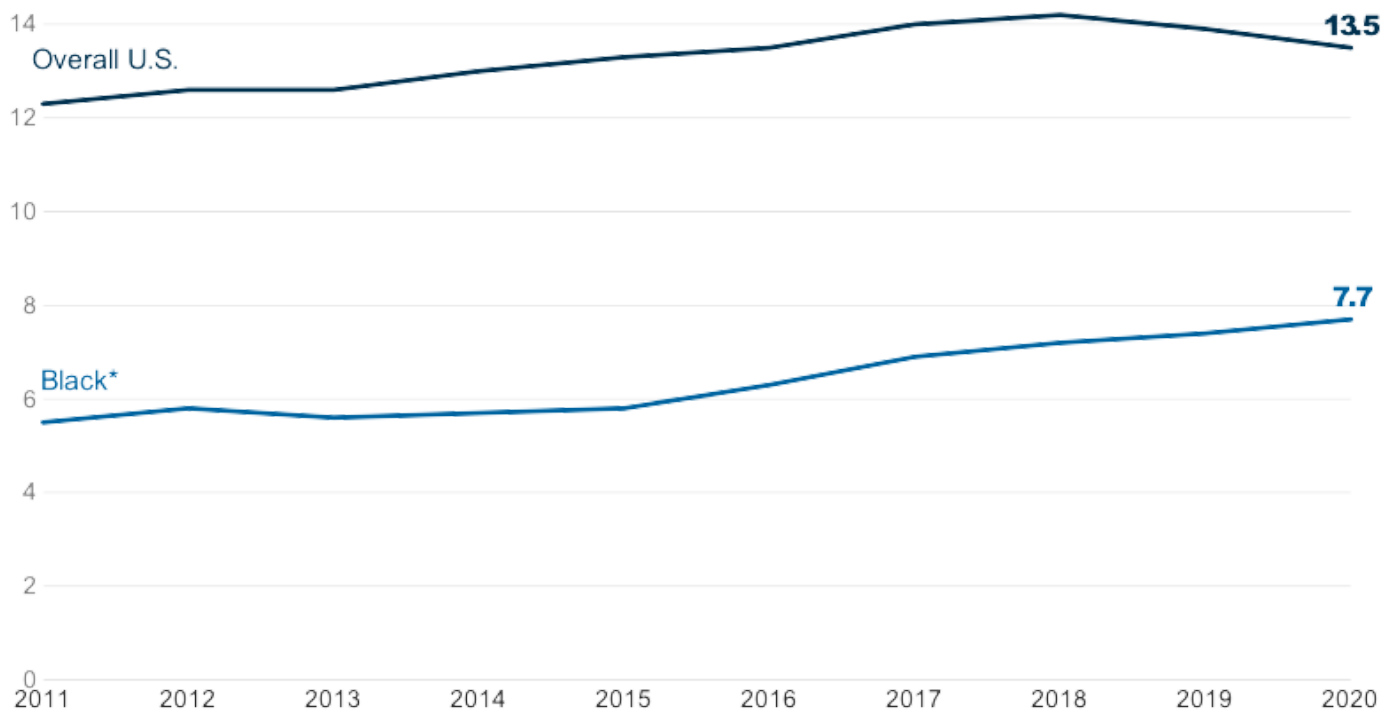
## *Understanding Depression & Suicide in Our Communities*

Suicide is one of the leading causes of death in the United States. According to the Centers for Disease Control and Prevention (CDC) WISQARS Leading Causes of Death Reports, in 2023, suicide was the eleventh leading cause of death overall in the United States, claiming the lives of over 49,300 people. And suicide was the second leading cause of death among individuals between the ages of 10 and 34 and the fourth leading cause of death among individuals between the ages of 35 and 44. (Centers for Disease Control and Prevention [CDC], 2025)

According to the Centers for Disease Control and Prevention (CDC), “During 2020, 18.4% of U.S. adults reported having ever been diagnosed with depression... approximately one in five U.S. adults reported having ever received a diagnosis of depression by a health care provider, with prevalence of depression higher in women, younger adults, and adults with lower education levels.” (Lee et al., 2023)

Within the Black community, depression and suicide represent pressing yet often underrecognized public health concerns. Although historical data once suggested lower suicide rates among Black Americans compared to other racial groups, more recent trends indicate rising rates—particularly among Black youth and young adults—highlighting an urgent need for targeted awareness and prevention efforts.

## Suicide Rates Among Black or African American Populations in the U.S., 2011-2020

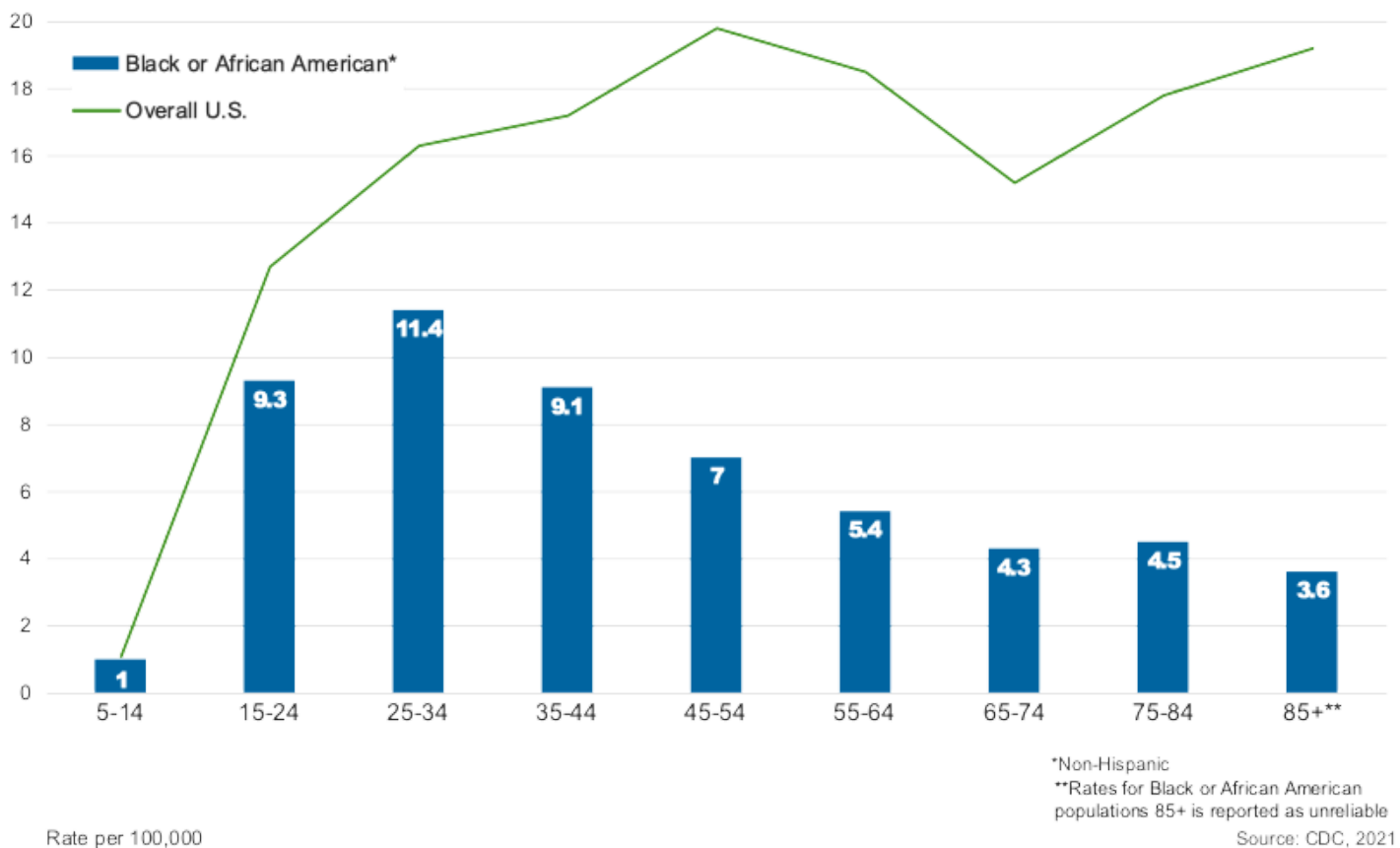


Age-adjusted rate per 100,000

\*Non-Hispanic  
Source: CDC  
2021

*According to the Suicide Prevention Resources Center, “suicide rates among Black or African American populations increased from 5.5 per 100,000 in 2011 to 7.7 per 100,000 in 2020”.*

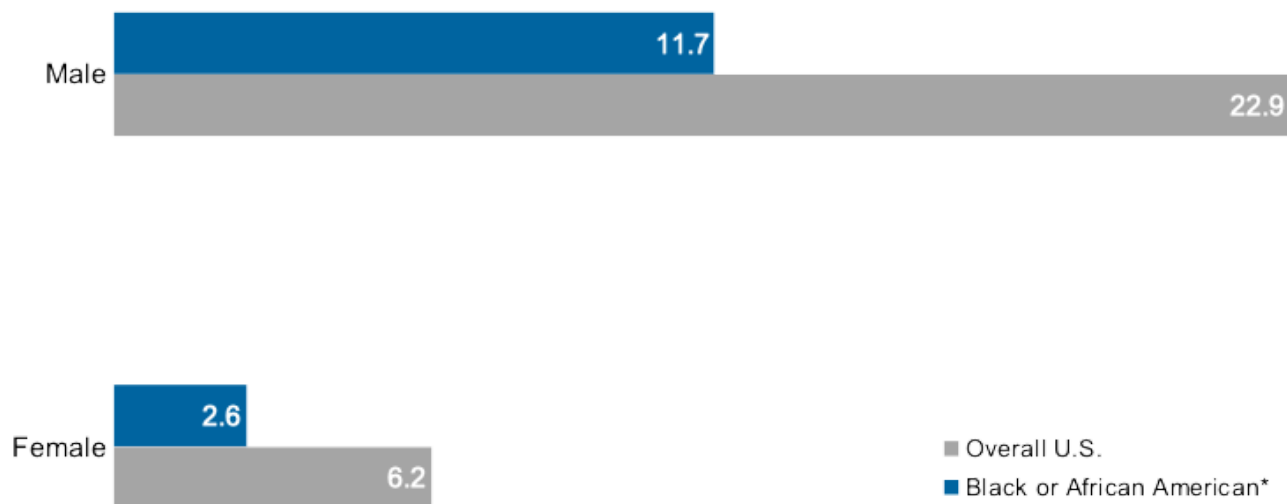
## Suicide Rates Among Black or African American Populations in the U.S. by Age, 2011-2020



*According to the Suicide Prevention Resources Center and the CDC, “Among Black or African American populations, suicide rates peak during adolescence and young adulthood, then decline through age 85+. This is a different pattern than is seen in the overall U.S. population, where suicide rates peak at ages 45 to 54, start a downward decline until age 74, and then increase starting at age 75 through age 85+.”*

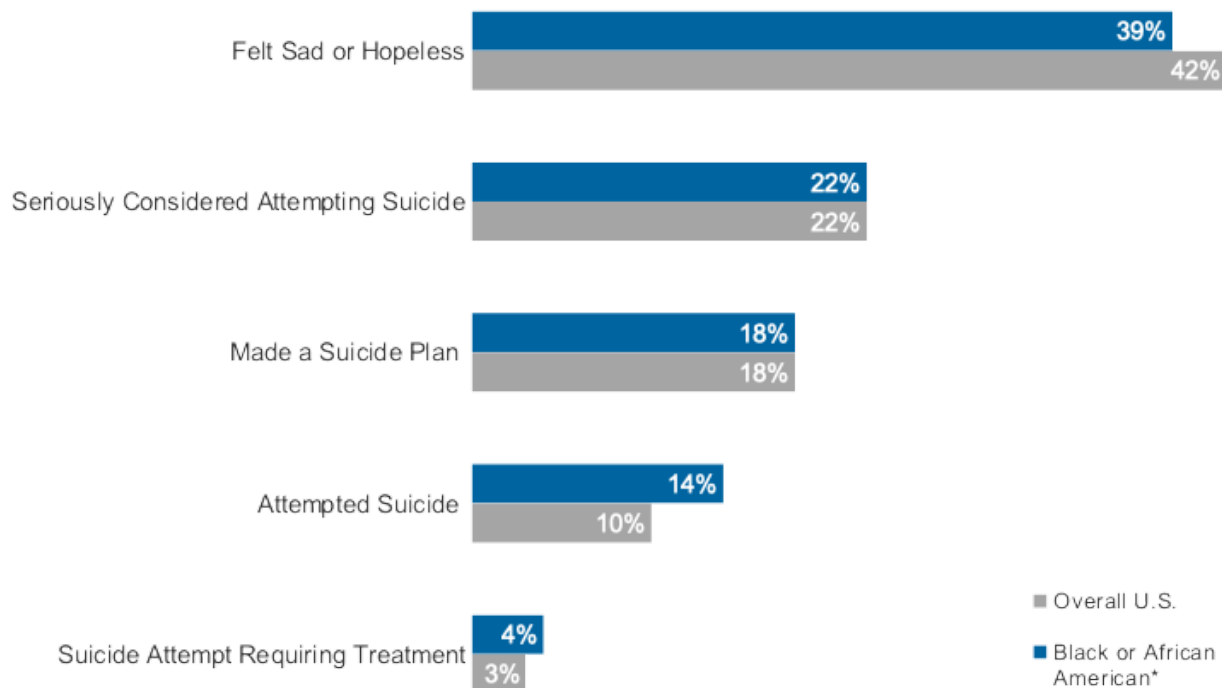
*African-American males are about 6 times more likely to complete suicide in comparison to African-American females.*

### Suicide Rates Among Black or African American Populations in the U.S. by Sex, 2011-2020



*Higher percentages of Black or African American high school youth reported attempting suicide and making a suicide attempt requiring treatment compared to youth in the overall U.S. population. (CDC, 2021)*

### Past-Year Suicidal Thoughts and Behaviors Among High School Youth in Black or African American Populations (U.S., 2021)



\*Non-Hispanic

*African American high school students are more likely than other high school students to attempt suicide.*

| Students in grades 9–12 who attempted suicide in the past 12 months, percentage, 2023 |        |                  |                        |
|---------------------------------------------------------------------------------------|--------|------------------|------------------------|
|                                                                                       | Black* | Total Population | Ratio (Black* / Total) |
| Male                                                                                  | 7.4    | 6.4              | 1.16                   |
| Female                                                                                | 13.4   | 12.6             | 1.06                   |
| Both Sexes                                                                            | 10.3   | 9.5              | 1.08                   |

Source: U.S. Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System. (2024). [1991-2023 High School Youth Risk Behavior Survey data: High school students who actually attempted suicide](#)  . U.S. Department of Health and Human Services.

# The Impact of Depression



Major Depressive Disorder (MDD) imposes a substantial economic and public health burden in the United States. In 2019, approximately 19.8 million adults were living with MDD, resulting in an estimated incremental societal cost of \$333.7 billion—about \$16,854 per affected individual—with major drivers including healthcare expenses, household-related financial strain, presenteeism, and absenteeism (Greenberg et al., 2023). Employees with MDD lost an average of 23 workdays annually due to reduced productivity, underscoring the significant occupational impact of the illness. Beyond economic costs, depression markedly diminishes quality of life and longevity. An estimated 80% of adults with depression report difficulty functioning in work, home, and social settings (Brody et al., 2018), and depression beginning at age 18 is associated with a 28.9-year reduction in quality-adjusted life expectancy—exceeding the burden observed in many chronic medical conditions (Jia et al., 2015). **Prevalence is disproportionately higher among women, Black non-Hispanic individuals, those with lower educational attainment, and individuals experiencing marital disruption, further highlighting the broad and inequitable impact of this disorder (Jia et al., 2015).** Collectively, these findings underscore that depression is a serious, life-altering condition with broad implications for individuals, families, workplaces, and communities.

***SUICIDE*** is not solely an individual or psychological phenomenon; it is deeply shaped by social context. Contemporary sociological research emphasizes that social integration, community belonging, economic stability, cultural norms, and exposure to inequality all influence suicide risk. (Mueller et al., 2021). Factors such as social isolation, stigma, strained family relationships, and structural disadvantage can heighten vulnerability, while strong social bonds and supportive institutions serve as protective factors. This framework underscores that effective suicide prevention must move beyond individual-level interventions and also address the broader social environments in which individuals live, work, worship, and form identity.

The economic consequences of suicide and nonfatal self-harm are profound. Recent national estimates demonstrate that suicide and self-harm result in billions of dollars annually in medical costs, lost productivity, and long-term economic losses for families and communities (Petereson et al., 2024). Earlier analyses from 2015 similarly found that suicide attempts and deaths generate substantial direct healthcare expenditures and indirect costs related to premature mortality and diminished workforce participation (Shepard et al., 2015). These financial burdens extend beyond individuals, affecting employers, healthcare systems, and society at large, reinforcing that suicide is both a public health and economic crisis.

Recognizing the social roots and systemic impact of suicide challenges stigma by reframing it not as a personal failing, but as a complex outcome influenced by social conditions, access to care, and collective responsibility. Effective prevention therefore requires coordinated efforts that strengthen social connectedness, reduce stigma, improve access to culturally responsive mental health services, and promote early intervention.

# *The Impact of Suicide*

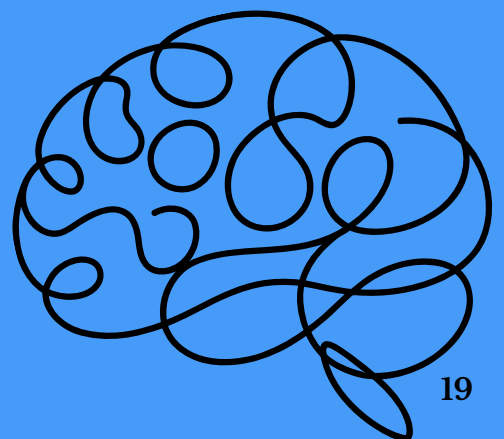
# Recognizing the Signs of Depression

*Identifying symptoms of depression while understanding the biological, psychological, social, and spiritual factors that shape mental health.*



# *Factor Contributing to Depression*

**Biologically**, depression develops through the complex interaction of biological vulnerability, psychological processes, social environment, and spiritual experience. Biologically, research points to genetic predisposition, dysregulation of neurotransmitters such as serotonin, norepinephrine, and dopamine, and alterations in brain structures involved in mood regulation, including the prefrontal cortex, amygdala, and hippocampus (Malhi & Mann, 2018). Chronic activation of the hypothalamic–pituitary–adrenal (HPA) axis—often triggered by prolonged stress—can lead to elevated cortisol levels, inflammation, and impaired neuroplasticity, all of which are associated with depressive symptoms. Additionally, medical conditions (e.g., thyroid dysfunction, cardiovascular disease), sleep disturbances, hormonal changes, and certain medications can contribute to or exacerbate depressive presentations. The genetic predisposition of depression can be influenced by the familial history of depression, thereby, leading to an increased risk of development of the syndrome.



**Psychologically**, depression is often maintained by maladaptive cognitive patterns such as persistent negative core beliefs, cognitive distortions (e.g., catastrophizing, overgeneralization), hopelessness, and diminished self-efficacy (Beck & Haigh, 2014). Exposure to early-life adversity, trauma, attachment disruptions, or chronic stress can shape vulnerability by influencing emotional regulation and stress responsiveness across the lifespan. Learned helplessness, rumination, and impaired problem-solving skills may further intensify and prolong depressive episodes. Importantly, psychological resilience—including adaptive coping skills, emotional awareness, and supportive relationships—can mitigate risk.

**Sociologically**, depression is strongly influenced by social determinants of health. Socioeconomic disadvantage, unemployment, housing instability, food insecurity, community violence, and limited access to quality healthcare increase both risk and chronicity. Experiences of discrimination, systemic racism, and marginalization contribute to chronic stress which negatively impact both mental and physical health. Social isolation and weakened community ties further elevate risk, whereas strong social integration, communal belonging, and supportive institutions serve as protective factors (Mueller et al., 2021).

**Spiritually**, an individual's faith framework can profoundly influence how depressive symptoms are interpreted and managed. Positive religious coping—such as prayer, communal worship, meaning-making, and a sense of divine support—has been associated with lower rates of depression and suicide, as well as increased resilience (Koenig, 2012). Conversely, spiritual struggle, feelings of abandonment by God, religious guilt, or stigmatizing beliefs about mental illness may intensify shame and delay help-seeking. For many individuals, particularly within faith-centered communities, integrating spiritual resources into a comprehensive biopsychosocial treatment approach can enhance engagement, foster hope, and support recovery. Understanding these interconnected contributors allows leaders and clinicians to respond with greater nuance, compassion, and effectiveness.

**For many individuals, particularly within faith-centered communities, integrating spiritual resources into a comprehensive biopsychosocial treatment approach can enhance engagement, foster hope, and support recovery.**

# *Case Example: Felicia Downey-Jackson*

Felicia Downey-Jackson is a 65-year-old woman who was brought to the Saint Francis Hospital Emergency Department after her family noticed she was acting strange. Her daughter reported that for the past few weeks her mother had been more confused, with increased tearfulness. Her mother typically can “hold it together” but now she is more tearful and irritable with common household and church responsibilities. Mrs. Downey-Jackson’s husband shares that his wife is not eating as much and appears to have low energy most days. They attribute it to depression since her mother’s mother died about 2 years ago. They report she died from cirrhosis due to her heavy alcohol use. Her mother has a history of diabetes mellitus, hyperthyroidism, and mastectomy in 2001 for breast cancer. She recently went to her primary care provider and started steroids after experiencing breathing difficulties. Her house is near a Tyson plant. It is common for residents in the area to develop Chronic Obstructive Pulmonary Disease, (COPD). Mrs. Downey-Jackson is retired but to help pay for her grandchildren’s school expenses she is working part-time at an auto shop as an administrative worker. During the hospital stay, the doctors discovered abnormally low blood counts to the point that she required immediate blood transfusion Mrs. Downey-Jackson admitted to feeling faint and weak for the past few years. She had noticed blood in her stools but did not feel comfortable getting a colonoscopy. In addition, abnormal labs reveal a low vitamin D level, and increased white blood cell counts. After completing a CT scan of her abdomen, it was revealed that Mrs. Downey-Jackson had a tumor-like area on the imaging scan of her abdomen. Mrs. Downey-Jackson's daughter and husband helped her to agree to get the colonoscopy to get a more accurate diagnosis. It was discovered that she had stage 2 colon cancer.

*Using a biopsychosocial-spiritual framework, the care team developed a treatment plan that included:*

1. *Biological:*

2. *Psychological:*

3. *Social:*

4. *Spiritual:*



# *Case Example: Marcus Jefferson*

Marcus Jefferson is a 28 year old African American man was brought to the outpatient mental health clinic by his sister after she noticed he had been unusually quiet, tearful, and irritable over the past six weeks. Marcus had previously been energetic and socially engaged, attending church regularly and participating in community sports. Recently, he has stopped attending Sunday services, avoided family gatherings, and expressed feelings of hopelessness about his career and personal life. Marcus works as a delivery driver but reports frequent fatigue and low motivation, missing work several days over the past month. He admits to skipping meals, having disrupted sleep, and feeling anxious about finances. Marcus recently experienced the loss of his uncle, who was a mentor and spiritual guide in his life. He shares that this loss has intensified his sadness and caused him to question his purpose, expressing guilt for not “being further along” and struggling to pray or connect with God. Marcus reports a history of a heart arrhythmia when he was younger, and gets seasonal allergies, but does not have any other ongoing medical conditions. He has smoked marijuana since age 17. He did feel a little depressed during college, but did not get any formal treatment for it.

*Using a biopsychosocial-spiritual framework, the care team developed a treatment plan that included:*

*1. Biological:*

*2. Psychological:*

*3. Social:*

*4. Spiritual:*



# *Biopsychosocial-Spiritual Assessment:*

## *Biological Factors:*

- Sleep disturbance, fatigue, and low appetite
- Mild weight loss reported over the past month
- Occasional headaches and shortness of breath during daily activities
- Cannabis misuse

## *Psychological Factors:*

- Persistent sadness, hopelessness, and low motivation
- Anxiety about work and financial stability
- Rumination on past events and spiritual guilt

## *Social Factors:*

- Limited social interaction; withdrawn from church and peer activities
- Financial stress related to rent and family responsibilities
- Family supportive but physically distant during the week

## *Spiritual Factors:*

- Historically engaged in church and prayer; now feels disconnected from God
- Experiences guilt and questions personal faith
- Reports spiritual distress contributing to depressive symptoms

# *Intervention Plan (Biopsychosocial-Spiritual Approach):*

## *Biological:*

- Referral to primary care for general health assessment, nutrition, and sleep hygiene
- Consider evaluation for antidepressant therapy if symptoms persist
- Counsel on cannabis cessation and the negative impact on mental health

## *Psychological:*

- Cognitive-behavioral therapy (CBT) to address negative thought patterns
- Supportive counseling to process grief and spiritual guilt

## *Social:*

- Re-engagement with supportive family and church community
- Encourage structured daily routines and participation in community activities
- Social work referral for financial or occupational support if needed

## *Spiritual:*

- Collaboration with pastor or spiritual mentor for faith-based support
- Encourage prayer, Bible study, and community involvement as coping mechanisms

# *Case Example: Jameson Wright*

Jameson Wright is a 42-year-old African American male who was referred to the outpatient mental health clinic by his pastor after his family noticed changes in his behavior. His wife reported that over the past two months, Jameson has been increasingly withdrawn, irritable, and tearful. He has stopped attending weekly Bible study, has trouble keeping up with household chores, and frequently expresses feelings of hopelessness about his future. His adult children report that he often complains of feeling “exhausted all the time” and has lost interest in his hobbies, including volunteering at the local community center.

Jameson has a past medical history of high blood pressure, stage 1 chronic kidney disease, and obesity. He was recently diagnosed with type 2 diabetes and has struggled with blood sugar management. Over the past year, he has experienced the death of his father, who was a pillar in his life and the church community, and this loss appears to have deeply affected him. His wife describes that Jameson often ruminates on past regrets and spiritual guilt, saying he feels he has “failed as a husband and father.” He reports difficulty sleeping, low appetite, and diminished energy, which has led him to miss work at his part-time job in a local warehouse, further increasing stress related to finances. During his evaluation, Jameson’s lab work revealed elevated blood sugar, borderline low blood counts, and low vitamin D. He also reported frequent headaches and dizziness but had delayed seeking care due to fear of “being a burden.” Screening confirmed moderate-to-severe depressive symptoms, and the clinician noted both psychological distress and social risk factors such as isolation, grief, and economic strain. In addition, Jameson expressed spiritual struggles, including feeling abandoned by God and guilt for not “being strong,” highlighting the importance of integrating spiritual assessment into care.

*Using a biopsychosocial-spiritual framework, the care team developed a treatment plan that included:*

*1. Biological:*

*2. Psychological:*

*3. Social:*

*4. Spiritual:*



# *Case Example: Aaliyah Brooks*

Aaliyah Brooks is a 19 year old African American woman who was referred to the university counseling center by her roommate after being found crying in her dorm room and expressing feelings of hopelessness. Over the past two months, Aaliyah has withdrawn from her friends, stopped attending church youth group activities, and frequently isolates herself in her room. She reports difficulty concentrating on assignments, missing several deadlines, and losing interest in hobbies she previously enjoyed, such as painting and volunteering. Aaliyah recently experienced the death of her grandmother, who was a primary caregiver and a spiritual mentor. She reports feeling “alone” and questions her self-worth and faith. She admits to occasional thoughts that life is not worth living, although she denies a specific plan or previous suicide attempts. She attributes her mood partly to academic stress, financial pressures, and ongoing family tension at home. She has a history of anxiety during high school that was treated with an antidepressant. Overall, she is an healthy young adult.

*Using a biopsychosocial-spiritual framework, the care team developed a treatment plan that included:*

1. *Biological:*

2. *Psychological:*

3. *Social:*

4. *Spiritual:*



# *Biopsychosocial-Spiritual Assessment*

## *Biological Factors:*

- Disrupted sleep patterns, frequent fatigue, and low appetite
- Reports headaches and occasional dizziness due to skipped meals and poor sleep
- No substance use reported

## *Psychological Factors:*

- Persistent sadness, guilt, low self-esteem
- Difficulty coping with grief and academic pressures
- Occasional thoughts that life is not worth living

## *Social Factors:*

- Social isolation from peers and church community
- Stress from family expectations and financial responsibilities
- Limited engagement with supportive network

## *Spiritual Factors:*

- Previously active in church, now disconnected
- Experiences spiritual distress and doubts about God's presence
- Struggles with feelings of guilt for "not being strong in faith"

# *Intervention Plan (Biopsychosocial-Spiritual Approach)*

## *Biological:*

- Encourage proper sleep hygiene, nutrition, and exercise
- Referral to primary care to rule out physical contributors to fatigue and mood changes

## *Psychological:*

- Cognitive-behavioral therapy (CBT) for negative thought patterns
- Grief counseling to process the loss of her grandmother
- Safety planning and regular check-ins to monitor suicidal ideation

## *Social:*

- Encourage reconnection with supportive friends and family
- Explore academic accommodations and tutoring resources
- Introduce support groups for young adults managing grief and stress

## *Spiritual:*

- Collaborate with a pastor, spiritual mentor, or faith-based counselor
- Facilitate engagement in prayer, scripture reflection, or church community events
- Incorporate spiritual coping strategies to build resilience and hope

# THREE

## Responding in Times of Crisis

*Learning Psychological First Aid and practical, evidence-based strategies to support congregants experiencing emotional or suicidal crisis.*

# Responding in Times of Crisis

**The Black Church** has always been a place where people bring their deepest pain, not just their praise. When life becomes overwhelming, many individuals turn first to trusted people in their church family before seeking professional help. Because of this, everyday congregants — not just pastors — may find themselves in situations where someone shares that they are depressed, hopeless, or even thinking about suicide. Knowing how to respond in these moments can literally save a life. Psychological First Aid (PFA) is a simple, evidence-based approach that anyone can learn. It is not therapy, counseling, or diagnosis. Instead, it is immediate emotional support that helps a person feel safe, calm, heard, and connected until additional help can be arranged.

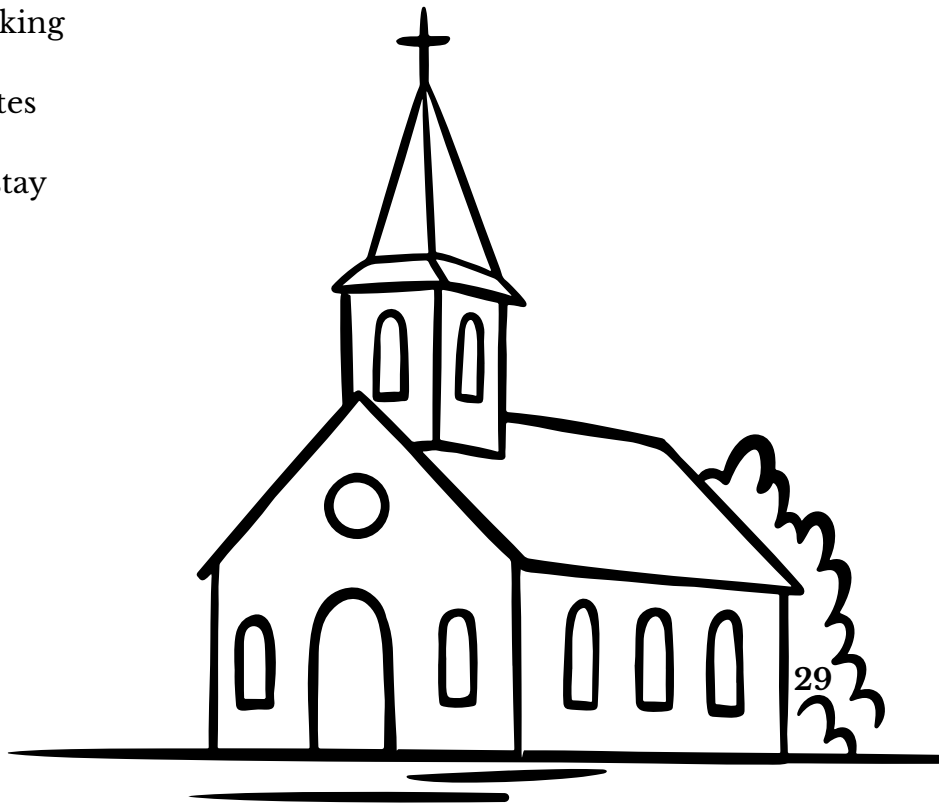
**A mental health crisis happens when someone feels overwhelmed by pain, stress, loss, or trauma and can no longer cope the way they normally would.** In these moments, people may feel trapped, ashamed, exhausted, or hopeless. Sometimes they withdraw from others, stop attending church activities, or speak as if life has no meaning. Warning signs of possible suicidal crisis can include statements such as “I can’t do this anymore,” “I feel like a burden,” or “Everyone would be better off without me.” Other signs may include giving away possessions, sudden mood changes, increased substance use, or pulling away from relationships. It is important to remember that people who are considering suicide usually want relief from pain, not death itself. Recognizing distress early allows the church to respond with care instead of silence.

*Psychological First Aid (PFA) is a simple, evidence-based approach that anyone can learn.*

Psychological First Aid focuses on five simple goals: helping the person feel safe, calming intense emotions, reducing isolation, restoring hope, and helping them regain a sense of control. **The first step is making sure the situation is safe. If someone seems at risk of harming themselves, do not leave them alone.** Stay with them or make sure another trusted person is present. If there is immediate danger, emergency services or the 988 Suicide & Crisis Lifeline should be contacted.

Next, approach the person with gentleness and respect. Speak calmly, introduce yourself if needed, and express concern without judgment. Simple statements such as “I’m really glad you told me,” “You matter to me,” or “You don’t have to go through this alone” can reduce shame and help the person feel supported. **One of the most important things you can do is ask directly if they are thinking about harming themselves.** Asking this question does not put the idea into someone’s mind; instead, it communicates care and opens the door for honest conversation. If they say yes, stay calm, stay with them, and seek additional help immediately.

People in crisis are often emotionally overwhelmed, so helping them calm down is essential. You might move to a quiet space, encourage slow breathing, offer water, or simply sit with them. If welcomed, gentle prayer can be comforting. Active listening is the heart of helping. **This means giving your full attention, allowing them to speak without interruption, reflecting what you hear, and avoiding the urge to fix the problem.** Statements like “That sounds incredibly hard,” or “I can hear how much pain you’re in,” validate their experience. Avoid minimizing phrases such as “Just pray about it,” “Stay strong,” or “Others have it worse,” because these can make the person feel misunderstood or dismissed.



As you listen, try to understand what is causing the distress and what support systems are available. Ask simple, open questions such as “What happened?” “Who do you feel safe talking to?” or “How can I help right now?” Offering practical help can make a big difference. This might include calling a trusted family member, helping them get home safely, sitting with them until help arrives, or assisting them in contacting a counselor or crisis line. When people feel overwhelmed, even small tasks can seem impossible, so practical support restores a sense of stability.

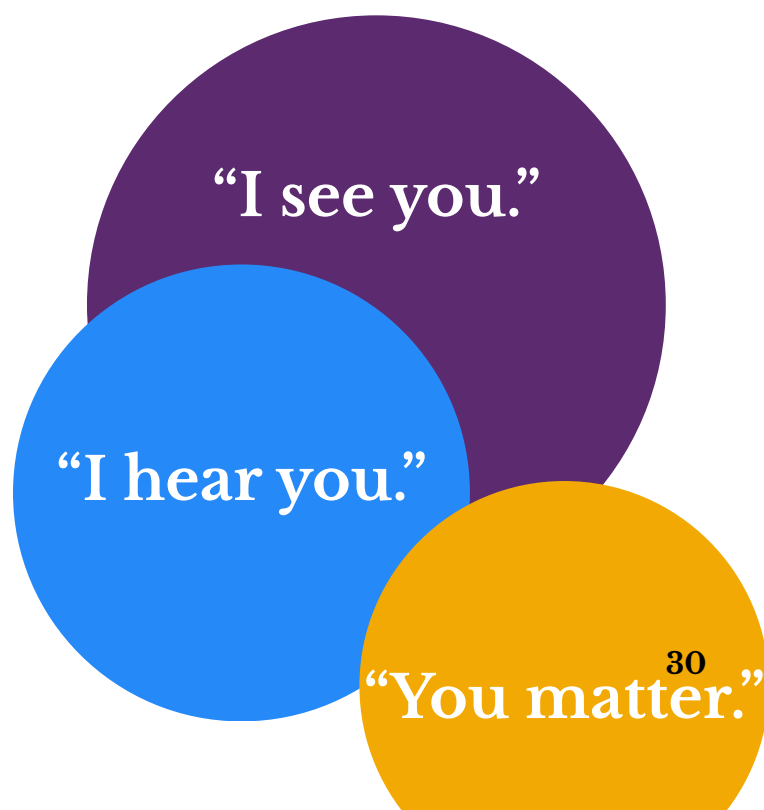
Connection is one of the strongest protections against suicide. **Encourage the person to stay connected to supportive people rather than isolating themselves.** Remind them that they are valued and not alone. Offering hope does not mean pretending everything will be fine; it means affirming that help exists and that their life matters. Hope can be communicated through presence, compassion, and reassurance.

Faith can be a powerful source of comfort. **Prayer, scripture, and spiritual encouragement should always be offered with sensitivity and consent.** Emphasize God’s love, compassion, and nearness to those who are hurting rather than suggesting that suffering is caused by weak faith or personal failure. Mental health struggles are not signs of spiritual weakness, and seeking professional help is not a lack of faith. In many cases, the most faithful response is to help someone access the care they need.

Congregants should also understand their limits. You are not expected to diagnose conditions or provide therapy. **Your role is to support, stabilize, and connect. Professional help is especially important if the person has a plan to harm themselves, appears severely impaired, is experiencing hallucinations, or cannot care for themselves safely.** In these situations, staying with the person while contacting trained professionals is the safest course of action.

Finally, helping someone in crisis can be emotionally heavy. It is important to talk with a pastor, ministry leader, or trusted person afterward (while respecting privacy), pray, and care for your own well-being. **Supporting others does not mean carrying their pain alone.**

In its simplest form, Psychological First Aid is a ministry of presence. It communicates: “I see you. I hear you. You matter. You are not alone.” When congregations learn these skills, the church becomes not only a place of worship but also a safe community where suffering can be spoken, stigma can be reduced, and lives can be protected.



# Psychological First Aid (PFA) Steps



## 1. Ensure Safety

- Stay with the person
- Move to a quiet space
- Do not leave them alone if they may harm themselves
- Get emergency help if needed

## 4. Connect to Support

- Ask who they trust
- Help contact family, friends, or leaders
- Encourage professional help
- Stay until support arrives



## 2. Listen with Compassion

- Give full attention
- Let them talk without interrupting
- Avoid judgment or quick fixes
- Validate their feelings

Helpful phrases:

“I’m glad you told me.”

“You don’t have to go through this alone.”

## 5. Encourage Hope

- Remind them they matter
- Emphasize that help is available
- Do not minimize their pain
- Your presence makes a difference



## 6. Follow up

- Stay connected to the person and what they are experiencing.



## 3. Help Calm the Person

- Speak slowly and gently
- Encourage slow breathing
- Offer water or a seat
- Sit quietly if needed

# Remember

You do not have to solve the problem

Listening is powerful

GET PROFESSIONAL HELP

# If There Is Immediate Danger

Call emergency services or 988 (U.S.)

Do NOT leave the person alone

# Psychological First Aid:

Stay calm, listen deeply, and connect the person to support.



*Interactive Group  
Exercises for Practice*

# Exercise 1: “Listen Like Jesus” — Active Listening Role-Play

## Purpose

*To practice compassionate, nonjudgmental listening — the most important skill in responding to someone in emotional or suicidal distress.*

## Group Size

Pairs or groups of three

## Instructions

Divide participants into pairs (or triads with an observer).

*One person plays the role of a distressed congregant.*

*One person plays the helper.*

*If in groups of three, the third person observes and gives feedback.*

After 5–7 minutes, switch roles.

## Scenario Prompt

*“You have not been sleeping. You feel overwhelmed by bills and family problems. You stopped attending events because you feel ashamed. You quietly tell someone at church: ‘I don’t think I can keep doing this. I’m so tired of everything.’”*

## Helper’s Task

Practice:

Staying calm

Listening without interrupting

Showing empathy

Using supportive/encouraging statements or scriptures

Prayer

Locate Further Support

Get Connected to Help

# Discussion

How did it feel to be listened to without being “fixed”?

---

---

---

---

---

---

What was difficult about not giving advice?

---

---

---

---

---

---

---

---

---

---

---

---

What responses felt comforting?

---

---

---

---

---

---

---

---

---

---

---

---

## Exercise 2: “Stay With Me” — Suicide Risk Response Practice

### Purpose

*To practice responding when someone expresses suicidal thoughts and to reduce fear around asking direct questions.*

### Group Size

Pairs or groups of three

### Instructions

Divide participants into pairs (or triads with an observer).

One person plays the role of a distressed congregant.

One person plays the helper.

If in groups of three, the third person observes and gives feedback.

### Scenario Prompt

*“After Bible study, a member says quietly:*

*‘Honestly... I don’t want to be here anymore. I’ve been thinking about ending my life.’”*

### Helper’s Task

Practice the key crisis response steps:

Stay calm

Express care

Listen

Use Spiritual Encouragement/Prayer

Ask directly about safety

Do not leave the person alone

Connect to help

## Reflection/Discussion Questions

What felt hardest to say?

---

---

---

---

---

---

---

---

What helped you remain calm?

---

---

---

---

---

---

---

---

---

---

What would you do differently in real life?

---

---

---

---

---

---

---

---

# Exercise 3: “What Would You Say?” — Response Building Drill

## Purpose

*To help participants practice finding compassionate, supportive words in difficult moments.*

## Instructions

Small groups of 3–5

Each group choose 2 to 3 scenarios.

Groups discuss and write down what they would say first.

Each group shares their response with the room.

## Sample Scenarios

*“I feel like nobody would miss me if I disappeared.”*

*“I’m ashamed of what I’m going through.”*

*“God must be disappointed in me.”*

*“I’m tired of pretending I’m okay.”*

*“I don’t want to wake up anymore. I’m just tired of everything.”*

*“Everyone comes to me for help, but nobody asks how I’m doing.”*

*“I keep praying, but nothing is changing.”*

*“I feel like a burden to my family.”*

*“I can’t stop worrying. My mind never rests.”*

*“I smile at church, but I cry all week.”*

*“I don’t feel close to God anymore.”*

*“If people knew what I was really going through, they’d look at me differently.”*

*“I feel so alone, even when I’m around people.”*

*“I’m trying to be strong, but I’m falling apart.”*

*“I don’t think anyone really understands me.”*

*“I’m afraid to tell anyone how bad it really is.”*

*“I keep messing up. What’s wrong with me?”*

*“I don’t have the energy to care about anything anymore.”*

*“I feel guilty for struggling when others have it worse.”*

*“I don’t want to worry my children, so I keep it to myself.”*

*“I’m exhausted from holding everything together.”*

*“I don’t know how much longer I can keep going like this.”*

## Exercise 4: “Barrier Breakers” — Overcoming Fear of Helping

## Purpose

*To address common fears that prevent congregants from responding to someone in crisis.*

## Common Fears to Explore

*“What if I say the wrong thing?”*

*“What if I make it worse?”*

*"I'm not trained."*

*"I don't know what to do if they cry."*

*"What if they get angry?"*

## Reflection Question

Which fear has stopped you from helping in the past? And why?

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

# Exercise 5: “Signs of Distress” — Observation Activity

## Purpose

*To sharpen awareness of warning signs that someone may be struggling*

## Instructions

In groups, participants sort them into three categories:

Normal Stress

Concerning — Check In

Urgent — Needs Immediate Help

## Example Behaviors

*Missing several church events*

*Sudden withdrawal from friends*

*Having a lack of appetite*

*Giving away prized belongings*

*Increased irritability*

*Talking about wanting to die*

*Trouble sleeping*

*Loss of interest in favorite activities*

*Feeling exhausted*

| Normal Stress | Concerning | Urgent |
|---------------|------------|--------|
|               |            |        |
|               |            |        |
|               |            |        |
|               |            |        |

## Reflection

Discuss which signs indicate the highest risk and why?

---

---

---

---

## Learning Point

Crises often show warning signs before escalation.

# Exercise 6: “Circle of Support” — Resource Mapping

## Purpose

*To help participants identify who and what resources are available when a crisis occurs.*

## Instructions

Remain in a group

Participants write their church in the center.

In surrounding rings, list people and resources they could contact:

*Trained church members*

*Pastors/ministry leaders*

*Mental health professionals*

*Crisis hotlines*

*Community resources*

## Discussion Questions

Who would you call first?

---

---

Which supports are strongest?

---

---

---

---

Where are the gaps?

---

---

---

---

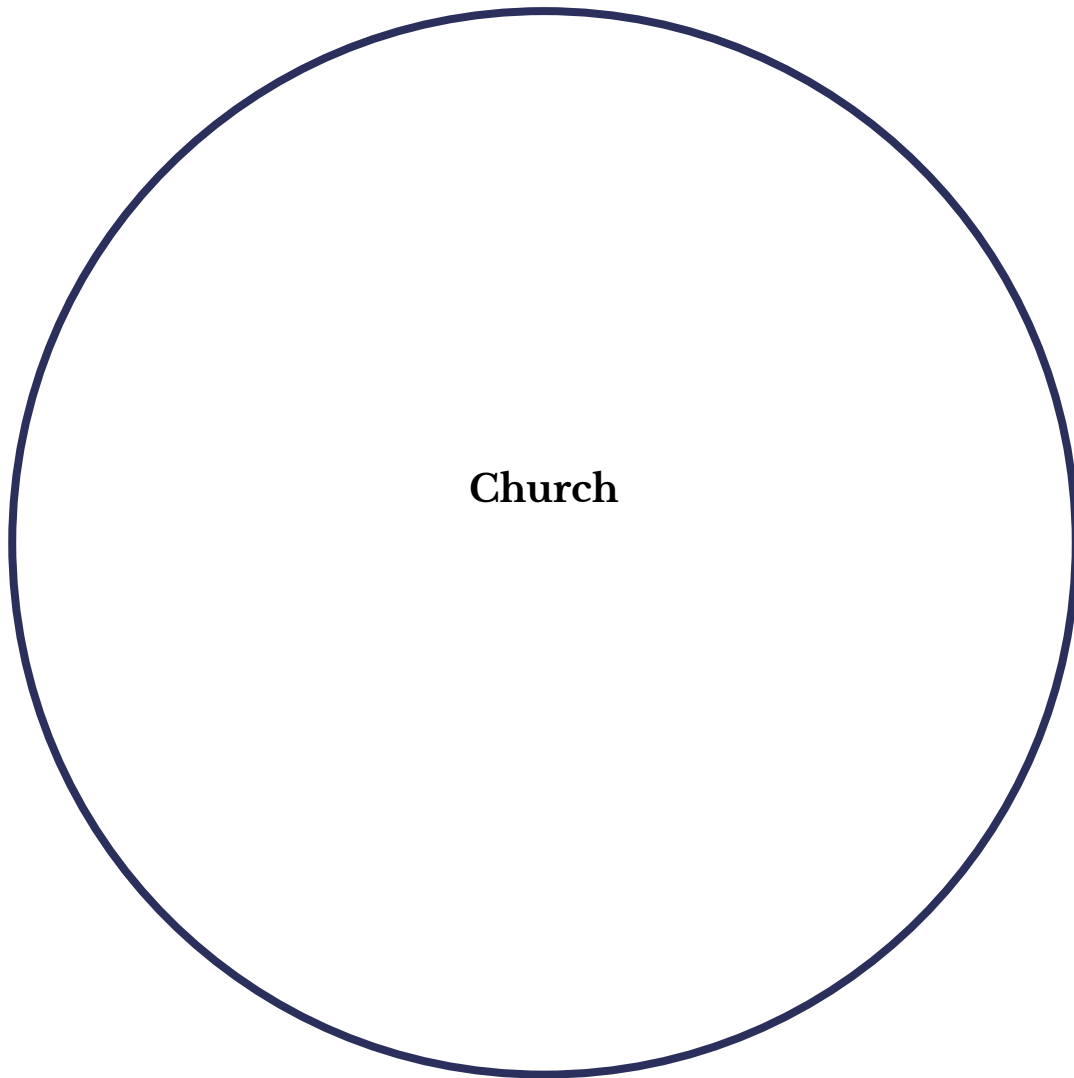
---

---

---

---

# Support Circle - Resource Mapping





# Confronting Mental Health Stigma in the Church

*Reflecting on personal and faith-based  
perspectives to build greater compassion,  
understanding, and supportive church  
communities.*

# *Confronting Mental Health Stigma in the Church*

This workshop aims to serve as a bridge between psychiatry and faith communities, fostering mutual understanding and collaboration. Dismantling these barriers is a shared responsibility among all members of the community. However, mental health providers may unintentionally reinforce stigma when they lack cultural insight into the importance of faith in certain populations. Stigma refers to the negative attitudes, beliefs, and stereotypes that lead to the marginalization and discrimination of individuals experiencing mental health challenges.

Mental health stigma within the church is shaped by a complex interaction of personal experiences, theological beliefs, and communal norms, which together influence levels of compassion, understanding, and support for individuals experiencing psychological distress. Research indicates that religious communities often serve as primary sources of help, particularly because many individuals seek clergy before mental health professionals; therefore, the attitudes and knowledge of church leaders significantly shape congregational responses to mental illness (Leavey, 2010).

When mental health conditions are interpreted through moral or spiritual frameworks—such as weakness of faith, sin, or spiritual attack—stigma tends to increase, leading to shame, social distance, and reluctance to pursue treatment (Peteet, 2019). However, research also shows that many faith community members recognize biological and situational causes of mental illness, suggesting that stigma is not universal and can be reduced through education and accurate understanding (Adams et al., 2018).

Personal familiarity with mental illness can foster empathy, yet evidence indicates that experience alone does not eliminate stigma—particularly for severe disorders—highlighting the importance of informed perspectives in cultivating compassion (Wesselmann et al., 2015).

Clergy play a pivotal role as cultural and spiritual authorities; studies demonstrate that their beliefs, language, and willingness to address mental health openly strongly influence whether congregations respond with acceptance or avoidance (Campbell, 2021). At the same time, churches can function as powerful protective environments by providing social support, meaning, and community belonging, factors consistently associated with improved mental well-being. Overall, examining mental health stigma through a personal and faith-based lens reveals that beliefs and experiences can either hinder or enhance compassionate care: when mental illness is framed as a moral failing, support decreases, but when it is understood as a multidimensional health condition, churches can become vital partners in healing, advocacy, and inclusive support (Peteet, 2019).

**Faith-based** support groups, pastoral counseling, and sermons that openly address mental health have been shown to normalize help-seeking and reduce feelings of isolation among congregants experiencing depression. For example, church-sponsored mental health programs that integrate scripture with psychoeducation have demonstrated improvements in depressive symptoms and willingness to seek treatment, particularly when delivered by trusted church leaders or trained lay ministers (National Alliance on Mental Illness, 2021). Additionally, communal practices such as collective prayer, fellowship, and practical assistance (e.g., meals, transportation, financial help) provide social support that is strongly associated with lower suicide risk. Research on African American suicide prevention highlights that **religious involvement and a sense of belonging within the church community can foster hope, meaning, and resilience**, which buffer against suicidal ideation (Centers for Disease Control and Prevention, 2022).

**Culturally** responsive initiatives within Black churches also address depression and suicide by acknowledging historical trauma, racism, and socioeconomic stressors that disproportionately affect African Americans. Programs such as training clergy to recognize warning signs, partnering with mental health professionals, and hosting educational workshops have been associated with increased referrals to treatment and reduced stigma (Hankerson et al., 2015). Importantly, **testimonies** from members who have experienced mental illness can humanize these issues and encourage others to seek help. The church's emphasis on spiritual meaning, communal responsibility, and unconditional support creates an environment where individuals may feel safe disclosing distress that they would otherwise conceal. Overall, research suggests that when churches combine spiritual care with evidence-based mental health education and professional collaboration, they can play a critical role in preventing depression from worsening and in reducing suicide risk within their communities (Hankerson & Weissman, 2012; Hankerson et al., 2015).

Testimonies from members who have experienced mental illness can humanize these issues and encourage others to seek help.

# Notes

[illegible]

Blank lined paper for writing.

Blank lined paper for writing.

Blank lined paper for writing.

# REFERENCES

- Adams, K. S., Tost, J. R., Whatley, M. A., Brown, M. C., Dochney, B. J., Taylor, J. M., & Neal, M. H. (2018). Relationship of Christian beliefs to attitudes toward people with mental illness. *American Journal of Psychotherapy*, 71(3), 104–109. <https://doi.org/10.1176/appi.psychotherapy.2018.71.3.104>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.
- Beck, A. T., & Haigh, E. A. P. (2014). Advances in cognitive theory and therapy: The generic cognitive model. *Annual Review of Clinical Psychology*, 10, 1–24. <https://doi.org/10.1146/annurev-clinpsy-032813-153734>
- Black Populations. (n.d.). Suicide Prevention Resource Center. <https://sprc.org/about-suicide/scope-of-the-problem/racial-and-ethnic-disparities/black-populations/>
- Campbell, A. D. (2021). Clergy perceptions of mental illness and confronting stigma in congregations. *Religions*, 12(12), 1110. <https://doi.org/10.3390/rel12121110>
- Centers for Disease Control and Prevention. (2021). 1991–2021 high school youth risk behavior survey data [Data set]. Youth Risk Behavior Surveillance System. <http://nccd.cdc.gov/youthonline>
- Centers for Disease Control and Prevention. (2022). Suicide prevention: Risk and protective factors. U.S. Department of Health and Human Services.
- Centers for Disease Control and Prevention. (2025). Web-based Injury Statistics Query and Reporting System (WISQARS). National Center for Injury Prevention and Control. <https://www.cdc.gov/injury/wisqars/index.html>
- Greenberg, P., Chitnis, A., Louie, D., et al. (2023). The economic burden of adults with major depressive disorder in the United States (2019). *Advances in Therapy*, 40(10), 4460–4479. <https://doi.org/10.1007/s12325-023-02622-x>
- Hankerson, S. H., & Weissman, M. M. (2012). Church-based health programs for mental disorders among African Americans: A review. *Psychiatric Services*, 63(3), 243–249. <https://doi.org/10.1176/appi.ps.201100216>
- Hankerson, S. H., Watson, K. T., Lukachko, A., Fullilove, M. T., & Weissman, M. M. (2015). Ministers' perceptions of church-based programs to provide depression care for African Americans. *Journal of Urban Health*, 92(4), 685–698. <https://doi.org/10.1007/s11524-015-9971-6>
- Jia, H., Zack, M. M., Thompson, W. W., & Crosby, A. E. (2015). Impact of depression on quality-adjusted life expectancy (QALE) directly as well as indirectly through suicide. *Social Psychiatry and Psychiatric Epidemiology*, 50(6), 939–949. <https://doi.org/10.1007/s00127-015-1019-0>

Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. *ISRN Psychiatry*, 2012, 278730. <https://doi.org/10.5402/2012/278730>

Lee, B., Wang, Y., Carlson, S. A., et al. (2023). National, state-level, and county-level prevalence estimates of adults aged  $\geq 18$  years self-reporting a lifetime diagnosis of depression — United States, 2020. *MMWR. Morbidity and Mortality Weekly Report*, 72(24), 644–650. <https://doi.org/10.15585/mmwr.mm7224a1>

Leavey, G. (2010). The appreciation of the spiritual in mental illness: A qualitative study of beliefs among clergy in the UK. *Transcultural Psychiatry*, 47(4), 571–590. <https://doi.org/10.1177/1363461510383455>

Malhi, G. S., & Mann, J. J. (2018). Depression. *The Lancet*, 392(10161), 2299–2312. [https://doi.org/10.1016/S0140-6736\(18\)31948-2](https://doi.org/10.1016/S0140-6736(18)31948-2)

Mental health in Black/African Americans. (n.d.). Office of Minority Health. <https://minorityhealth.hhs.gov/mental-and-behavioral-health-blackafrican-americans>

Mueller, A. S., Abrutyn, S., & Pescosolido, B. A. (2021). The social roots of suicide: Theorizing how the external social world matters to suicide and suicide prevention. *Frontiers in Psychology*, 12, 621569. <https://doi.org/10.3389/fpsyg.2021.621569>

National Alliance on Mental Illness. (2021). FaithNet: Mental health resources for faith communities. NAMI.

Peterson, C., Haileyesus, T., & Stone, D. M. (2024). Economic cost of U.S. suicide and nonfatal self-harm. *American Journal of Preventive Medicine*. Advance online publication. <https://doi.org/10.1016/j.amepre.2024.03.002>

Peteet, J. R. (2019). Approaching religiously reinforced mental health stigma: A conceptual framework. *Psychiatric Services*, 70(9), 846–848. <https://doi.org/10.1176/appi.ps.201900162>

Shepard, D. S., Gurewich, D., Lwin, A. K., Reed, G. A., Jr., & Silverman, M. M. (2015). Suicide and suicidal attempts in the United States: Costs and policy implications. *Suicide and Life-Threatening Behavior*, 46(3), 352–362. <https://doi.org/10.1111/sltb.12225>

Wesselman, E. D., Day, M., Graziano, W. G., & Doherty, E. F. (2015). Religious beliefs about mental illness influence social support preferences. *Journal of Prevention & Intervention in the Community*, 43(3), 165–174. <https://doi.org/10.1080/10852352.2014.973251>

