

Faith and Suicidal Ideation: Young Nigerians' Voices on Pastoral Care Gaps

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Abstract

Continuous reports of suicide cases match efforts to prevent suicide. Various sectors and groups are exploring and initiating mental health awareness campaigns. This paper examines the key issue of how faith communities can provide more effective support to individuals experiencing emotional distress and suicidal thoughts. Focus group discussions with young Nigerian university students aged 15 to 35 who have survived these conditions are used to focus on this issue. These young people had inadequate or no support from their faith communities. Notable contributors to their mental health crises include academic stress, family dysfunction, financial hardship and social expectations. The study reveals a disconnect between the pastoral care provided and the actual needs of those affected: compassion, empathy, practical support and confidentiality. The study recommends a holistic pastoral care model that combines emotional intelligence with spiritual and material support.

Keywords: Suicidal ideation, Pastoral care, Mental health, Faith communities

1. Introduction

Suicide remains a global public health issue. The World Health Organisation reports that over 720,000 people die by suicide every year and that it is the third leading cause of death among young people. Their report shows that 73% of the global suicide cases in 2021 occurred in low- and middle-income countries.¹ It is a complex phenomenon that constitutes the leading cause of death.² Nigeria falls within this category of countries with a higher suicide rate. Local records confirm this statistic in print or digital media and academic research.³ It has a far-reaching impact, especially among young people.⁴ It distorts their perception of reality and anticipation of a better future.

Despite the alarming rate of suicide cases, there is still little attention given to this phenomenon. Many individuals experiencing suicidal ideation remain silent, isolated, and unsupported. Young people who will often turn to faith-based groups for support are confronted with many obstacles. Religious interpretations have reinforced the cultural perception of emotional distress and mental

¹ World Health Organization, *Suicide*, accessed March 25, 2025, <https://www.who.int/news-room/fact-sheets/detail/suicide>.

² Centers for Disease Control and Prevention, *Preventing Suicide*, accessed May 2024, <https://www.cdc.gov/suicide/facts/index.html>.

³ Nigeria Health Watch, *World Suicide Prevention Day 2023: Creating Hope Through Action*, modified September 14, 2023, <https://articles.nigeriahealthwatch.com/world-suicide-prevention-day-2023-creating-hope-through-action/>; Chukwudum Abamara Nnaemeka and Onyinye Ezinne Ozongwu, "The Rising Cases of Suicide among Nigerians: What Are the Risk Factors, Prevention, and Remedies?" *Consortium Psychiatricum* 5, no. 3 (2024): 56–61; Gabriel Oshokha, *Nigeria Ranks Sixth Globally in Suicide Rates – Don*, accessed December 17, 2024, <https://punchng.com/nigeria-ranks-sixth-globally-in-suicide-rates-don/>.

⁴ Glory Eseohe Okoedion and Ugo Chuks Okolie, "Youth Suicidal Behaviour: An Evaluation of Risk Factors in Edo State, Nigeria," *World Scientific News* 125 (2019): 51–71; Olukunle Olagunju, John Lola and Ololade Gbeminiyi, "Socio Cultural Causes of Suicide Among Nigerian Youth: A Myth or Reality," *International Journal of Scientific Research in Social Sciences & Management Studies* 7, no. 1 (2023): 352–361.

health issues. These and the obstacles shared by participants complicate the ability to seek help. However, most religious communities lack the necessary competencies to address suicidal ideation effectively.⁵ Their attempts to provide pastoral care through spiritual guidance have often proven inadequate in preventing suicide.

Insufficient focus has been placed on the actual needs expressed by individuals in suicidal crises. This study amplifies the voices of survivors through focus group discussions. The results of these discussions will inform the development of a training model for chaplains and other pastoral caregivers, enhancing their skills for suicide prevention. Consequently, this paper examines the lived experiences of young Nigerians who have experienced emotional distress and faced suicidal ideation. This proposes a holistic and compassionate pastoral care system grounded in empathy, emotional awareness, and spiritual sensitivity.

2. Methods

Pastoral caregivers try to provide pastoral care for emotional or spiritual distress and mental health issues for members of their faith communities. While this is commendable, most care has been based on the pastoral agent's determination of the nature of the situation and not mainly on what the care receiver needs. This research seeks to gain a more in-depth understanding of the support that the care receivers needed during their crises. Hence, qualitative research was initiated as a way of giving voice to people who struggle with suicidal ideation and did not get sufficient help that would have been appropriate.

The method of data collection was through focus group sessions. There were four sessions (reference in the tables as *fg 1-4*) with

⁵ Raphael E. Ogbolu *et al.*, "Channeling the Right Path-to-care: Improving Religious Leaders' Knowledge and Beliefs about Suicide Prevention in Southwest Nigeria," *Research Square* (2020): 13; Collins Ikeokwu Nwafor, "Suicide Prevention Strategies in Nigeria: Exploring Religious Roles, Insights, and Challenges," *Religions* 15, no. 64 (2024): 1–12.

different sets of participants, consisting of five young people between 15 and 35 years who have experienced suicidal ideation and emotional distress. Thirty young people passed the inclusion criteria for the focus group, but only twenty-two people participated in the focus group sessions. Five out of the twenty-two focus group participants were following a post-graduate degree, while the remaining seventeen were in various levels of undergraduate studies. In terms of gender, there were ten male and twelve female participants, respectively.

The conversation usually started after brief introductions, restating the goal, procedure, and reassurance of confidentiality. Afterwards, the session continued with open-ended questions⁶ that elicited responses and further participant discussions. Two recording devices were used to capture the reflections for each session. This guaranteed an accurate reproduction of the correct transcripts of the session proceedings. The responses were pseudonymised using the tokenisation method (using random nicknames to substitute the participants' names. Participants' responses form the data analysed with thematic coding on the NVivo software to determine the emerging themes and patterns of interventions among young people.

3. Results

This study explores suicidal ideation among young people in Nigeria, focusing on insights from both pastoral caregivers (Catholic priests) and young people (students) to inform a suicide prevention model rooted in pastoral care. The results presented here encompass themes

⁶ These questions went through a rigorous process of examination by an interdisciplinary expert team. See Serena Margaret Saliba and Collins Ikeokwu Nwafor, "The Inclusion of an Interdisciplinary Expert Advisory Group in Doctoral Research on Chaplaincy: Insights from Two Doctoral Researchers," *Journal of Pastoral Care and Counseling* (2025): 1–6.

from the focus group sessions with young individuals who have experienced emotional distress and suicidal ideation. Other components fall outside the scope of this paper. The focus group sessions were conducted using open-ended questions, allowing participants to contribute whichever they preferred. Participants could also build upon another participant's points or seek clarification. This facilitated a seamless and coherent discussion.

From their reflections, the emerging themes highlighted the underlying issues that lead individuals towards suicidal thoughts, along with the emotional burden and mental state that arise from the contributing factors. Participants also described how suicidal ideation manifests in their behaviours and shared their urges to attempt suicide. They discussed various experiences that serve as barriers to accessing or benefiting from support. There was an acknowledgement of the potential of faith, belief systems, and emotional grounding as helpful anchors during their crises. Consequently, most participants emphasised the importance of safe spaces, vulnerability, and sharing recovery experiences. They provided suggestions for tangible ways individuals can manage their mental health and prevent relapse, along with recommendations for how faith communities and leaders can proactively support individuals more effectively.

Contributing factors to suicidal ideation: Several cumulative life stressors and emotional strains were identified in participants' responses, contributing to suicidal ideation. The factors include psychosocial and environmental stressors and emotional, relational, and health challenges. These are recognised risk factors and contextual contributors to suicidal ideation. They become very sensitive triggers for suicide, especially when they are comorbid and have not been adequately resolved. Some thematisation of participants' responses is represented in the figure below:

Category	Contributing factors	References
Psychosocial & Environmental	Academic pressure	There have been times in my life when I have just felt pressured to do this... I have been pressured to meet specific standards and be the best at certain things, all this perfection stuff. However, yes, there have been times when I have cried and been depressed about certain things, mostly academic. (Titilayo, fg1)
	Goal-driven exhaustion	Another thing is the fact that you are trying to achieve something. I am an inquisitive person. So, I set myself high goals. When you try to achieve something, you put in your best effort for three or four years, but do not see the results. Those kinds of things can be exhausting, both mentally and physically. (Opeyemi, fg1)
	Indebtedness	Mine specifically came about two years ago when I had to come to terms with the idea of debt. It came as a result of borrowing multiple times. As a student trying to make ends meet, I ventured into that. I would call it a devilish act because it happened multiple times. (Okechukwu, fg3)
	Pressure of social expectation	My own came from being the eldest child. Yes, as the eldest child, a lot is expected of you. It is like everybody is expecting things of you, and with all these experiences and Gen Z stuff, you are always trying to meet some kind of expectation. However, regarding depression and stuff like that (referring to suicidal ideation), whenever that thought comes to mind, I just get depressed. As the firstborn, much is expected of you. (Damilayo, fg1)
	Toxic environment	The funniest part is that the first thought of suicide came during my time studying for a Bachelor's degree in Theology. I started working in the church as a part-time pastor during this time. After my degree, I became a full-time pastor. I was an associate pastor, working under the leader. He is a choleric. He has a sanguine nature as well as a choleric one. It is wild! My God!... I was persecuted because of my submission to that pastor. (Ayomide, fg2)

	Dysfunctional home	I think it was actually due to family issues. It is like being in an abusive family where every day is filled with fighting, war, violence and physical abuse... Because I was always on my own, people thought that everything that was happening was my fault. They always felt that I was just there observing, and nothing was wrong. However, they never knew that I was emotionally affected by everything I saw. (Olawumi, fg2)
Emotional & Relational	Being neglected	Another thing that caused it is what I call neglect. This is when you feel that people around you are neglecting you and not paying attention to you. You are just on your own. You have no friends, and no one talks to you. This is especially true if you are an introvert, as I am. (Opeyemi, fg1)
	Betrayal	The second instance I can remember was when I experienced betrayal for the first time. There was another guy I used to call 'brother', so I did not expect that from him... Before I knew it, a meeting had been arranged behind my back. The person I called 'brother' made a statement that pushed the others to act, saying things like 'Let's hurt him.' I felt so, so bad. My emotions were manipulated. It was excruciating because someone I had taught — someone who had learned almost everything they knew from me — told me that I did not understand ministry etiquette. I did not want to talk to anyone again. I just wanted to be alone. (Makinde, fg2)
	Loss of loved ones	My dad was my only financial support. When he died, I cried and fell into a depression. I became suicidal. (Aidevoh, fg3)
	History of being bullied	One of the things that caused my depression was being bullied at secondary school. I went to a girls' school for four years... I was bullied for about two years. (Opeyemi, fg1)
Health crisis	Mother's illness	I have actually had suicidal thoughts before, around 2022, when there was an eight-month strike. During that time, I went home and found out that my mum had to have an operation. She was complaining about something, so she went to the hospital, had some tests, and discovered that she had something called... It was related to pelvic cancer or something similar. (Eseola, fg4)

Overwhelming despair and hopelessness: Participants shared recurring feelings of worthlessness, hopelessness, anxiety, panic, and the mental burden of academic, financial, and personal struggles. Some expressions coded under this theme include: “I feel so downcast. I just feel like Jesus should come and take me away. Why am I even here in the first place?... Sometimes there is a series of things. Sometimes there are things you cannot do. I am just overwhelmed, especially at school” (Abisola, fg2), “Sometimes I feel the world should just dissolve” (Makinde, fg2), “I started feeling useless. I felt like I was useless; I was worthless. I was; I am just out of it” (Shade, fg3). These dire conditions are significant contributors to intrusive thoughts of suicide.

Suicidal urges and actions: This theme reflects the intrusive thoughts and attempts by respondents during their crisis period. They expressed these dispositions for suicide in the following words: “Being on buildings that are tall and high... just jump and end it” (Titilayo, fg1), “I almost tried it, that I wanted to cut myself” (Ibiyemi, fg1), “So that thing just came on me that, why don’t you just end this now? All the struggles will stop” (Opeyemi, fg1), and “I would have taken an overdose” (Ayomide, fg2). These impulses are serious triggers for completing suicide. They are overwhelming and reveal the depth of these individuals’ internal struggles.

Barriers to adequate support: This theme describes participants’ challenges in obtaining adequate and trustworthy support. Some systemic and interpersonal barriers include a lack of skill, generational disconnect, confidentiality issues, and inadequate resources. A participant acknowledged that “There is actually support from religious communities. But sometimes just to an extent. Not everyone in the religious community can relate. Moreover, most people tend to judge... So most people would just like... that is why most people do not even want to go to church because they feel like they will still judge you on certain things” (Titilayo, fg1). Another participant recounted their experience in these words: “The pastor was telling me that I have an issue, that is a demon. They did not understand what I was experiencing... Bringing it to you is like exposing myself unnecessarily” (Makinde,

fg2). These examples of participants' statements highlight the barriers that hinder receiving meaningful help or care, particularly in the urgent context of suicidal ideation.

Spiritual and emotional foundation: This theme emerges from the responses of participants, highlighting an interplay of spiritual reliance – such as faith, scriptures, and belief in God's presence – and personal resilience through self-motivation, emotional endurance, and dependence on supportive relationships when confronting psychological difficulties and other existential challenges, often rooted in personal setbacks that can lead to depression and suicidal ideation. One participant shared a moment of divine intervention: "I held the knife. I was about to, and something came to me... I knew at that point that God was speaking to me... I still love you as my daughter. I just heard that voice, I just dropped the knife, and I started crying" (Opeyemi, fg1).

Similarly, another participant expressed a mindset that provides emotional strength. According to this participant, "Do not worry about tomorrow, tomorrow will take care of itself. Just worry about today... that was really, really calm. It is something that I hold as one of those quotes that, okay, yes, I somehow like to live by" (Shade, fg3). Bible stories were another source of strength referenced by a participant. Sharing a particular biblical figure's story, a participant recounted: "I used to make use of Job stories... the story of Job... still he had to renew his strength when he got to a point and God had to restore everything... even if it is not good now, it is really good" (Damilayo, fg1). These examples illustrate participants' perceptions of the role of faith and inner strength amid emotional struggles.

Healing through openness: Participants also reflected on the need to open up and speak up about their conditions. Such an attitude, they shared, helped them in getting the required support. For example, a participant acknowledged their pastor's role in helping them recover. This participant credited the pastors with these words: "For me, my pastor played a major role in bringing me out of the recent one I had about 2-3 years ago. In fact, he played most of the role. One thing I did was ensure I kept him updated on

everything I experienced. If pastors are to help people, one thing is that people must be ready to open up. Otherwise, they will not know how to help” (Makinde, fg2).

Another participant pointed out the need to create a safe space to share. They appreciated this focus group session, where they talked about their suicidal ideation experience as therapeutic and a significant step in solidifying their healing. This participant said, “I would like to thank you for this opportunity. When you told me about it, I saw it as a personal opportunity to talk about my experience of suicide” (Okechukwu, fg3). This participant also noted that many people struggle silently, but healing begins when they find someone willing to listen. Hence, allowing people to share in sessions such as this focus group session becomes an avenue where listening and support are achieved. According to this participant, “People are going through a lot, yet there is hardly anyone to listen to them. However, when they eventually open up, the healing process begins” (Okechukwu, fg3). This ties in, therefore, with another participant who admonished people going through a mental health crisis or suicidal ideation to speak up. In the words of this participant, “The victim in question should learn to open up to people and religious leaders” (Ibukun, fg4). The importance of openness with spiritual leaders can not be overemphasised; however, a conducive atmosphere that will encourage young people to approach these caregivers must be provided.

Practical coping and self-management strategies: This theme captures how participants cope during a crisis. It reflects the mix of techniques that are both healthy and potentially harmful. They use these strategies to manage stress, emotional distress, and negative thoughts. These strategies include avoidance, engagement, spirituality, social connection, and sometimes withdrawal or addictive behaviours. The table below captures all the coping mechanisms shared by participants, which they deployed for emotional regulation and distraction from contemplating suicide.

Healthy	Harmful
A talk or a visit to someone	Crying
Self motivation	Absent-mindedness
Listen to songs	Addiction
Praying	Daydreaming
Avoid and limit access	Withdrawal
Keep yourself busy randomly	
Participating in a religious community	
Listening to sermons	
Stay cool	
Reading	
Playing games	

Propositions for pastoral care: This theme encompasses participants' views that call for a compassionate support system. Participants were able to communicate what they experienced was lacking in the (pastoral) support they received during their crisis. For them, there is a need for proactive, versatile, and empathetic care. This care has to be holistic, spiritual, material, and emotional. It should be cared for by a well-equipped and accessible pastoral caregiver within a safe and non-judgmental environment. The table below contains participants' recommendations that are described, based on the number of references, as critical in addressing suicidal ideation within a faith community.

Propositions	References
Avoid inauthentic care & over-spiritualisation	"The church should try not to be fake. Some people act like they care, but they actually do not... People in the church did not know that I was not fine... She [church female coordinator] did not know what was wrong with me... She said I have backslidden because the devil has seen that I have a glorious destiny... They said we should do a three-day fast and prayer for me. Furthermore, that was not what I needed" (Ifeoluwa, fg4).
Create a safe space	"They should create a safe space for people to be free... for people to be able to open up. That will be based on the setting, based on the kind of environment that the church leadership would determine" (Abisola, fg2). "It needs people that can be secretive enough, that I can open up my burden to and trust you... It can really damage the mental state of the person, so we need people that we can rely on" (Ibukun, fg4).
Training and awareness campaigns	"I also think the church should dedicate one service a month to people who are planning to commit suicide. Depression can be overwhelming. If they organise a sermon for these people, they may have a rethink... They should also have pamphlets and CDs with stories that could change their lives. While they are reading, God may work a miracle" (Dare, fg3). "Our leaders need to go for extra knowledge... You want to become a counsellor in church, you should know that part... because when they get to the point that they go to schools and stuff like that, I feel like things will get better" (Ibukun, fg4).
Being proactive	"I would say the support that the church or religious organisation should have, first of all, already from the onset, you begin to look out and watch out for the

Propositions	References
	importance of the healthy mental health of each of the young people in the church" (Okechukwu, fg3). "If the Reverend called his father immediately, that the guy is serious about it, maybe the guy may be saved" (Dare, fg3).
Material support	"With an interaction, you will know that it is not just a headache that the person is having; it might be hunger... After prayer, what happens?" (Makinde, fg2). "The church can also donate. They will see that they are going through financial hard times and having financial issues, then they can also donate by contributing to them" (Adebayo, fg4).
Change of worldview	"They need to come into the awareness of the evolving society. They need to evolve. They need to stop being rigid... They need to be able to recognise the needs of the new generation that is coming and developing" (Olawumi, fg2). "Most churches... the doctrine from 200 years, 400 years, 1000 years, they still want that doctrine to be involved, they are not changing. The world is moving, but... the doctrine is not moving at all" (Ibukun, fg4).

Besides the above critical recommendations, participants suggested others that are also worth noting. Participants also identified that pastors were not discreet in their sermons, causing more harm through references to a member's shared condition. Transformational leaders who can provide spiritual care, teach the correct doctrine, and encourage pastoral caregivers to share their vulnerability are needed. This assures the person that everyone is vulnerable and that the pastoral caregiver should be available and accessible.

4. Discussion

This study set out to survey the experiences of young people who have survived extreme mental health struggles and suicidal ideation. The study discovered that the mixture of emotional, social, and spiritual challenges causes suicidal ideation. These challenges included factors like academic pressure, family issues, and hopelessness. The study found out that many young people who experienced these challenges and often desired help rather faced judgment and a lack of support within religious communities. This discouraged help-seeking. However, it was also found that faith, emotional resilience, and openness were key to healing. Participants, therefore, called for a more compassionate and holistic pastoral care system, which can only be guaranteed or attained with better-trained pastoral care agents.

The contributing factors to suicidal ideation were identified by participants who shared an array of life stressors, such as academic pressure, family dysfunction, financial struggles, betrayal, illness, and toxic work or church environments. These often took various forms and occurred progressively at different times, making their management emotionally overwhelming. These findings are consistent with the diathesis-stress model of suicide,⁷ which explains suicidal ideation as the result of the interaction between several factors that reflect individual vulnerabilities and environmental stressors. However, the presence of these stressors does not always amplify vulnerability to suicidal ideation.⁸ The point here is that pastoral caregivers must be aware that suicidal ideation has to do

⁷ Kees Van Heeringen, "Stress–Diathesis Model of Suicidal Behavior," in *The Neurobiological Basis of Suicide*, ed. Yogesh Dwivedi (London: CRC Press/Taylor & Francis, 2012), 113–23; Daryl B. O'Connor, Nicola Gartland and Rory C. O'Connor, "Stress, Cortisol and Suicide Risk," *International Review of Neurobiology* 152 (2020): 101-130.

⁸ Tay Jeong, "Do More Stress and Lower Family Economic Status Increase Vulnerability to Suicidal Ideation? Evidence of a U-Shaped Relationship in a Large Cross-Sectional Sample of South Korean Adolescents," *PLOS ONE* 16, no. 4 (2021): 1-19.

with the interaction of several complex factors. It involves an interplay of the individual's external conditions and internal struggles. Suicidal ideation is not because of spiritual weakness or a consequence of a lack of faith. Therefore, pastoral caregivers should be trained in psychosocial risk assessment and encouraged to develop the attitude of making referrals to appropriate professionals. Faith communities should generally create healthy and safe avenues to share these complex struggles.

One critical aspect in participants' reflection was overwhelming despair and hopelessness. During their experiences, they found it difficult to process and express their emotions effectively. They often felt worthless and spiritually abandoned. Being in such a state further compounded their sense of isolation and disconnected them from having the capacity to find meaning and purpose in life. Several studies have identified hopelessness as a strong predictor of suicidal behaviour.⁹ Likewise, despair from the feeling of abandonment by one's faith community or the divine has been linked to increased suicide risk.¹⁰

Pastoral caregivers should ensure that young people, especially those experiencing existential challenges, do not feel abandoned. While they attend to the theological questions of the young person

⁹ David E. Klonsky, Titania Dixon Luinenburg and Alexis M. May, "The Critical Distinction between Suicidal Ideation and Suicide Attempts," *World Psychiatry* 20, no. 3 (2021): 439-441; Fan Ko Sun et al., "Meaning in Life as a Mediator of the Associations among Depression, Hopelessness and Suicidal Ideation: A Path Analysis," *Journal of Psychiatric and Mental Health Nursing* 29 (2022): 57-66.

¹⁰ David Choon Liang Teo et al., "Religion, Spirituality, Belief Systems and Suicide," in *Suicide by Self-Immolation: Biopsychosocial and Transcultural Aspects*, ed. César A. Alfonso, P. S. Chandra, and T. G. Schulze (Switzerland AG: Springer Cham, 2021), 183-200; Laura Upenieks, "Religious/Spiritual Struggles and Suicidal Ideation in the COVID-19 Era: Does the Belief in Divine Control and Religious Attendance Matter?" *Psychology of Religion and Spirituality* 14, no. 3 (2022): 338-350; Justin W. Dyer, Michael A. Goodman and Sam A. Hardy, "Adolescent Suicide Ideation in Utah: The Role of Religion and Family," *Psychology of Religion and Spirituality* 14, no. 1 (2022): 86-96.

seeking answers for their conditions, they should also give ample attention to possible emotional despair. Emotional despair is often responsible for the persistent feeling of hopelessness. Therefore, a system of support that offers spiritual encouragement is needed. For example, the faith community could develop “hope-focused group sessions” for young people. Factors which could help to build resilience could be included in the sermons delivered in such a community. Pastoral caregivers could also be trained to focus more on emotional and spiritual care and encouraged to use scriptural narratives that foster and restore hope.

Many of the participants revealed that their experiences were marked by a strong desire to kill themselves. They expressed it with statements like “I felt like ending it all”, “I just want to leave this place...everything,” “I felt like God should come and take me away,” “If I end it now, all these pains will go away.” Some of them even shared how these intrusive urges were intensified and how they attempted to act on them. Participants felt overwhelmed during these periods and described it as impulsive, whereby they sought ways to take away the pain. Theoretical frameworks, such as the Fluid Vulnerability Theory¹¹ and the Narrative Crisis Model,¹² highlight the dynamic nature of suicide. They show that a rapid increase in suicidal crises is often caused when an individual experiences emotional distress, isolation, and hopelessness simultaneously.

¹¹ David M. Rudd, “Fluid Vulnerability Theory: A Cognitive Approach to Understanding the Process of Acute and Chronic Suicide Risk,” in *Cognition and Suicide: Theory, Research, and Therapy*, ed. T. E. Ellis (Washington, D.C.: American Psychological Association, 2006): 355–68; Kelsi F. Rugo-Cook et al., “Fluid Vulnerability Theory as a Framework for Understanding the Association between Posttraumatic Stress Disorder and Suicide: A Narrative Review,” *Journal of Traumatic Stress* 34 (2021):1080–98.

¹² Lisa Janet Cohen et al., “The Narrative-Crisis Model of Suicide and Its Prediction of near-Term Suicide Risk,” *Suicide and Life-Threatening Behavior* 52 (2022):231–43; Sarah Bloch-Elkouby et al., “The Narrative Crisis Model of Suicide: A Review of Empirical Evidence for an Innovative Dynamic Model of Suicide and a Comparison with Other Theoretical Frameworks,” *Personalized Medicine in Psychiatry* 45–46, 100131 (2024): 1–9.

A combination of frameworks, such as Fluid Vulnerability Theory and the Narrative Crisis Model, helps in identifying *when* suicidal risk is likely to occur.¹³ Unlike the interpersonal–psychological theory of suicide, which focuses on a limited set of factors to determine *who* may be susceptible to attempting suicide, these frameworks emphasise the timing, context, and dynamic nature of vulnerability.¹⁴ Therefore, pastoral care must be promptly provided by identifying the warning signs and acting appropriately to save the victim's life. Hence, training of pastoral caregivers in suicide intervention skills can not be overemphasised. There should also be provision for accessible mental health emergency contact and a steady response team within faith communities.

Despite the apparent increase in suicide cases in society, those who make efforts to get help often encounter some difficulties. Some of these difficulties are surprising because they emerge in settings where help is supposed to be obtained. Participants expressed that they were often misunderstood and judged within the religious circle, especially by pastoral care agents. There was spiritual misdiagnosis that often over-spiritualised their condition, confidentiality breaches that impeded trust, and generational disconnection whereby the pastoral agent did not understand the contemporary forms of emotional expressions or comprehend that such expressions were free to be expressed. These constitute some of the common barriers to seeking help.

Several studies show that stigma and fear of judgment are significant barriers to help-seeking for mental health conditions.¹⁵

¹³ Andrea L. Wolfe-Clark & Craig J. Bryan, "Integrating Two Theoretical Models to Understand and Prevent Military and Veteran Suicide," *Armed Forces and Society* 43, 3 (2017): 478–99.

¹⁴ Kimberly A. Van Orden et al., "The Interpersonal Theory of Suicide," *Psychological Review* 117, no. 2 (2010): 575–600.

¹⁵ Donte T. Boyd et al., "Perceived Discrimination, Mental Health Help-Seeking Attitudes, and Suicide Ideation, Planning, and Attempts among Black Young Adults," *BMC Public Health* 24, 2019 (2024): 1–11; Jessica M. Wyllie et al., "Suicide-Related Stigma and Its Relationship with Help-Seeking, Mental Health, Suicidality and Grief: Scoping Review," *BJPsych Open* 11, e60 (2025): 1–16.

Some studies suggest that religious beliefs and teachings reinforce and sometimes amplify the disposition not to seek help.¹⁶ Others point help-seeking behaviour away from professional institutions to their religious organisation because spiritual interventions are sufficient.¹⁷ When pastoral agents embody such dispelling attitudes and are visible, those in crisis alienate themselves and further entrench the feeling of shame. An uninformed or spiritually reductionist responses of a pastoral caregiver deter people having mental health crises from seeking help. Therefore, confidentiality policy guidelines should be followed for pastoral care. Also, there should be an ongoing mental health awareness campaign for members of the faith community, particularly pastoral care agents who are the gatekeepers. Unique avenues to tackle these barriers are through using destigmatising sermons and initiating community discussions on suicide and mental health-related issues.

Despite these barriers, certain spiritual and emotional foundations were observed among participants. Faith, scripture, inner resilience, and emotional grounding become anchoring forces that sustain participants during crises. This aligns with studies that highlight spiritual coping mechanisms as protective factors against suicide.¹⁸ Ryan Lawrence, Maria Oquendo and Barbara Stanley were

¹⁶ Curtis S. Lehmann, Carol A. Leung, Ivana Miller & Samuel M. Girguis, "An Action Research Framework for Religion and the Stigma of Suicide," *Religions* 12, 802 (2021): 1–32; Fatimah Zarah, "The Stigma Attached to Mental Health in Religious Communities," *The Seattle Collegian* (January 25, 2023), <https://seattlecollegian.com/the-stigma-attached-to-mental-health-in-religious-communities/>.

¹⁷ Blessing Fanegan, Ashley Marie Berry, Jennifer Combs et al., "Systematic Review of Religiosity's Relationship with Suicidality, Suicide Related Stigma, and Formal Mental Health Service Utilization among Black Americans," *Psychiatric Quarterly* 93 (2022):775–82.

¹⁸ Jennifer Kyle, "Spirituality: Its Role as a Mediating Protective Factor in Youth at Risk for Suicide," *Journal of Spirituality in Mental Health* 15, 1 (2013): 47–67; Freyana Shinde & Rekha Rekhawagani, "The Role of Spirituality on Suicide Prevention and Well-Being: An Exploratory Inquiry," *Indian Journal of Physical Education, Sports and Applied Science* 12, 1

more specific that spirituality protects against suicidal attempts, but not necessarily suicidal ideation.¹⁹ Nevertheless, believing in divine presence alongside emotional resilience strongly supports most existential crises, as these offer hope and social support. There is a need, then, for a holistic pastoral care model. This includes addressing the spiritual and emotional dimensions of the individual's life. It encompasses understanding the inherent struggles that coexist with and accompany faith. If possible, pastoral care agents should integrate spiritual practices (such as prayer, meditation, scripture reflection) within their faith communities with emotional wellness exercises in their pastoral programs. It is also required that these agents be given adequate training on how to nurture resilience through both spiritual disciplines and emotional intelligence efficiently.

As noted earlier, there is a strong negative perception of mental health issues. Suicidal ideation was even a more difficult condition to be, because of the increased stigma and taboo around it. These and several other factors were responsible for the lack of disclosure by people experiencing such challenges. Interestingly, participants began to share only when they were assured of safe spaces. Such a guaranteed environment initiated the healing process for most of them. Having a safe space creates an opportunity that reassures the person of the love of God. This becomes a form of strength that spurs the person to speak up and share their struggles. Once there was openness, a trusting relationship was strengthened, and meaningful support was offered.

Emmanuel Lartey explored the importance of developing pastoral caregivers' listening skills to enable them to understand the real-

(2022): 54–61; Collins Ikeokwu Nwafor, "Suicide Prevention Strategies in Nigeria: Exploring Religious Roles, Insights, and Challenges," *Religions* 15, 64 (2024): 1–12.

¹⁹ Ryan E. Lawrence, Maria A. Oquendo & Barbara Stanley, "Religion and Suicide Risk: A Systematic Review," *Archives of Suicide Research* 20, 1 (2016): 1–21.

life experiences of the people they minister to.²⁰ Their capacity to listen becomes the therapeutic thread in the healing process, giving the person agency and dignity. This dynamic has further been underscored using the concept of “sacred listening.”²¹ It fosters trust and connection, thereby allowing for transference and countertransference.

Opening up, however, can be tricky for many reasons.²² In the case of suicide, there are consequences noted to be associated with disclosing suicidal ideation.²³ Creating a non-judgmental space within the faith community is essential. Because healing cannot take place in a space where people feel stigmatised and not listened to. The result showed that participants in such a safe environment disclosed their condition and got the help they needed, though insufficient. It becomes therapeutic disclosure when the appropriate conditions are established and techniques are deployed. Therefore, a system that encourages openness should be fostered in the faith community. There should be tolerance for vulnerability, establishing a support network and storytelling or (mental health) narrative events to reinforce the value of speaking out.

People who go through difficult experiences, such as suicidal ideation, do not always sit on their hands. In most cases, they try to find ways to manage their conditions. Notable efforts were identified by participants who described both healthy (prayer, reading, music,

²⁰ Emmanuel Y. Lartey, “Embracing the Collage: Pastoral Theology in an Era of ‘Post-Phenomena’,” *Journal of Pastoral Theology* 12, 2 (2002): 1–10.

²¹ Josh Packard & Megan Bissell, “Research-Backed Practices to Engage Youth in a Vibrant Catholic Church: The Case for Implementing Sacred Listening Practices,” *Journal of Moral Theology* 13, 2 (2024): 252–70.

²² Gøril Solberg Kleiven, Aslak Hjeltne, Marit Råbu & Christian Moltu, “Opening Up: Clients’ Inner Struggles in the Initial Phase of Therapy,” *Frontiers in Psychology* 11, 591146 (2020): 1–11.

²³ Myfanwy Maple, Laura M. Frey, Kathy McKay, Sarah Coker & Samara Grey, “‘Nobody Hears a Silent Cry for Help’: Suicide Attempt Survivors’ Experiences of Disclosing During and After a Crisis,” *Archives of Suicide Research* 24, 4 (2020): 498–516.

social support) and unhealthy (addiction, withdrawal, avoidance) methods with which they managed their emotional pain and suicidal thoughts. Studies have shown that using coping strategies has a significant influence on the outcome of suicidal ideation.²⁴ Strategies that directly tackle the problems or focus on the emotions of the troubled person can be effective when supported simultaneously in meaning-making.

Pastoral care should guide individuals toward adaptive coping mechanisms and provide accountability for avoiding harmful ones. These unhealthy or maladaptive coping strategies distort the meaning-making process and perpetuate the cycle of suicidal behaviour by allowing the emergence of conditions that bring about suicidal ideation.²⁵ The contrasting nature of coping strategies demands that proper awareness and education should be provided through workshops and the availability of resources on mental wellness, self-care, and spiritual coping mechanisms. Leaders of faith communities should collaborate with other necessary

²⁴ Adam G. Horwitz, Ewa K Czyz, Johnny Berona & Cheryl A. King, "Prospective Associations of Coping Styles with Depression and Suicide Risk Among Psychiatric Emergency Patients," *Behavior Therapy* 49 (2018): 225–36; Elsie Ong & Catherine Thompson, "The Importance of Coping and Emotion Regulation in the Occurrence of Suicidal Behavior," *Psychological Reports* 122, 4 (2019): 1192–1210; Franca Obiageli Okechukwu, Kalu T.U. Ogba, Juliet I. Nwifo et al., "Academic Stress and Suicidal Ideation: Moderating Roles of Coping Style and Resilience," *BMC Psychiatry* 22, 1 (2022): 1–12; Stiths Gómez-Tabares Anyerson, Jessica Paola Carmona Marín, Alejandro Muñoz Vanegas et al., "The Effect of Coping Strategies on the Risk for Suicidal Ideation and Behavior in Adolescents," *Mediterranean Journal of Clinical Psychology* 10, 2 (2022): 1–21.

²⁵ Stéphanie Alix, Louise Cossette, Mireille Cyr et al., "Self-Blame, Shame, Avoidance, and Suicidal Ideation in Sexually Abused Adolescent Girls: A Longitudinal Study," *Journal of Child Sexual Abuse* 29, 4 (2020): 432–47; David John Hallford, Emily J. Wallman, Ryan A. Kaplan & Glenn A. Melvin, "Suicide and Coping: Specific Coping Behaviours Associated with Suicidal Ideation and Differences between Predicted and Actual Coping among Help-Seeking Individuals," *Center for Open Science* (2022): 1–19.

professionals to design faith-informed self-management plans for individuals at risk.

Besides the recommendations associated with the various themes discussed, participants made some direct propositions for pastoral care. Participants demanded a more compassionate, trained, and proactive pastoral care system. They called for less spiritualisation, more discretion, and practical support, including financial assistance and ongoing education. This proposition is encapsulated in the idea of a “therapeutic community.”²⁶ This is a way of recovery and rehabilitation where spiritual, emotional, and physical needs are addressed collectively and holistically. Pastoral care emphasises shared faith responsibility in supporting at-risk individuals to attain wellness. This is one of the ways that churches and faith communities can become true sanctuaries of hope for people in need of mental health care or at risk of suicidal ideation. This entails having empathy, using discretion, and appropriate competence.

5. Conclusion

This paper has highlighted the desires of young people who have experienced emotional distress and suicidal ideation. It revealed a disconnection between the pastoral care provided and the actual needs of those going through the crisis. Participants needed to be cared for more discreetly and with lots of empathy; practical support should accompany spiritual guidance.

From the study conducted, this paper recommends that pastoral caregivers ought to be equipped with trauma-informed care training and encouraged to take a proactive approach by implementing routine mental health awareness campaigns in their faith communities. They should provide material support by developing welfare ministries that address vulnerable members’

²⁶ Rex Haigh, “Therapeutic Community,” *International Encyclopedia of the Social & Behavioral Sciences* 2, 24 (2015): 274–80; Gideon Ngi Nganyu, “The Church as a Therapeutic Community: Exploring the Intersection of Christian Psychotherapy and Congregational Care,” *Greener Journal of Social Sciences* 15, 1 (2025): 54–63.

emotional distress and financial needs. In addition, two fundamental aspects are central to suicide prevention. The first is the necessity for a cultural shift in the perception of mental health and suicide. Pastoral caregivers should offer care with doctrinal flexibility and recognise generational sensitivities. Human nature and worldviews evolve with societal changes. The second aspect is that confidentiality must always be paramount in any pastoral care engagement. Therefore, a framework of pastoral ethics should safeguard trust and privacy within faith communities.

The data used in this study came from young people's reflections within academic environments. This poses a limitation, as it does not capture the broader experiences of young people in other settings, such as rural areas or non-academic environments. Additionally, it may be questionable to depend on self-reported experiences of a past condition, considering the potential for memory bias. Notwithstanding these limitations, adhering to the recommendations of this paper will aid in addressing the core needs of individuals in situations similar to those of the research participants. Faith communities can serve as sanctuaries of healing through a form of pastoral care that is non-judgmental, empathetic, and capable of creating a safe space for those at risk of taking their own lives.

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