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Identifying and Addressing Youth Depression and Suicidality in the Black Church

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Abstract

For years depression and suicide were thought to be conditions that only adults experienced. Today, we are more knowledgeable and understand that youth are experiencing depression and suicide at alarming rates. Unfortunately, depressive symptoms in children and adults are equally debilitating and often result in suicide. Research asserts that African American children are twice as likely to commit suicide than their white counterparts. It is crucial to understand youth depression and suicide and the correlational factors that precipitate African American mental illness symptomology. Out of any other race, notably, African Americans are the most spiritual. The Black Church has collectively been the main source of support for this community. Understanding the stigma associated with mental illness, help-seeking behaviors, and the church's impact on this population is essential to suggest future ways the church can effect change. The purpose of this study is to understand the unique factors that affect African American youth and catalyze increased suicide rates over the last decade. This study seeks to provide clergy with the information that will help them identify and address youth suicide and depression within the church and community.

Keywords

Depression, Suicide, Youth, African-Americans, Spirituality

1. Introduction

Over the past few years, many stressful events have impacted society's mental health and the ability to cope with everyday life. Children are no exception to these impactful events. The number of children who suffer from depression has drastically increased (Wilson & Dumornay, 2022). Before the current understanding of

childhood depression, when a child displayed depressive symptoms, it was attributed to hormonal changes due to puberty (Petito et al., 2020). Today, depression affects more than 1.9 million children in the United States (Ghandour et al., 2019), and suicide is the second leading cause of death for this vulnerable population (MacDonald et al., 2021). African American children are more likely to die by suicide than any other race (Martin et al., 2022). Recent theoretical and empirical studies (Neathery, 2023; Journal of the National Medical Association, 2024) emphasize the complexity of depression in African American youth, particularly in faith-centered communities.

The rates of suicide among African American youth are steadily increasing, and they have the highest death rate by suicide (Lindsey et al., 2019). They are more likely to experience issues that put them at a higher risk for depression, such as discrimination and poverty but are less likely to receive treatment (Bridge et al., 2018). With minimal resources and poor help-seeking attitudes on behalf of parental supports, research implies an increase in suicidal ideation. Suicide attempts in African American youth increased over 70% within the last 20 years, while the prevalence of suicide attempts did not change significantly among other races and ethnicities (Xiao et al., 2021). Of greater concern, is evidence suggesting African American youth are least likely to disclose suicidal ideation (Morrison & Downey, 2000). Research supports a correlation between suicidal ideation and stigma regarding mental health, lack of awareness and education on depressive symptomology, indicators of suicidality, and a history of generational mistrust of the medical community.

Research has consistently shown that in African American communities, clergy are often the first point of contact for individuals facing mental health crises. One survey revealed that 92% of African American adults regularly attend religious services, and many prefer spiritual support over professional counseling (Bilkins et al., 2016). While some research has been conducted in this area, continued focus and development of interventions is warranted. Parents and clergy must be able to talk about, identify, understand, and manage the risks for the youth of any race. Equipping primary supports of African American youth is key to addressing stigma and myths about depression and suicide.

This study will explore current research on youth depression and suicide, how the African American culture is particularly impacted, and how the Church can help by being a transformative intermediary between parents, children, and therapists. A workshop will be designed to aid clergy in gaining better awareness of youth depression and suicide, how the African American experience with helping professionals and mental health stigmas create barriers to seeking help, and how the Church ministry can bridge existing gaps. This researcher aims to examine the existing literature and develop a workshop series to be used by clergy that targets adolescents and provides a chance for open dialogue and helpful resources for all those who want to reach the youngest congregants beyond the church walls.

2. Statement of the Problem

Depression and suicide can be complex topics of discussion within the African American community and the church. Even though these mental health issues are common, in this community, they are often seen as being physically weak and in faith (Dempsey et al., 2016). The church has been a safe-haven and place of strength to African Americans over the years, and where they often turn in times of need, even in dealing with mental health issues (Dempsey et al., 2016). Research emphasizes the importance of spiritual-based coping and the hyperfocus has rested on how spirituality impacts mental health outcomes. Still, African Americans' experience is limited and has not been thoroughly examined (Turner et al., 2018).

Recent studies have shown an increase in suicide rates among African American youth, which is alarming compared to other races and ethnicities. The precursors to suicide, one of which is depression, must be addressed, diagnosed, and treated. There also must be an awareness on this current crisis by informing and soliciting the help of clergy and other significant figures in the African American community.

Numerous studies discuss youth depression and suicide; however, there are multiple limitations and gaps in research regarding African American youth. There are gaps in research on treatment for mental illnesses such as depression and suicidality in African American youth (Pina et al., 2019). There is limited research on the effectiveness of interventions and evidence-based treatment of depression for African American youth (Higa-McMillan et al., 2015). Some studies did not report race which caused a missed opportunity to gather vital data. Studies with young African American participants failed to explore treatment outcomes (Pina et al., 2019).

Additional research is needed to understand the racial disparities of suicide, current trends making African American youth more susceptible to suicide, utilization of mental health resources, and understanding both risk and protective factors.

3. Definition of Terms

Several terms must be defined based on their use within this literature review and program resource development. The terms are listed in alphabetical order.

Adverse Childhood Experiences (ACE): psychosocial stressors that occur during the period defined as childhood or adolescence (Lê-Scherban et al., 2018). Some examples of adverse childhood experiences include child abuse and neglect, parental incarceration, witnessing interpersonal violence, parental mental illness and parental substance abuse.

Black Church: is the body of Christian congregations and denominations that are made up of predominately African American members. The Black Church has been the source of spiritual guidance and social support in the African American community and has advocated for social justice for the disadvantaged (Brewer &

Williams, 2019).

Cultural Mistrust: apprehensiveness and defensiveness towards a dominant culture (Dempsey et al., 2016).

Pastoral Care: spiritual, emotional, and social support provided by clergy (Kramer et al., 2007).

Clergy: An individual (male or female) ordained or licensed to function as a spiritual leader (Lindberg, 2009).

Help-seeking Behavior: the act of seeking help from mental health professionals for mental health concerns (Umubyey et al., 2016).

Hidden Ideators: a name given to those youth who do not self-disclose suicidal ideations (Morrison & Downey, 2000).

Intergenerational Trauma: adverse experiences that impact parents and children in a continuous cycle, generation after generation (Yehuda & Lehrner, 2018).

Lay Counseling: any counseling provided by clergy or designee who is not licensed to give professional counseling (Hammar, 2010).

Spiritual Coping: praying, meditating (Koenig, 2015).

Spirituality: Religion and spirituality are often used interchangeably. Although they have the same foundation, religion has community involvement, and spirituality is an individual's own personal beliefs (Colucci & Martin, 2008). For the purposes of this literature review, the term spirituality will be used to describe them both.

Therapeutic Alliance: the collaborative relationship between a patient and therapist in mental health care (Stubbe, 2018).

4. Literature Review

The literature review for this dissertation seeks to explore the impact of depression and suicidality in African American youth and how the Black Church can become a communal change agent to build positive relationships between communal citizenry and local helping professionals. The selected literature examined ranges in publication from over the last ten years. A few older studies were used to provide a historical context of depression, suicide, and the impact of the Black Church. An exhaustive literature review was conducted to obtain knowledge on youth depression, youth suicide, barriers that impact the underutilization of mental health care, the role of the Church in the African American Community, adverse childhood experiences, and pastoral care. Research implies a need to educate clergy on depression and suicide to gain a better awareness of youth depression and suicide, provide resources and empower their families to seek help. This literature review examines the themes of childhood mental health, barriers that impact help-seeking behaviors, the role and impact of the Black Church, adverse childhood experiences, spirituality, and pastoral care.

4.1. Childhood Mental Health

More than 22% of youth and adolescents have a mental health disorder (DuPont-

Reyes et al., 2020). One in 10 children in the U.S. suffers from mental illness that is severe enough to cause impairment (Lindsey et al., 2010). Planey et al. (2019) conducted a systemic review and found that more than 44% of African Americans report a mental health disorder before age 18. Childhood mental health disorders are concerning due to their prevalence and early onset. In addition, childhood mental illness has a significant impact on children and their families as well. Although childhood mental illness remained stable over the years, a study by Ghandour et al. (2019) found that depression has increased. While depression trends have increased, treatment utilization remains low, especially among those children diagnosed with the disorder. This is due to various factors, including adverse childhood experiences, parental mental health issues, lack of education on mental illness symptomology, and lack of diagnoses in this population. In 2016, 1.9 million children had depression, and 9.7% were severely affected. 45% were rated as moderate (Ghandour et al., 2019).

4.1.1. Depression

Depression is a common mental health illness that severely reduces an individual's quality of life and restricts psychosocial functioning (Malhi & Mann, 2018). Depression is one of the five leading causes of disability (Breland-Noble et al., 2015). Daly (2022) conducted a secondary analysis to address the gap in research to study major adolescent depression. Findings show an eight percent increase in depression across all races; African American youth only had a four percent rise. An earlier study by Bryant et al. (2013) has similar findings and suggested that African Americans are less likely to suffer from depression than their white counterparts. Even though they are less likely, it is notable that they have more severe and prolonged symptoms (Bryant et al., 2013). Research supports that within the last 30 years, children and adolescents started to be included. The debilitating effects of depression can lead to poor outcomes for children, such as decreased academic performance, impaired relationships, poor physical health, poor quality of life, and suicidal ideations (Breland-Noble et al., 2015). Depression can lead to suicide and is a significant cause of concern in the United States. Death by suicide increased by over 57% for adolescents and young adults between 2007-2018 (Daly, 2022).

4.1.2. Suicide

Historically, White youth have higher rates of attempted suicide than any other race or ethnicity. A study by Bridge et al. (2018) found that within the last 20 years, the rate of suicide has increased in black youth ages 5 - 12. The suicide rate in this population increased by 118% (Price & Khubchandani, 2019) and over 79% in black male youth (Xiao et al., 2021). This age group is twice as likely to commit suicide than their white counterparts (Bridge et al., 2018). Suicide completion is the leading cause of adolescent death (DuPont-Reyes et al., 2020). Males make up more than 80% of African American youth that commit suicide (Lindsey et al., 2010). Lindsey et al. (2019) found that African American boys use effective lethal

suicidal means. Price and Khubchandani (2019) confirmed these results and found that African American boys and girls were more likely to use firearms or hang/suffocate themselves to commit suicide.

African American youth are the only ethnic group with increased suicide attempts between 1991 and 2017. Although, few studies have examined the underlying causes of suicide attempts in Black adolescents (Xiao et al., 2021). Findings from Lindsey et al. (2019) suggest that the rise in suicide rates could be attributed to disparities in mental health treatment and social factors that African American youth face disproportionally, such as race discrimination and adverse childhood experiences. Xiao et al. (2021) sounded a clarion call necessitating a response and a diverse approach to suicide prevention.

4.1.3. Self-Disclosure

African American youth are least likely to disclose depressive symptoms and suicidal ideations (Bryant et al., 2013). Morrison and Downey (2000) found that this population is considered "hidden ideators" because they do not self-disclose suicidal ideations as quickly as other races nor disclose it on suicide risk assessments, despite the presence of suicidal ideations. Race is also essential in determining self-disclosure. Morrison and Downey (2000) surveyed over 300 students and found that African Americans who experienced instances of racism were less likely to disclose suicidal ideation to white counselors. The lack of self-disclosure may be why research suggests that African Americans have lower rates of suicidal ideations. High completion rates do not correlate to high ideation rates (Morrison & Downey, 2000). Other barriers prevent African American youth from disclosing and seeking treatment for mental health concerns which will be discussed below.

4.2. Barriers That Impact Mental Health Treatment

African Americans do not utilize mental health services as often as their White counterparts. This is equally true for African American youth (Breland-Noble et al., 2015). Several barriers prevent this population from seeking mental health care services. Those barriers to treatment include stigma, racial biases and discrimination, misdiagnoses, quality of care, and cultural mistrust. Religion and spirituality may also play a role in help-seeking behaviors (Breland-Noble et al., 2015). Each of these barriers will be discussed below.

4.2.1. Stigma

Stigma is defined as a negative attitude based on stereotypes that typically leads to discrimination (Byrne, 2009). Breland-Noble et al. (2015) found that African American youth were afraid of being judged if they disclosed depressive symptoms or suicidal ideations. An earlier study by Bryant et al. (2013) had similar findings in their qualitative analysis. It also found that African American males were least likely to disclose and seek help due to stigma in the African American community. It is believed that those who struggle with their mental health are often seen as weak, crazy, and even spiritually flawed (Dempsey et al., 2016). Af-

rican American male youth are negatively influenced by their peers' perception of mental illness and help-seeking (Lindsey et al., 2010). Children learn mental health stigma from their parents' perceptions rather than their own, and African American males are more susceptible to gender-based messages such as emotions are equated to being weak (Lindsey et al., 2010). Prior research has shown that existing stigmatized groups avoid seeking treatment to prevent a second stigmatized mental health label (DuPont-Reyes et al., 2020).

Martin et al. (2022) conducted a study to examine if utilizing a brief social contact-based video intervention would successfully reduce depression stigma and increase help-seeking behaviors in youth. Contact-based interventions are interventions where individuals with a mental illness or mental health concern interact socially with community members. The findings revealed that these videos successfully increased help-seeking behaviors and decreased the stigma associated with depression on a short-term basis. This intervention has been proven to be the most effective in combatting mental health stigmas. It is suggested that these interventions need to be tailored to the unique experiences of African American youth (Martin et al., 2022).

4.2.2. Lack of Education

Mental health stigma is also often associated with a lack of education regarding mental illness. DuPont-Reyes et al. (2020) conducted an analysis surveying over 600 middle school students. The findings suggested that African American youth had less knowledge regarding mental illness and reported fewer positive attitudes. They also were more uncomfortable around students with mental illnesses and wanted to be distanced from them. They believed that people with mental illnesses were terrible and not likely to improve with treatment (DuPont-Reyes et al., 2020). Sherry et al. (2007) conducted a study that showed that more than 76% of youth surveyed had been exposed to a peer who either had suicidal ideations or attempted suicide. The youth were unaware of the seriousness of depression and suicidality in the African American community. In addition, the children surveyed considered suicide a "White phenomenon" (Sherry et al., 2007). Even though statistics support the notion that African American youth are in a mental health crisis, this information is not being disseminated to the community. This demonstrates a need for education and prevention efforts to target this community explicitly.

4.2.3. Medical Mistrust

Due to systemic and racial discrimination and a history of slavery, African Americans mistrust the mental health care system and medical professionals (Bilkins et al., 2015; 2016). Hammond (2010) found that this population reported more instances of medical mistrust due to substandard health care, misdiagnoses, as well as a host of other reasons (Hammond, 2010). These multifaceted factors contribute to the underutilization of mental health care services (Bilkins et al., 2015, 2016).

4.2.4. Racial Biases and Discrimination

African Americans report higher instances of being misdiagnosed due to cultural differences and racial biases. Bilkins et al. (2015, 2016) conducted a survey and found that over 90% of the respondents have experienced racial discrimination. Planey et al. (2019) conducted a study to examine the barriers to mental health treatment in African American youth. The findings suggest that African American children are misdiagnosed and, in some instances, undiagnosed. African American children are diagnosed with behavioral and conduct disorders more often than White children. Caseworkers are less likely to refer African American children for mental health services while in custody (foster care, detention), and 76.5% of these children who need mental health services are not receiving them (Planey et al., 2019).

4.2.5. Additional Barriers

African Americans face additional barriers that prevent them from seeking mental health care services, including a lack of representation in the mental health field and cultural mistrust (Campbell & Winchester, 2020). Cultural mistrust is an attitude of apprehensiveness and defensiveness toward a dominant culture (Dempsey et al., 2016). Those seeking treatment report low quality of care, which perpetuates racial disparities (Breland-Noble et al., 2015). In addition to the barriers that cause underutilization in mental healthcare, some factors make this population more resilient. Themes of resilience will be discussed in the subsequent paragraphs.

4.3. Social Supports

Although many barriers prevent African American families from accessing mental health care, the closeness of the family unit and other social supports make them more resilient (Ghandour et al., 2019). An earlier study by Lindsey et al. (2010) examined the impact of mental health stigma and social support regarding depression on African American male youth and their help-seeking behavior. The findings show that mental health stigma and social support impact depression symptoms and help-seeking behaviors in African American male youth. Having more social support decreased depressive symptoms in childhood. Where males are least likely to disclose or express vulnerability, they noted that it would be family if they chose to be vulnerable with anyone, as they are the first source of help (Lindsey et al., 2010). Spirituality continues to be the most significant social support in the African American community. The Black Church has the most significant impact on influencing the social behaviors of the parishioners and the community (Sherry et al., 2007).

4.4. The Black Church

Out of any other race, notably, African Americans are the most spiritual (Breland-Noble et al., 2015). This has a lot to do with how instrumental the Black Church has been in the progression of African Americans since its inception during slav-

ery throughout Civil Rights and into the 21st century (Avent & Cashwell, 2015). The Black Church was also vital in spearheading several important initiatives within the African American community (Taylor & Chatters, 2010). It is more than just a building; it is collectively seen as not only a place of worship but is made up of those who attend. It is central to the African American experience (Bryant et al., 2013). The Church has played an important role in every social movement and has been a source of advocacy for this population (Watson & Stepteau-Watson, 2015). Clergy and the Church are very influential in the African American community (Avent & Cashwell, 2015) and ultimately deciding whether an individual seeks professional counseling.

4.4.1. The Church and Help-Seeking Behaviors

Minimal research exists as to why African Americans rely more on their spiritual communities for support with mental health issues rather than seeking help from professional mental health counselors (Avent & Cashwell, 2015). The Black Church has always been and will continue to be the safe place many African Americans go to for support (Bilkins et al., 2015, 2016). A survey by Bilkins et al. (2015, 2016) found that 92 % of African American adults attended church services regularly. Previous research has suggested that many African Americans are more likely to seek care from the clergy than from a formal mental health professional, even when experiencing serious issues such as depression (Bilkins et al., 2015, 2016). African Americans who went to the clergy first were less likely to seek help from a mental health professional later. They were also more likely to seek help from a mental health professional after being referred by clergy, suggesting that the church was meeting their mental health needs (Turner et al., 2018). Future research is needed to understand the relationship between African Americans and spiritual coping mechanisms and how this may impact help-seeking behaviors and attitudes (Ward & Heidrich, 2009). It is also helpful to understand the clergy's attitude toward treatment for mental health. Previous research by Bilkins et al. (2015, 2016) surveyed over 100 clergy to understand their attitudes and beliefs toward mental health counseling. They found that they are, much like their parishioners, not trustful of formal healthcare entities and often rely on the church community and alternative services. Therefore, they were least likely to refer to formal mental healthcare services. Help-seeking differences in the African American community can be attributed to their spiritual beliefs and previous counseling experiences (Avent & Cashwell, 2015).

4.4.2. Spirituality and Help-Seeking Behaviors

Despite systemic and attitudinal barriers that influence help-seeking behaviors in the African American community, a new theme in research has emerged that has impacted the African American community and help-seeking behaviors. That theme is spirituality. Studies have been inconsistent with the correlation between spiritual beliefs and help-seeking behaviors. Research conducted by Turner et al. (2018) found that African Americans have reported that prayer and spirituality

are vital in dealing with life challenges and serve as a coping mechanism. Many African Americans seek mental health support from the clergy and God (Andrews et al., 2011). An earlier study by Ward and Heidrich (2009) confirmed those findings and suggested that African American women were more likely to rely on their spirituality to cope with mental health concerns than to seek help from a professional. This is true even if they suffer from depression and depressive symptoms (Nadeem et al., 2008). African American women were more likely than any other race or ethnicity to believe that their spirituality was enough to get them through their depression and depressive symptoms (Nadeem et al., 2008). A study by Ayalon & Young (2005) found that African Americans with strong spiritual beliefs were less likely to rely on formal mental health services when dealing with mental health issues and relied solely on their spirituality.

African Americans who have received professional mental health treatment in the past are unlikely to seek the same services in the future. A study conducted by Broman (2012) identified that secular mental health professionals were insensitive to the spiritual needs of African Americans, primarily those who have a strong spiritual foundation. Studies have found that clinicians often avoid spiritual practices (Brown et al., 2011) and have also suggested that spiritual-based coping is maladaptive to mental health counseling (Entwistle, 2009). This has ultimately damaged the therapeutic alliance between African Americans and mental health professionals, which is another factor that helps to understand help-seeking behaviors in this population. It is vital to understand the importance of spirituality in the African American experience, especially when understanding their help-seeking behaviors for mental health.

4.5. Adverse Childhood Experiences

Adverse childhood experiences (ACE) are psychosocial stressors that occur during the period defined as childhood or adolescence. These stressors are traumatic and can majorly impact one's well-being later in life (Lê-Scherban et al., 2018). A study conducted by Anda et al. (2008) identified that exposure to ACEs could lead to long-term negative consequences. These negative consequences can also lead to an increased risk of depression and suicide (Lê-Scherban et al., 2018). These adverse experiences range from child abuse, neglect, witnessing interpersonal violence, and exposure to parents being imprisoned and battling mental health and addictions (Brown et al., 2010). This list is not all-inclusive, as continuous efforts are being made to expand this list to include inequities such as police contact (Geller, 2021). ACEs are often concurrent and result in repeated traumatic generational cycles (Casanueva et al., 2014). There are several different ACEs, but the most prevalent are childhood abuse and neglect, interpersonal violence, parental incarceration, parental mental health, and parental substance abuse.

4.5.1. Childhood Abuse

Child abuse is defined as the intentional infliction of physical injury to a child that leaves them with a mark or impairment (Norman et al., 2012). Several surveys

indicated that one-fourth of all adults had experienced abuse during childhood (World Health Organization, 2019; Dube et al., 2001), and it was often a result of some sort of punishment (Norman et al., 2012). A household member also inflicted this abuse (Devries et al., 2018), and parents committed over 92% of child abuse (Child Welfare Information Gateway, 2017). Child abuse, including corporal punishment, has been found to lead to an increase in depression and suicide symptoms and increased chances of substance abuse and interpersonal violence in later life (Straus & Kantor, 1994). There is also the likelihood that the victim will also expose their children to ACEs and intergenerational trauma (Straus & Kantor, 1994). Findings from Wong et al. (2020) found that those who were abused as children were three times more likely to attempt suicide than those who were not abused.

4.5.2. Neglect

Neglect is the willful negligence of a parent to provide for the basic needs of their children (Child Welfare Information Gateway, 2019). Much like child abuse, neglect can have severe consequences, such as increased depression, physical illnesses, mental illness, developmental delays, and even death (Papp, 2012). Studies showed that in homes where there was interpersonal violence, there was an increased likelihood of abuse and neglect (Fantuzzo et al. 1997).

4.5.3. Interpersonal Violence

Interpersonal violence is a household dysfunction-related ACE. African American youth are twice as likely to witness another person being seriously injured or murdered compared to their white counterparts (Schilling et al., 2007). This group is also disproportionately affected in terms of witnessing interpersonal violence (Fantuzzo & Fusco, 2007). Studies have found that witnessing interpersonal violence can cause an increase in anxiety, depression, aggression, and oppositional behaviors in children (Fleck-Henderson, 2000). A child's risk dramatically increases when the victim is a close family member (Fantuzzo et al. 1997). Findings from Fantuzzo et al. (1997) indicated that these homes were low socioeconomic status, single-parent homes with lower educational achievements from the parents; there was an increased risk of interpersonal violence (Fantuzzo et al. 1997).

4.5.4. Parental Incarceration

Another household dysfunction-related ACE is parental incarceration. Parental incarceration is defined as having at least one parent who is currently or was previously incarcerated (Dube et al., 2001). More than 7% of children in the United States have had at least one parent incarcerated (Wakefield & Wildeman, 2018). Over 1.4 million adults have been in the prison system, as reported in 2017 by the Bureau of Justice. African American men were six times more likely than White males to be incarcerated, and African American women were twice as likely as White women to be incarcerated (Lee et al., 2015). This ACE disproportionately affects African American children (Foster & Hagan, 2009). A study conducted by

Murray and Farrington (2005) unveiled that parental incarceration increased anxiety and depressive symptoms in children. A later study by Gjelsvik et al. (2014) confirmed these findings as significant for African American children, which resulted in poorer physical health outcomes later in life.

4.5.5. Parental Mental Health

Parental mental health is also considered to be one of the household dysfunction-related ACEs. Parental mental health encompasses a multitude of psychological disorders (Backer et al., 2017). Several studies have confirmed that in homes where at least one parent had a mental health concern, there were also instances of child abuse and neglect, leading to anxiety and depression in children (Craig & Bromet, 2004; Brown et al., 2010). Further research reports when a parent had a significant mental health impairment, it increased the likelihood that their children would also develop a mental health disorder in either their childhood or as an adult (Mars et al., 2012; Timko et al., 2002). The more severe the mental health disorder, especially without any interventions, the more the transmission of mental health concerns to the children (Timko et al., 2002; Birmaher et al., 2010).

4.5.6. Parental Substance Abuse

A study conducted by Dubowitz et al. (2011) found that all the ACEs related to abuse, neglect, mental health, and substance abuse had a significant impact that increased the risk of mental health and substance abuse issues later in life. An earlier study conducted by Dube et al. (2001) found that parental substance abuse was the most prevalent of all the ACEs at 26%. A later study by Dubowitz et al. (2011) confirmed these findings while also indicating that children with parents with substance abuse or mental health issues were more likely to be abused. Over 50% of adults in the U.S. have confirmed experiencing at least one ACE in their childhood (Choi et al., 2017).

4.6. Impact of ACE by Race

Prior research studies have shown that African American children are at a higher risk for adverse childhood experiences than white children due to historical risk factors and intergenerational trauma (Lee & Chen, 2017). Although a study by Gilbert et al. (2015) found that African Americans reported higher instances of ACEs, a later study conducted by Lee and Chen (2017) found that African Americans reported more instances of household dysfunction than instances of child abuse and neglect. This suggests there may be certain ACEs that are unique to African Americans. Freeney et al. (2021) found that African Americans are also more likely than any other race or ethnicity to experience six or more ACEs. It was also reported that African Americans have higher instances of physical neglect (Hussey et al., 2006) as well as higher instances of household dysfunction (Raley et al., 2015). Adverse childhood experiences disproportionately affect African Americans, and they are therefore more likely to experience more incidents of depression and suicide (Hampton-Anderson et al., 2021).

4.7. ACE and Suicide

Studies have shown that children who have experienced one ACE are twice as likely to commit suicide (Dube et al., 2001) and increase to six times more likely if they have experienced three or more ACEs (Felitti et al., 1998) than those who reported no ACEs. Children with 4 or more ACEs doubled that risk (Dong et al. 2004). Studies have also shown that those who have experienced 4 or more ACEs were four times more likely to have depression and 30 times more likely to attempt suicide than those who had no ACEs (Hughes et al., 2017), which is consistent with previous findings. In a study by Dong et al. (2004), 8,629 adults were surveyed. Two-thirds of those respondents reported having experienced one ACE, and 81% had experienced at least one additional ACE. These findings suggested that ACEs do not occur independently but rather are interrelated. A prior study by Felitti et al., 1998 showed similar findings. They reported that ACEs were perhaps experienced in conjunction with at least one other ACE, and psychological abuse occurred with child abuse in more than half of the cases studied. Without any intervention, children subjected to adverse childhood experiences are more likely to have major negative impacts on their mental health and well-being later in life (Lê-Scherban et al., 2018). Fortunately, spirituality and the church can be a protective factor, especially for those with strong spiritual ties.

4.8. Spirituality as a Protective Factor

Religion and spirituality are often used interchangeably. Although they have the same foundation, religion has community involvement, and spirituality is an individual's personal beliefs (Colucci & Martin, 2008). Several studies over the years have found that spirituality can buffer many negative effects of life and improve overall improvements not only in one's mental health but also in overall well-being (Hill et al., 2020). Molock et al. (2006) found that spiritual coping significantly reduced behaviors that lead to suicide, such as depression, the feeling of hopelessness, and suicidal ideations in children. Hill et al. (2020) conducted a study and found that the risk of death decreased by 24% for those individuals who participated in spiritual activities more than once a week compared to those who never engaged in any spiritual activities. The same was true across varying demographics (Hill et al., 2020). No research supports that spiritual coping alone reduces mental illness symptoms. Still, studies have shown that it has been successful in combination with other methods and provided the best outcomes (Cruz et al., 2016). In addition, those who use spiritual coping are far more resilient and have fewer stressors than their counterparts who do not utilize spiritual-based coping (Jans-Beken, 2019).

Koenig (2015) conducted a study and found that those who participated in spiritual activities and were strongly committed to their beliefs were more likely to use and benefit from spiritual coping to deal with life's challenges. Findings also suggested that individuals who participated in spiritual activities find purpose in living, engage in healthier activities, become more resilient, and develop positive

coping strategies (Koenig, 2015). An earlier study by Colucci and Martin (2008) found that individuals who engaged in spiritual activities could cope with traumas such as adverse childhood experiences, which reduced depressive and suicidal behaviors. This is also especially true for African American youth. Breland-Noble et al. (2015) conducted a focus group with African American youth between the ages of 11 - 17 years old and found that spiritual coping was a significant factor in how African American youth experience depression. Incorporating spiritual coping in treatment could help increase help-seeking behaviors in this population. De Berardis et al. (2020) found that spiritual-based coping also correlated to suicide in positive and negative circumstances. However, positive spiritual coping is a protective factor in combatting traumas, depressive symptoms, and suicidal ideations (De Berardis et al., 2020).

4.9. Pastoral Care and Suicide

Historically, clergy have been the first place parishioners, and those in the community seek when they need help. Those needs can range from necessities to mental health concerns. This is especially true in the African-American community (Bilkins et al., 2016). When a parishioner seeks guidance or help from the clergy, generally, there is no concern regarding their ability to guide them through their presenting issues. However, when the parishioner is amid a mental health crisis or even suicidal, the education and training of the clergy becomes a major concern. This concern is not just from a mental health care perspective but also a concern for the clergy as well. Weaver et al. (2002) surveyed over 200 clergy to understand their opinion when addressing mental health issues such as depression and suicide. The findings suggested that the respondents were not confident in handling such roles and believed they would benefit from more clinical counseling education. With the need to address such pressing issues, there is a lack of research that seeks to understand the basic level of understanding and capabilities that the clergy have in identifying and addressing the signs of depression and suicide (Kramer et al., 2007). Kramer et al. (2007) conducted a small focus group to address that issue. The focus group consisted of 12 college-educated clergy, with whom the majority identified themselves as Christian. Only one of the 12 clergy had a mental health background and could clinically assess for depression. The researchers sought to understand the clergy's views on depression, their level of understanding regarding depression and treatment, and what they specifically do to provide care for those experiencing depression (Kramer et al., 2007).

In terms of the clergy's role in providing care for those experiencing depression, they all expressed a similar procedure (Kramer et al., 2007). The clergy listened to the parishioners and, based on that conversation, would determine the need of the member, whether it was a spiritual need, social need, life crisis, or mental crisis. The mental crisis only involved suicidal ideations, psychosis, or violence. The clergy believed that they were able to assist in all other areas. The treatment that the clergy provides consists of prayer, scripture reading, and counseling through

the church or referral to professional counseling (Kramer et al., 2007). The clergy did state that they consider their capabilities, possible legal ramifications, what they are legally able to do, and their educational background and training in determining the treatment approach that they consider.

When the clergy did refer out to professional counseling, they preferred Christian counselors. Still, they were more concerned that the parishioner received qualified care above all other concerns to address their issues (Kramer et al., 2007). Of the 12 clergy, two of them had experienced bouts of depression in the past and openly discussed with their parishioners to acknowledge and reduce the stigma associated with depression and mental health (Kramer et al., 2007). When a parishioner did express suicidal ideations, all clergy made sure that the parishioners were connected to formal services such as therapy and ensured their safety until they were able to receive treatment. The clergy also noted that they provide pastoral care in conjunction with any additional services their parishioner receives and encouraged them to continue treatment, whether it is medicinal or therapy (Kramer et al., 2007).

The findings from the Kramer et al. (2007) focus group indicates that there is a mental health crisis in the church and that the clergy feel emotionally overwhelmed; the clergy are also concerned regarding their roles as a counselor and as clergy. All clergy face educational and training boundaries that adequately prepare them to properly identify and address depression in their church (Kramer et al., 2007).

4.9.1. Training and Education

While the previous studies by Weaver et al. (2002) and Kramer et al. (2007) indicated a need for clergy to have formal training to identify and address mental health issues, this group can be the important link between mental health awareness and public perception to reduce the stigma associated with mental health. The church is often the first resource when a parishioner seeks help; the clergy can often serve as the bridge between the church and secular counseling (Kramer et al., 2007). As previously noted, many clergy lack education and training in regard to mental health issues. An earlier study by Domino (1990) found that college students enrolled in an introductory-level psychology course possessed more knowledge of psychopathy than the clergy.

4.9.2. Negligent Counseling

Even with the best intentions, there is a risk associated with pastoral care and a lack of education and training. This risk is called negligent counseling (Hammar, 2010). When an individual, even clergy, offer lay counseling services, they are at risk for legal actions brought against them for negligent counseling. When a parishioner is at risk for suicide, clergy have a legal responsibility to connect these individuals to a mental health agency or emergency services. Failure to do so can result in legal liability should a suicide occur while under their care (Hammar, 2010).

4.9.3. Bridging the Gap

With this knowledge from literature, laws, and the clergy themselves, implications exist that suggest clergy or those working in counseling and mentorship capacities be sufficiently trained in clinical psychology. This training would enhance their ability to properly identify and address mental health issues and refer their parishioners to the appropriate services. This not only provides protection to the parishioners but to the clergy as well. Depression and suicide are not just faith-based community concerns. Less than half of those diagnosed with depression seek and receive care. However, research conducted by Kramer et al. (2007) supports that the church is the needed entity to bridge the community and mental health professionals regardless of race and ethnicity. The church plays an important role in being able to help destigmatize mental illness, providing links to resources, and educating the community regarding mental health issues. Findings by Campbell and Winchester (2020) suggest that the Black Church is in a unique position to effectively address African Americans' unmet mental health needs by delivering community-based mental health services that are culturally appropriate and destigmatizing mental health in this community. To help accomplish this, trust must be built between the clergy and mental health professionals. In addition, the clergy must be provided with the appropriate support and educational resources to walk confidently in their roles and continue to be what God has called them to be.

5. Workshop Development and Implementation

The proposed clergy workshop will be a two-day, in-person seminar facilitated by licensed clinical psychologists and culturally competent trainers. The training will cover topics such as recognizing symptoms of depression and suicidality, making appropriate referrals, establishing collaborative care relationships with mental health professionals, and maintaining pastoral boundaries. Learning outcomes include increased confidence in identifying mental health concerns, reduced stigma toward mental illness, and a structured referral process. The program will also include role-playing scenarios, screening tool demonstrations, and discussions about the historical role of the Black Church in public health.

6. Collaboration between Clergy and Mental Health Professionals

Clergy can collaborate with mental health professionals by establishing referral partnerships with culturally competent clinicians, creating a directory of services, and co-hosting support groups. These partnerships foster trust and ensure congregants receive comprehensive care. Open lines of communication, including quarterly check-ins and feedback sessions, can help sustain long-term, effective relationships between faith-based and clinical providers.

7. Youth Perspectives on the Church's Role

While the paper focuses on clergy training, it is equally important to incorporate

the voices of African American youth themselves. Emerging research suggests that African American youth often express ambivalence about the Church's role in mental health, citing generational gaps and fears of judgment (Sherry et al., 2007). Youth-inclusive strategies and peer-led discussions can help bridge these gaps and provide more relevant support systems.

8. Justification for Older Studies

Although some of the studies cited (e.g., Morrison & Downey, 2000) are over two decades old, they remain foundational in understanding the persistent stigma and disclosure issues within African American communities. Their continued citation reflects the enduring nature of these challenges and the need for ongoing investigation. When possible, contemporary sources are used to supplement these foundational texts and provide updated context.

9. Implications for Future Research

Even though prior and current research has identified various causes and risk factors for youth depression and suicide. More research is needed concerning youth depression and suicide in African American populations. There is a gap in the literature concerning the etiology and prevention of suicide in African Americans, racial disparities in suicide, mental health stigma in youth, spiritual coping and help-seeking behaviors in African Americans, and the effectiveness of faith-based programs in addressing mental health concerns. There is a lack of understanding of the underlying causes of suicide attempts in African American children and a lack of awareness of depression and suicide in the African American community. Implications for future research should also be directed towards prevention methods, education, and intervention and methods. This can assist clergy, and lay leaders to empower themselves to appropriately respond to youth depression and suicide and address it within their congregations. This is also beneficial in helping clergy to understand how depression and suicide impact their African American parishioners and the community.

The lack of understanding regarding mental illness has been a point of contention within the Black Church and its congregants. Mental illness and concerns have often been seen as weakness or unsteady faith. The Church must look beyond the idea of mental health equating to spiritual attacks.

10. Summary

Research surrounding African American youth suicide and depression research and programming must continuously develop. Every child deserves the right to grow up, experience life, and have support without ridicule when facing life challenges to heal and live their best life. At the heart of every African American community is the church, and there is no other entity more trusted and able to get the message across.

11. Conclusion

African American youth face significant, disproportionate risks for depression and suicide. While formal systems often fall short in reaching this population, the Black Church holds a trusted position within the community. Empowering clergy through education and collaboration can foster early identification and intervention. This clergy-centered workshop seeks to serve as a culturally responsive bridge between spiritual and clinical support systems.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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