

Basic Mental Health Literacy for Accompaniment & Psychological First Aid



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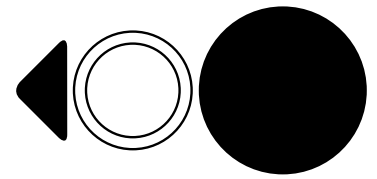
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COURSE OVERVIEW

The course is designed for parishioners, clergy and religious who are engaged in Catholic mental health ministry and to equip them with the practical information about mental health necessary to support, build and nurture mental health ministries in Catholic communities. It will also be useful for anyone in our Catholic communities, even if they are not directly involved in a mental health ministry, insofar as improved mental health literacy benefits all.

In this course, we will provide information about major mental health conditions so that Catholic mental health ministers, clergy and other parishioners will have basic mental health literacy to accompany our fellow parishioners who are experiencing mental health problems. This course DOES NOT prepare the learner to diagnose mental illness, nor offer any other type of mental health clinical care, nor offer advanced spiritual care.

This course will provide a foundational understanding of mental health literacy¹ within the context of Catholic faith and practical strategies for creating supportive environments. Mental health literacy includes a person's knowledge and beliefs about mental illness. There are five main components of mental health literacy:

1. Recognizing disorders and signs of psychological distress.
2. Knowledge of risk factors, causes and appropriate responses.
3. Awareness of mental health professional support available to the community.
4. Knowledge, attitudes and skills that encourage help-seeking behaviors.
5. Acknowledging when to obtain mental health information and guidance.

Keep in mind a mental health ministry team is not a *therapy* team; however, a mental health ministry team's ability to combine faith-based practice and the use of language, knowledge, and support consistent with mental health literacy can directly influence the attitudes and perceptions surrounding mental health. Essentially, the goal of improving mental health literacy is to reduce mental illness stigma, encourage conversations around mental

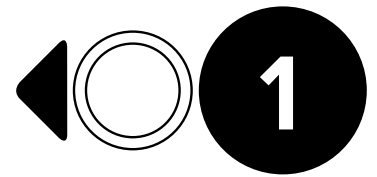
¹ Our definition of mental health literacy is consistent with the idea of task shifting, a public health concept that promotes the training of lay people to provide basic health assistance (see World Health Organization, 2008, for more information on task shifting).

illness, and create a safe environment for individuals to share and seek help surrounding their mental illness (Callahan and Martinez, 2023).

The course is organized into six lessons along with a reflective assignment and brief assessment. This workbook is intended as an accompaniment to either the online course, hybrid course or the in person group course. These lessons include the following:

1. Review and understand the general principles of mental health ministry within the framework of our Catholic faith and social teachings.
2. Recognize the signs, symptoms and risk factors associated with depression and anxiety.
3. Recognize the signs, symptoms and risk factors associated with schizophrenia and other psychotic disorders.
4. Recognize the signs, symptoms and risk factors associated with bipolar disorder.
5. Recognize the signs, symptoms and risk factors of trauma and post-traumatic stress disorder.
6. Understand the basic concepts of psychological first aid and how to apply them in mental health ministry.

Vignettes are embedded in the course for the participant to practice how to respond in situations related to mental health concerns. Questions following each lesson ask the course participants to reflect on how they would apply the course content in their unique parish, diocese or organization. Reflections may be individual or shared in group discussion, depending on the course delivery format. The course assessment is designed to assist the participant to check for understanding and consolidate their learning.



GENERAL CONSIDERATIONS IN MENTAL HEALTH LITERACY

"May the God of peace himself sanctify you entirely; and may your spirit and soul and body be kept sound and blameless at the coming of our Lord Jesus Christ." (1 Thessalonians 5:23).

We are created as body, mind and spirit. All are interconnected and for abundant life all are in harmony. This lesson is intended to instruct the learner on general considerations important to address before embarking on mental health ministry. These general considerations include how a supportive parish is essential to support an abundant life, pastoral and episcopal support and authorization for the ministry as well as ethical considerations for the avocation and role of lay ministers. Considerations also covered in this lesson include situations involving suicidality or risk of harm, and when to contact emergency medical services.

How can a supportive and understanding church community reduce stigma and help people live in recovery and feel included in parish life? Pope Francis (2021) has made it clear that we are compelled to take action to "fully overcome the stigma that mental illness is often tainted with." Speaking at an Italian Health Ministry conference on mental health, The Holy Father also recommended that we move toward a "culture of community." At the parish level, accompaniment and acceptance of our fellow parishioners who are coping with mental health problems as full members of our parish can move us toward developing such an inclusive church community.

In his Epistle to the Galatians (6:2), St. Paul asks us to "Carry one another's burdens, and in this way you will fulfill the law of Christ." Paul is encouraging us to help each other through difficulties and hardship as a demonstration of Christian love. This verse can help us to understand the importance of mutual support and compassion within our faith community, and provides us with guidance to create such a supportive, compassionate and inclusive community in our own parishes.

Ethics

As with any ministry or church program, there are ethical considerations that each lay minister or volunteer will be expected to know and understand. A diocese should have "Standards of Conduct" or "Ethical Standards" that outline expectations for all clergy, pastoral counselors, volunteers and lay ministers within that diocese. Additionally, dioceses should have a clearly defined scope of duty for lay ministers and volunteers. It is important that anyone who comes forward with a desire to serve on a Mental Health Ministry Team consider a variety of

legal and ethical issues that are not only guided by the principles of ministry or the diocese's ethical standards, but by the sensitive nature of interacting with a person experiencing mental health afflictions. Those mental health ministers who hold active professional licenses or credentials in the mental health field should consider the legal and ethical expectations set by their licensing boards. Although these ministers are volunteers and not formally working in their capacity as a mental health professional, there should be a personal understanding of any moral obligations (or professional ethical and legal obligations) that may apply to a variety of situations. Indeed, it is our recommendation that health and mental health practitioners involved in the mental health ministry assume roles that support the ministry directly (i.e., organizing, leadership, facilitating large group presentations) but do not necessarily involve individual accompaniment for parishioners. This practice helps limit the potential for dual relationships and confusion of the nature of the lay ministerial relationship on the part of the parishioner. Whether a mental health professional by trade or not, mental health ministers should always maintain appropriate ministerial boundaries and adhere to the scope of duty defined by their diocese or other governance structure.

Boundaries with Minors

A mental health ministry will need to be firm and clear on its purpose/mission, scope of work, intention, and boundaries or limitations. Mental health ministry is not mental health *treatment*; this cannot be emphasized enough. While that limitation is clear, in practice, setting boundaries can be far more challenging, especially when working with the mental health issues of minors. Pope John Paul II was known for his focus on transforming the hearts of the youth through concerted ministry efforts. He is credited with saying that it is a “vocation to love that naturally allows us to draw close to the young.” Some mental health ministers may find setting boundaries with minors to be especially compelling as encountering young people with any degree of mental health challenges can spark a great desire to help. In the end, all ministers should be able to manage their emotional reactions and boundaries with any parishioner with whom they may potentially work. Diocesan *standards of conduct* or other processes for orienting volunteers and ministers to work with youth will always guide the boundaries set in ministry, especially when working with minors.

Cultural Considerations

There are many reactions and various levels of receptivity to mental health issues based on beliefs, values and cultures that vary from person to person, family to family, community to community, and so on. Taking an honest personal inventory of the messages you received throughout your lifetime about mental health, or having serious problems and seeking help, will give you an indication of how perceptions are formed. Your own impressions of mental health may differ greatly from someone with whom you would consider yourself close. Building your self-awareness about your reactions, thoughts, and beliefs about various aspects of mental health, including an honest

acceptance of what aspects you feel most drawn toward and what aspects you are most hesitant to encounter, will be a necessary part of building a strong mental health ministry team. Likewise, communicating these reactions to those on the mental health ministry team will help ensure that fulfilling the mission of the mental health ministry team is done with great intention and care.

Just as your own impressions about mental health may have been influenced by culture, those that the mental health ministry team will serve will also come with perceptions about mental health that have been formed by a multitude of interactions and messages received. There are some general known culturally-influenced attitudes about mental health and related help-seeking behavior. Some folks, by heritage or lifestyle, prefer natural and holistic approaches to all health issues. It is important to acknowledge how difficult help-seeking for mental health concerns can be for people in general, but especially for those whose culture may stigmatize mental health and its treatment.

Caring for Ourselves and Having the Right Motivation for Entering Lay Mental Health Ministry On the topic of self-care, Housel (2023) wrote that the “*Mental health ministry calls for ministers to enter into the lives of, and to walk alongside, people in some of the most challenging experiences of their lives. This ministry requires much from those who serve within it, and because of the nature of this mission, it is possible for mental health ministers to experience burnout and spiritual fatigue as a result of this work.*”

These words ring true each time they are read and speak to the need for mental health ministers to care for themselves in order to effectively accompany those seeking the ministry. Our self-care includes the basics of nutrition, sleep, recreation (including getting outdoors!), time spent in healthy interpersonal relationships and of course our spiritual practices. Self-care for the mental health minister also necessitates an honest discernment of our motivations to help. We are of most help to others when we are motivated to help for selfless reasons. If we are motivated to help to make us feel better about ourselves, or to feel better than others, then we will be of limited help to others and will be likely to do harm and should not enter lay ministry. If we are motivated to help others by our love of God, as St. Francis and St. Clare were, then we are likely to do good and should proceed to prepare for mental health ministry.

Talking Person to Person

For the person seeking or receiving mental health support it is important for them to feel seen and heard in a non-judgemental setting. There is no one size fits all solution for a person dealing with mental health issues and each individual must be treated as such. Effective communication with the person seeking help is crucial and can help to de-escalate a potential crisis in a safe and respectful way.

When engaging, speak slowly and confidently with a gentle, calm and caring tone. Use affirmative words and phrases such as “stay calm” and “let’s collect ourselves” instead of negative words like “don’t fight” or “you need to

calm down.” Don’t respond in a hostile, disciplinary or challenging manner. Indeed, avoid argumentative or threatening language, as this may increase fear or prompt aggressive behavior.

It is also important to remain respectful to the person’s space at all times. As appropriate, do not restrict the person’s movements. Try to calm yourself and avoid nervous behavior. Remain aware that certain acts such as involving law enforcement might exacerbate the situation.

Consider taking a break from the conversation for a chance to calm down. It is perfectly acceptable and often helpful to sit in silence with someone who is experiencing mental illness.

In many cases, time, space and respectful conversation will deescalate a distressing situation. Providing meaningful assistance such as offering prayerful accompaniment or assistance with referrals to mental health services are more readily received once the individual is no longer experiencing agitation or distress. If the situation continues to escalate despite these attempts, consider calling for emergency services following the instructions described below in this lesson.

Suicidality and Risk of Harm

At times a person who is experiencing mental health problems may also experience acute distress that requires emergency medical treatment. This is particularly true of any of the psychiatric conditions we discuss in this program (ie, schizophrenia, depression, anxiety, bipolar disorder and PTSD). That is, each of these conditions elevates one’s risk for suicide.

Additionally, acute distress may include active suicidal behavior and/or threatening behavior. Active suicidal behavior refers to the intention and plan for serious self harm. Threatening behavior refers to the intention and plan to do harm to others. The mental health minister’s only role in these situations is to try to maintain the safety of themselves, the person in crisis and others that may be in the area (e.g., if the crisis is occurring during a parish event or church service). In the event that a person you have engaged with is in an acute state of distress you may need to call emergency medical services.

For an acute mental health crisis, CALL FOR EMERGENCY SERVICES IF ANY OF THE FOLLOWING ARE PRESENT:

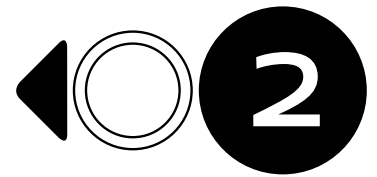
- Someone is in immediate danger of hurting themselves or others
- They are taking pills or dangerous substances, using a weapon, or threatening harm.
- They are violent or suicidal.
- It is not safe to or you cannot drive yourself or the person to the emergency room.

Inform the emergency medical service that you are calling because of a mental health emergency and describe the situation, including any potential threat to the health safety of the person or others. Be sure to keep the person experiencing the emergency in sight, to the degree possible in order to maintain your safety, until emergency services arrive.

Lesson 1 Reflection (optional small group discussion if in a live virtual or in-person setting):

How can lay mental health ministers effectively engage in person-to-person conversations to ensure individuals feel seen and heard in a non-judgmental setting?

How can lay mental health ministers effectively set boundaries with minors while managing their emotional reactions, and ensuring the safety and well-being of the youth they serve?



RECOGNIZING THE SIGNS AND SYMPTOMS OF DEPRESSION AND ANXIETY DISORDERS

Beginning with this lesson we will discuss the signs, symptoms and risk factors associated with depression, anxiety, schizophrenia, bipolar disorder and post-traumatic stress disorder. We focus on these disorders because they are the most commonly occurring mental illnesses and mental health ministers are therefore most likely to support parishioners with these disorders. There are other psychiatric disorders such as personality disorders, obsessive compulsive disorders and dissociative disorders; as well as neurodevelopmental disorders such as attention deficit hyperactivity disorder and autism that certainly impact mental health. However, the inclusion of these disorders is beyond the scope of this introductory course.

Depression and Anxiety

The American Psychological Association (APA, 2018) defines depression as a negative affective state, ranging from unhappiness and discontent to an extreme feeling of sadness, pessimism, and despondency, that interferes with daily life. The APA defines anxiety as an emotion characterized by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe, or misfortune.

As noted by the APA, depression can include unhappiness, sadness and generally feeling down. These feelings are normal from time to time and by themselves do not indicate mental illness. When these feelings persist over a long period of time without improvement is when they may be considered to be indicative of a depressive disorder or other mental illness. Risk factors for depression include genetics (ie, heredity as well as genetic vulnerabilities that may influence neurotransmitter function), personality traits, stressful events and substance abuse.

Additionally, other serious health conditions may increase risk for depression. For example, individuals with schizophrenia, cancer or heart disease often also experience depression.

Similarly, anxiety is characterized by fear of something very bad happening. Some describe it as a feeling of impending doom. As with depression, feeling anxious from time to time is a normal part of being human, and may actually be helpful. For example, feeling nervous or jittery before a big athletic event or work presentation might actually enhance your performance. However, when feelings of apprehension and body tension with thoughts of terrible events that might occur dominate most days, then anxiety may be considered a mental illness.

Risk factors for anxiety include family history, experiencing trauma, stress, personality traits (such as shyness, perfectionism or low self-esteem) as well as certain medical conditions. For example, individuals with thyroid disease or heart arrhythmia may also experience anxiety secondary to their medical problems. Substance abuse can also trigger or worsen anxiety.

Individuals experiencing depression are more likely to have an anxiety disorder. Exposure to traumatic or stressful environmental factors during childhood, including being raised by a parent with an anxiety disorder, can increase risk of developing anxiety.

Vignette: Paul and Sam

Paul shows a change in behavior such as withdrawal from group activities, lack of enthusiasm, and a change in grooming habits. Sam, one of Paul's friends, notices and intervenes by: identifying and evaluating potential risk of harm; listening with empathy and without judgment; offering reassurance and accurate information; promoting engagement with appropriate professional services; and supporting the use of self-help and additional support resources. Sam does not believe Paul is going through a crisis but still wants to help. Listening nonjudgmentally is important at this stage to help the person feel heard while not being judged.

Sam: *Hey Paul I noticed you've been a bit quieter lately, and don't hang out in the group as much. Is everything okay?*

Paul: *I've just been feeling down lately like nothing good happens to me.*

Sam: *I understand that you are going through a hard time right now, if you want to talk about how you are feeling I am here to listen.*

Paul: *No, not right now, thanks.*

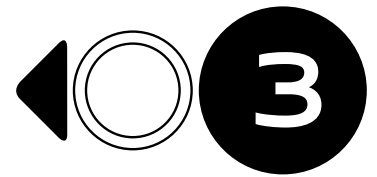
Sam: *I completely understand Paul. If you decide you do want to talk more I am available and can provide you with resources if you would like.*

Paul: *Ok I appreciate you checking in.*

Lesson 2 Reflection (optional small group discussion if in a live virtual or in-person setting):

How might you respond to a parishioner who shares concerns about anxiety that is interfering with their everyday life?

How might Sam's approach to offering reassurance and resources without pressuring Paul to talk immediately, contribute to a supportive environment for someone struggling with mental health issues?



RECOGNIZING THE SIGNS AND SYMPTOMS OF SCHIZOPHRENIA AND PSYCHOTIC DISORDERS

The American Psychological Association (2018) defines psychosis as an abnormal mental state involving significant problems with reality testing. It is characterized by serious impairments or disruptions in the most fundamental higher brain functions—perception, cognition and cognitive processing, and emotions or affect—as manifested in behavioral phenomena, such as delusions, hallucinations, and significantly disorganized speech. Cognition refers to thinking while cognitive processing refers to closely related processes such as attention, reasoning, memory and judgement. Delusions refer to rigid and highly irrational beliefs that a person clings to despite evidence to the contrary. Hallucinations are perceptions of things by any of our senses that are not actually present. The most common are visual hallucinations (ie, seeing things that aren't there) and auditory hallucinations (ie, hearing things such as voices that aren't there). Disorganized speech refers to speaking in an incoherent manner and may include expressing illogical thoughts or using made up words. Schizophrenia can also be considered a group or spectrum of related psychotic disorders that have strong familial (ie, genetic), neurophysiological and neurochemical causes. Additionally, schizophrenia can often co-occur with substance abuse problems and depression or mania. In some cases, this combination of symptoms of schizophrenia, depressed mood and mania is diagnosed as schizoaffective disorder.

While psychotic behavior is much less common than depression or anxiety, we can all think of friends, family members, clergy, teachers or other acquaintances that have unusual cognition or thinking, overly rigid or fixed beliefs and even altered perceptual experiences. Any one of these behaviors or cognitions do not necessarily indicate a mental illness and may be difficult to distinguish from those who experience deep spirituality and strong devotion to the faith. In a Catholic context, when these experiences include hyper-religiosity² and/or scrupulosity³ they may be indicative of a psychotic disorder. Consultation with clergy and possible referral to licensed mental health professionals are often indicated in these situations. Indeed, when these thoughts, behaviors and perceptions

² Hyper-religiosity refers to an exaggerated or affected religious zeal.

³ Scrupulosity refers to over conscientiousness with respect to matters of right and wrong, often manifested as an obsession with moral or religious issues and can be associated with obsessive-compulsive disorder.

significantly alter a person's functioning and connection with reality they may be indicative of a psychotic disorder such as schizophrenia.

Risk factors for schizophrenia include genetic and family history. Indeed, there is 10 percent risk of schizophrenia in individuals with at least one first degree biological relative with schizophrenia. The predominant theory of schizophrenia risk is known as the diathesis-stress model which proposes that a biological risk for the disorder (ie, diathesis) is inherited that may be triggered by environmental or other stressors. These stressors may include factors ranging from pregnancy and birth complications, including maternal influenza during pregnancy, as well as exposure to environmental toxins and substance abuse. It is important to note that there is no clear single cause for schizophrenia and current research suggests that it is likely a combination of multiple factors that trigger the diathesis.

Vignette: Kate and Sarah

Kate has been acting differently and after talking to her you have learned that she believes she is being watched by people, hearing voices, and believes she cannot attend her prior community group meetings due to having to be ready for a secret mission she believes she must go on. You (Sarah) are concerned because Kate has started withdrawing from her friend groups and peers.

Sarah : *Hi Kate, I wanted to check in and see if everything is going ok?*

Kate: *I'm not sure, (looks around) I'm tired of everyone watching me.*

Sarah : *Who is watching you Kate?*

Kate: *The people standing over there, I can hear them speaking to me too.*

Sarah: *I understand Kate. Can you tell me if you feel safe here and if you have any thoughts of harming yourself or others?*

Kate: *Yes, I feel ok here and I do not want to hurt myself or anyone, I just want the voices to tell me when I am leaving for my mission.*

Sarah: *I understand and I appreciate you sharing that with me. How long have you been feeling like this Kate?*

Kate: *Hard to say, I'd guess for a few weeks now.*

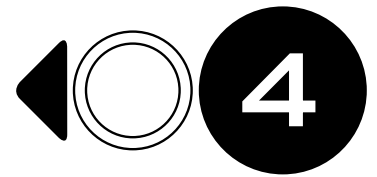
Sarah: You are not alone in feeling like this Kate, if you like I can provide you with resources for information and perhaps someone who knows more about what you may be feeling?

Kate: Yeah that sounds good with me.

Lesson 3 Reflection (optional small group discussion if in a live virtual or in-person setting):

How can one assist a parishioner with a psychotic disorder who may also show signs of hyper-religiosity and scrupulosity?

Considering the importance of early recognition and intervention in cases of schizophrenia and psychotic disorders. How can understanding the signs and symptoms, as demonstrated in the vignette with Kate and Sarah, help in providing timely support and resources to individuals experiencing these mental health challenges?



RECOGNIZING THE SIGNS AND SYMPTOMS OF BIPOLAR DISORDERS

The American Psychiatric Association (2025) defines bipolar disorders as mental health conditions characterized by periodic, intense emotional states affecting a person's mood, energy, and ability to function. These periods, lasting from days to weeks, are called mood episodes. Mood episodes are categorized as manic/hypomanic episodes when the predominant mood is intensely happy or irritable, or depressive episodes, when there is an intensely sad mood or the ability to experience joy or pleasure disappears. People with bipolar disorder generally have periods of neutral mood as well. When treated, people with bipolar disorder can lead full and productive lives. While people without bipolar disorder may also experience mood fluctuations, mood changes that are part of commonly lived experience typically last hours rather than days and are not accompanied by extreme changes in behavior or changes in functioning, such as difficulties with daily routines and social interactions. Bipolar disorder can disrupt a person's relationships with loved ones and cause difficulty in working or going to school.

The bipolar disorders include bipolar I and bipolar II. Bipolar I disorder is characterized by what is known as a manic episode. The manic episode is a period of at least one week when a person's mood is highly elevated or irritable for a period of most days and the person is experiencing very high energy levels. The person also has a decreased need for sleep, increased or faster speech, uncontrollable racing thoughts (or quickly changing topics when speaking), distractibility, increased activity and increased risk or impulsive behavior (e.g., reckless driving, spending sprees and/or sexual promiscuity). During a severe manic episode some people may also experience psychotic symptoms such as disorganized thinking, false beliefs and or hallucinations. A manic episode often requires hospitalization. A person with bipolar I disorder may also experience depressive episodes as well as periods of neutral mood.

Bipolar II disorder is characterized by a major depressive episode and at least one hypomanic episode. Hypomanic episodes are characterized by less severe manic symptoms that last only four days in a row rather than a week. Hypomanic symptoms do not lead to the major problems in daily life that manic episodes typically cause.

Risk factors for bipolar I disorder also include genetic predisposition and family history. The age of onset for bipolar disorders tends to be in the early 20s. Genetic variations are associated with risk, although specific genes implicated for bipolar disorder have yet to be identified.

Childhood trauma, stressful life events and substance abuse can also increase risk of bipolar I disorder. Additionally, ongoing substance abuse can complicate treatment and recovery from bipolar I disorder. Bipolar II disorder shares similar risk factors as bipolar I disorder, but the exact cause remains unknown. As with each of the disorders discussed in this course, people with bipolar I disorder frequently have other mental disorders such as anxiety disorders, substance use disorders, and/or attention-deficit/hyperactivity disorder (ADHD). The risk of suicide is significantly higher among people with bipolar I disorder than among the general population.

Vignette: Jane and Tina

Jane has been experiencing extreme mood swings and periods of depression, mania (think opposite of depression; elevated mood, energy or both, periods of intense emotional and physical activity) as well as periods of normal mood in between these symptoms. You (Tina) are concerned and would like to help Jane.

Tina: *Hi Jane, I wanted to check in and see how you're doing. You've seemed a bit different lately.*

Jane: *I'm not sure, Tina. Sometimes I feel on top of the world, and other times I can't even get out of bed.*

Tina: *I hear you, Jane. Can you tell me more about these feelings? Have you had any thoughts of harming yourself or others?*

Jane: *No, I don't want to hurt anyone, including myself. It's just these mood swings are really intense.*

Tina: *I'm glad to hear that you are feeling safe from harm, Jane. It's important to talk about these things. How long have you been experiencing these mood swings?*

Jane: *It's been going on for a few months now. Sometimes I feel like I am full of energy and confidence that I can do anything, and other times I just feel so low and don't feel like doing anything.*

Tina: *Thank you for sharing that with me, Jane. You're not alone in this. There are many people who go through similar experiences. Would you be open to talking to a professional who can help you manage these feelings?*

Jane: *Yeah, I think that might be a good idea.*

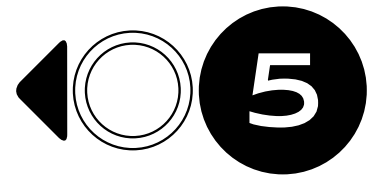
Tina: *Great. I can help you find some resources and connect you with someone who can provide more support. It's important to take care of yourself, and there are people who can help.*

Jane: *Thanks, Tina. I appreciate it.*

Lesson 4 Reflection (optional small group discussion if in a live virtual or in-person setting):

How can one differentiate between normal mood fluctuations and the mood episodes characteristic of bipolar disorders?

Reflect on the key signs and symptoms of bipolar I and bipolar II disorders, how can recognizing these help in providing timely support and intervention?



RECOGNIZING THE SIGNS AND SYMPTOMS OF TRAUMA AND POST-TRAUMATIC STRESS DISORDERS

The word trauma originates from the Greek word *traûma* which means wound. As in the second definition below, this can mean a physical, bodily wound, or as in the first definition above, it can also refer to a psychological wound stemming from a negative or disturbing experience. Just as we all have suffered physical traumas (i.e., cuts, bruises, burns and perhaps even broken bones or surgery) we all suffer emotional traumas. Indeed, injury and suffering is part of life. However, when these injuries occur repeatedly, at critical development periods or sometimes at the hands of trusted adults, loved ones, or those in positions of power, the healing and recovery can be complicated and require additional support.

The American Psychological Association (2025) defines trauma as:

1. any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning. Traumatic events include those caused by human behavior (e.g., rape, war, industrial accidents) as well as by nature (e.g., earthquakes) and often challenge an individual's view of the world as a just, safe, and predictable place.

OR

2. any serious physical injury, such as a widespread burn or a blow to the head.

According to the United State Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), some of the immediate reactions to trauma include numbness and detachment, anxiety or severe guilt, anger, sadness, feelings of unreality or depersonalization as well as feeling a loss of control. Delayed emotional responses to trauma include irritability or hostility, depression, mood instability, anxiety and fear. Long term changes in behavior may also follow such as avoidance of reminders of the traumatic event, social isolation, decreased activity level, increase in high-risk behaviors as well as alcohol and substance abuse. Sometimes a traumatic event may lead to a sense that the person's life or future is curtailed or shortened.

When an individual witnesses or experiences a traumatic event in which they believe that there is a threat to life or physical integrity and safety and experiences fear, terror, or helplessness; a psychologist, psychiatrist or

physician may diagnose post-traumatic stress disorder (PTSD). This disorder is characterized by (a) reexperiencing the trauma in painful recollections, flashbacks, or recurrent dreams or nightmares; (b) avoidance of activities or places that recall the traumatic event, as well as diminished responsiveness (emotional anesthesia or numbing), with disinterest in significant activities and with feelings of detachment and estrangement from others; and (c) chronic physiological arousal, leading to such symptoms as an exaggerated startle response, disturbed sleep, difficulty in concentrating or remembering, and guilt about surviving the trauma when others did not. This disorder may be acute (ie, lasting less than 4 weeks), chronic or delayed (ie, occurring months or years after the event).

The primary risk factor for post-traumatic stress disorder (PTSD) is the experiencing of a traumatic event as described above. Having a prior history of trauma also elevates risk for PTSD, especially repeated trauma beginning in childhood. Other mental health conditions such as depression and anxiety also increase vulnerability to PTSD. Social and environmental factors including lack of social support, poverty and stressful life events can increase risk of PTSD. Additionally, biological factors such as genetics, brain chemistry and sex (ie, women are somewhat more likely to develop PTSD) can also increase PTSD risk. Finally, psychological factors such as personality traits such as neuroticism and lower intelligence may also increase PTSD risk.

Vignette: Chris and Alexis

Chris, a military veteran, is experiencing feelings of intense fear and helplessness related to his experiences in combat while in the Army. He has frequent dreams of his time in the military as well as occasional flashbacks and memories of his traumatic experiences in service. You (Alexis) have noticed Chris has been acting differently such as withdrawing from attending service as well as seeming irritable and easily startled. You (Alexis) intervene by assessing for risk of harm; listening non judgmentally; giving reassurance and information; encouraging seeking appropriate professional help; and encouraging self-help and other support strategies.

Alexis: Hi Chris, I wanted to check in and see how you're doing. I've noticed you seem a bit different lately.

Chris: I'm not sure, Alexis. I've been having these intense dreams and flashbacks about my time in the military. It's really hard to deal with and I haven't been getting much sleep.

Alexis: I hear you, Chris. Can you tell me more about these experiences? Have you had any thoughts of harming yourself or others?

Chris: No, I don't want to hurt anyone, including myself. It's just these memories are so vivid and scary.

Alexis: I'm glad to hear that you are feeling safe from harm, Chris. It's important to talk about these things. How long have you been experiencing these flashbacks and dreams?

Chris: It's been happening for a while now. Sometimes I feel like I'm right back in those moments.

Alexis: Thank you for sharing that with me, Chris. You're not alone in this. Many people who have been through similar experiences feel the same way. Would you be open to talking to a professional who can help you manage these feelings?

Chris: Yeah, I think I can be open to that if it'll help.

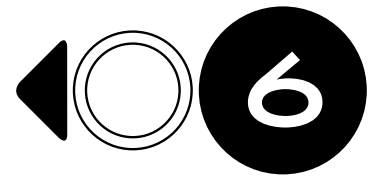
Alexis: Great. I can help you find some resources and connect you with someone who can provide more support. It's important to take care of yourself, and there are people who can help, you are not alone in getting help and support.

Chris: Thanks, Alexis. I appreciate it.

Lesson 5 Reflection (optional small group discussion if in a live virtual or in-person setting):

What are some normal emotional responses to trauma? What are some signs of Post-Traumatic Stress Disorder (PTSD)?

How can recognizing avoidance behaviors and diminished responsiveness help in accompaniment for individuals who have experienced trauma?



(PART I): INTRODUCTION TO PSYCHOLOGICAL FIRST AID

In this lesson we will learn about psychological first aid (PFA) and why PFA is beneficial in Catholic parishes and communities. This lesson includes information about the impact of stress and distress on the brain, body, and spirit; the 3 principles of PFA: Look, Listen, and Link; as well as the importance of self-care in offering PFA.

Psychological first aid (PFA) is an evidence-informed approach that is built on the concept of human resilience. It aims to reduce stress symptoms and assist in a healthy recovery if someone is experiencing a mental health challenge, or following a stressful event, natural disaster, or in humanitarian settings (Minnesota Department of Health, 2025).

In this training, we will learn more about and aim to practice the three PFA action principles of “Look, Listen, and Link” (World Health Organization, 2011). This Catholic mental health ministry (CMHM) model of PFA addresses the spiritual needs of those in distress and is for use in a Catholic parish or community setting. For those who find comfort and meaning in their Catholic Faith, spiritual accompaniment and support offered through the CMHM model of PFA is invaluable in helping them to thrive as a whole person: mind, body, and spirit.

PFA is becoming increasingly popular and recognized more and more as an effective way of helping people in distress all over the world. Different models are used by different organizations, but the aim of PFA is the same, to empower people with the knowledge and skills to be able to provide PFA to people in distress. The same basic principles are used in approaching someone in distress, assessing what help the person needs together with him or her, and helping them to access this help.

PFA follows expert consensus on guidelines for behavioral health and post disaster interventions. These include:

- Be proactive, prepared, and pragmatic
- Be flexible and match services across recovery time
- Address the resilience of individuals and community
- Do no harm
- Utilize local resources
- Integrate with community resources

- Address the spectrum of behavioral health recovery needs

What PFA Is (And What it is Not)

Psychological first aid is a set of skills that you can use to cope with distressing situations and events. You can use psychological first aid skills to deal with your own experiences and to support others who are in distress.

Psychological first aid aims to reduce stress symptoms and to assist in a healthy recovery if someone is experiencing a mental health challenge or following a stressful event such as a natural disaster.

Psychological first aid involves recognizing when someone is in distress and taking action to help. What actions you take depends on the situation and what help the person needs. Your response is likely to differ every time you offer help.

Psychological first aid is not clinical mental health care. Those offering PFA do not diagnose, they do not prescribe medication, and they do not offer or prescribe psychotherapy or clinical counseling.

PFA CAN BE	PFA IS NOT
Comforting someone who is in distress and helping them feel safe and calm	Something only professionals do
Listening to and assessing someone's needs and concerns	Diagnosing or prescribing medication for treating mental illness
Helping to protect people from further harm	Professional counseling or therapy
Providing emotional and spiritual support and prayer	Encouraging a detailed discussion of what has caused someone distress
Potentially helping people to access information, services, and support for immediate basic needs	Fixing someone's mental illness or distress

Why PFA is Beneficial in Catholic Parishes and Communities

The Catholic Mental Health Ministry (CMHM) model of PFA addresses the spiritual needs of those in distress. For those who find comfort and meaning in their Catholic Faith, spiritual accompaniment and support offered through the CMHM model of PFA is invaluable in helping them to thrive as a whole person: mind, body, and spirit. Multiple levels of care are needed to meet the global mental health crisis. Many communities have significant obstacles to accessing clinical care. These may include a lack of mental health clinicians, economic barriers to clinical care, and stigma around seeking clinical care, among others.

Even in those communities where high-quality and accessible clinical care is readily available, some individuals do not need professional care but will still benefit from non-clinical, community support as they live with a mental health challenge. For those who do receive clinical care, additional support offered by members of that person's community can be a significant boon to their recovery process and quality of life.

PFA is one tool that a Catholic parish or community can use in meeting this need for community and spiritual support. As shown in Figure 1 below, a smaller subsection of people will use clinical/professional mental health care services, many more can use and can benefit from community mental health support. For Catholic parishes and communities, community mental health support imbued with Catholic faith practices can offer an additional level of spiritual support.

Figure 1. Why is it good for MH ministers to learn PFA?



The CMHM Model of PFA can benefit our Catholic communities by giving our members the information and confidence they need to be willing to step forward and offer help. PFA will assist our Catholic community members to:

- notice someone may be suffering and have an idea of how to respond
- offer someone the gift of our time and presence, to offer accompaniment
- offer someone the love of Christ
- know our role as mental health ministers/Catholic community members and know which level of care is appropriate for us to offer

- know when someone's need is beyond our scope and how to potentially link someone to additional help or supports:
 - local resources to help meet basic needs
 - clergy
 - mental health, medical, or safety professionals

There are many situations that might lead someone to need support offered by the CMHM model of Psychological first aid. In many mental health ministries, this may mean offering ongoing accompaniment and spiritual support for someone living with a mental illness or their loved ones. PFA can also be beneficial for a person or in communities that have experienced a traumatic or distressing event such as a natural disaster or large-scale violence such as a mass shooting or war. PFA can be beneficial in any situation that causes someone to experience stress or distress.

When a person experiences frightening or distressing events, they react with their bodies, thoughts, and feelings. They may experience faith and spiritual reactions too. This is normal. All people react when they go through something stressful and difficult. Most people recover from difficult experiences by themselves or with the help of friends, family, or others.

One aspect of PFA is knowing some common reactions to distressing events and how to help people cope with these reactions. Offering PFA can help people to better cope with their distress, and in this way it can help to reduce negative impacts.

The Impact of Stress and Distress on the Brain, Body, and Spirit

Stress is a state of pressure or strain that takes place in many different situations. It can be caused by any change – positive or negative. Stress is an ordinary part of everyday life. It is positive when it makes a person perform well, for example, in a test or exam. However, stress can also be negative and lead to distress and crisis. (Minnesota Department of Health, 2025). How someone reacts to stress and distress depends on many factors, some of which include whether they have experienced something similar before, what kind of support they have, their physical health, their pre-existing state of mental health, and their cultural background. Most people who experience distressing or traumatic events have common reactions and recover well, especially if they can restore their basic needs and receive support from people around them. Others may have very strong reactions and need more specialized help. We will discuss this in more detail later.

Chronic illness, including chronic mental illness, is different than a single, acutely distressing event and those who live with (or who care about someone who lives with) a chronic illness may benefit from long term, ongoing support from our mental health ministries (MHMs) and Catholic communities.

Common physical reactions to stress and distress are sleep difficulties, gastrointestinal problems (diarrhea, cramps), stomach upset, nausea, elevated heart rate, blood pressure and blood sugar, and with extended stress one may experience suppression of immune system functioning

Common emotional reactions to stress and distress are fear and anxiety, sadness and depression, anger and irritability, numbness, withdrawal, or disconnection, a lack of involvement or enjoyment in favorite activities, a sense of emptiness or hopelessness

Common behavioral reactions to stress and distress are family difficulties, substance abuse, overprotection of family, keeping excessively busy, isolating oneself from others, being very alert at times, startling easily, avoiding places, activities, or people that are distressing or that bring back distressing memories

Common cognitive reactions to stress and distress are difficulty concentrating, difficult memories, recurring dreams or nightmares, flashbacks, difficulty communicating, difficulty following complicated instructions

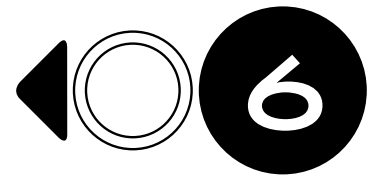
Common faith and spiritual reactions to stress and distress are reliance upon faith, questioning values and beliefs, loss of meaning, directing anger toward God, cynicism

There are experiences that can help us to better cope with the distress caused by living with a mental illness, supporting a loved one with a mental illness, or caused by any of the many potential causes of distress in our communities. These helpful experiences can include:

- Having someone listen and be present, having the option to tell our story
- Identifying, labeling, and expressing our emotions
- Regaining some sense of mastery and control over our life
- Processing the distressing experience or circumstances in the context of our Catholic faith
- Experiencing the love and support of God and our Catholic faith community
- Whether someone is experiencing a limited or acute distress response, or is living with a chronic illness, through offering PFA we hope to help an individual move toward some improved level of relief or recovery.

Lesson 6-I Reflection (optional small group discussion if in a live virtual or in-person setting):

1. Think of a time in your life when you experienced something that was difficult to handle and led to distress.
2. How did your experience relate to the information offered about common reactions to stress and distressing circumstances? Which reactions did you experience?
3. Did someone respond to you in ways that were not helpful? Please explain.
4. Was anyone helpful to you when you had this experience? If yes, what did this person(s) do or say that was helpful?



(PART 2). THE 3 PRINCIPLES OF PFA: LOOK, LISTEN, AND LINK

The goal of using PFA in our Catholic parishes, communities, and mental health ministries is to help people rebuild resilience and hope. As Catholics, we are people of hope, and we are called to share hope – especially during challenging situations. Our intention in offering PFA is so the person benefiting from our offer of care will:

- Get needed support, comfort, and prayer from their Catholic community
- Feel that they have some level of control over their present
- Have hope that they can experience some relief or achieve some level of recovery
- Potentially be connected to community resources that may help address their most pressing needs

In offering PFA we do NOT diagnose mental illness, nor offer any other type of mental health clinical care, nor offer advanced spiritual care.

The action steps for offering PFA are Look, Listen, and Link. They are easy to remember and are useful prompts in providing PFA to someone in distress.

The order of these three action steps may be different and may take place in different ways and in different sequences depending on the situation. At times some of the action steps may take place simultaneously.

Some people may need more help than can be provided by PFA. Part of learning psychological first aid skills is learning how to recognize when someone needs other types of help and knowing who to contact if the person in distress needs more help than we are qualified to give.

We will talk more about this later in the training, but whenever you are offering PFA, it is critical to remember that everyone's physical, emotional, psychological, and spiritual safety is paramount. With everyone's safety as a top priority, keep in mind the following:

- Do not engage in PFA if it will put yourself or others' safety at risk
- If you are in any doubt, consult someone with more knowledge or experience
- Contact professional mental health professionals or safety professionals if necessary

LOOK

The first step is to “Look”, to observe. Does someone seem to be struggling with a mental health challenge, or struggling as they care for someone with a mental health challenge? Does anyone need to be connected with immediate safety professionals or professional mental health support? Is someone seeking support from your mental health ministry? In the case of a disaster or traumatic event in your community, you could look for:

- information on what has happened and is happening, and who may need help
- any safety and security risks, any physical injuries
- any immediate basic and practical needs
- emotional reactions people may be experiencing

If, based on your initial observations, you decide to practice the CMHM model of PFA, it is important to be thoughtful about how you will engage or approach, and how you will potentially offer care. We will go into more detail about this in the “Listen” portion of this training.

The “Look” portion of the action plan is continuously practiced throughout PFA. If you decide to practice the “Listen” step and/or the “Link” step, it is important to continue observing how your engagement with the person is progressing so that you can maintain everyone’s safety and potentially alter your approach.

LISTEN

The second action principle, “Listen”, refers to the way you communicate with someone. The “Listen” step begins from the very first moment you approach and interact with the person in distress.

It is crucial that you follow the lead of the individual in discussing what happened or what their struggle is. Avoid asking for in-depth descriptions of traumatic experiences and remember that individuals should not be pressed to disclose details of any trauma or loss if they do not wish to share them.

“Listen” refers to how the PFA provider:

- approaches someone, or engages with a person who has approached him or her
- introduces oneself, if they do not already know the person
- pays attention and listens actively, listens to someone’s needs and concerns
- accepts others’ feelings and listens nonjudgmentally
- acts as a calming and compassionate presence

If you do not yet know the person with whom you will be interacting, how will you introduce yourself? It may be helpful to engage with different people with some consideration of their culture and context. For example, you might engage with a man or a woman, or with an older person or a younger adult in different ways.

When we offer PFA to someone who is in distress, we can practice communication skills that are more helpful. Some of the ways we can practice being more helpful are:

- Planning to talk privately, if possible, at a mutually convenient time in a place free of distractions
- Being aware that a person may not open up to you until they are sure that you care
- Knowing that a person may downplay what they are going through to avoid upsetting you or they may not recognize there is a problem
- Letting the person know you are ready when they are — not pressuring them to talk right away
- Offering statements or questions that are open-ended, inviting the person to share more
- Using a nonjudgmental tone.
- Using “I” statements, these can feel less threatening than “you” statements
- Sharing that you are concerned
- If you don’t know an answer, saying “I’m not sure what to do, but I may be able to help you find someone who does.”

In PFA, we do not simply listen, we employ the practice of active listening. Active listening is an attitude and a set of skills that can be helpful to someone in distress. It is more than sitting passively while someone speaks to you. Active listening is both verbal and nonverbal.

Non-verbal active listening can entail:

- Using body language, such as eye contact, facial expressions, gestures
- Being aware of space, such as how you distance, position, and orient yourself in relation to the other person
- Taking the time needed to understand what the other person is going through
- Being comfortable with and allowing periods of silence

Verbal active listening can entail:

- Asking questions to improve understanding (not to judge), but not interrupting the person while they are speaking
- Restating and summarizing what the person has said in your own words to ensure understanding
- Being encouraging and positive
- Accepting others’ feelings and trying to avoid judging a person’s reactions
- Offering to pray together

When we wish to offer PFA and hope to offer comfort, we may wonder, “What is the right thing to say?”. We may worry that we will do harm by saying the wrong thing to someone who is in distress.

It is the case that some things may be less helpful to say to someone who is in distress. Here are some examples:

- Let’s talk about something else.
- You should just pray more.
- It is God’s will.
- I know exactly how you feel.
- You’ll feel better soon.
- You did everything you could.
- You are lucky to be alive.
- You need to relax.

Saying some of these things can make someone feel their distress is being dismissed. These statements may shut down someone’s willingness to talk and so may hamper our opportunity to be a helpful presence. Additionally, some of these statements may not be true.

We want to offer comfort, but we must always offer the truth and not false platitudes. Do not overpromise, instead be honest about what you are and are not able - or willing - to do for the person. While we express hope in our interactions, we must also acknowledge the reality of a person’s distress and not minimize or dismiss their experience through over-spiritualization.

Some examples of over-spiritualization are to say to someone who is in distress, “You just need to have more faith”, or “You just need to go to Mass and to the Sacrament of Reconciliation more often.” Engaging in practices that increase our faith likely will benefit us, but these practices by themselves almost certainly will not cure a chronic mental illness or restore someone’s home if it has been damaged by a hurricane or flood.

Examples of Active Listening

Practice Active Listening:

1. Separate into pairs
2. Think of a problem you feel comfortable talking about
3. Practice (6 minutes total)
 - Person A tell Person B about your (person A’s) problem, Person B practices active listening
 - Switch roles Reflections for discussion:

As the speaker consider the following:

- Did the listener pay attention to you?
- How could you observe that?
- How did the listener make you feel with his or her attitude of listening?

As the listener consider the following:

- How easy or difficult was it to listen? Why?
- What did you do to show active listening?

When we wish to offer PFA and accompany those with severe, untreated mental illness there is no simple answer to how best to help people who are living in such a situation. A first question that can be helpful to ask is, “Do you have housing?” It can be difficult to accompany someone toward recovery from their distress if they are not in stable housing. For this reason, it can be helpful for your parish or community to become familiar with local housing and social service agencies to help someone find housing. It is amazing how people can recover and stabilize once they are in stable housing.

Sometimes a person will refuse to cooperate in the process of obtaining housing or in getting other care. In these cases, there is little we can do beyond treating that person with dignity, offering to pray with them, and welcoming them to church to worship with us. These actions are still a great gift. In humbly accepting that we cannot fix everything, we are comforted knowing that all people are in the hands of a loving God.

In review, when offering a calm and supportive presence as you practice the “Listen” step of PFA, remember to:

- Meet the person where they are
- Don’t push for information
- Be flexible and supportive

Most often, people just need someone to talk to about their experience. They need someone to care, to really listen, to pray or cry with. They need someone to be present with them.

LINK

In the “Link” step of the PFA action plan, we listen as someone shares their needs and concerns and potentially help the person to connect to other resources. This step may not be necessary, someone may simply wish to have

the opportunity to be with and to talk with you. If someone does not want additional help in the form of connections to resources, do not impose it.

Potential exceptions to this, only in cases where a person(s) may be in immediate critical danger, will be discussed later in the training.

In the CMHM model of PFA, prayer is an important resource with which we can link someone. In knowing how best to offer prayer during PFA, we must employ both the “Look” and the “Listen” steps of the action plan.

If the person we are engaging with does not seem open to prayer, or if it seems this is not the right time to talk about prayer with this person, we always have the option to pray silently for them. We can include that person in our own prayers, add their needs to our community prayers (maintaining confidentiality), and in any other available way lift up their needs and intentions.

If it seems appropriate, we can let the person know they and their intentions will be in our prayers. Additionally, if it seems appropriate, we can ask the person if they would like to pray together with us. We might pray (out loud or silently) the Rosary, the Stations of the Cross, the Lord’s Prayer, or a prayer that rises out of our hearts. Remember, in the “Link” portion of the action plan, only give accurate information about what you and/or your community may be able to offer. Do not offer platitudes, false hope, or false promises.

Particularly in our parish communities, we may be offering PFA to someone who will benefit by being “Linked” to someone with more spiritual knowledge or authority than we possess. If the person seems to be in grave spiritual distress or confusion, we can “Link” that person with a priest, other clergy, or a trained spiritual advisor. Anytime someone presents a situation that is beyond our PFA spiritual support scope, it is vital that we offer to connect them with a clergy person or other trained spiritual advisor and not try to help in ways in which we are unqualified.

Similarly, anytime someone presents a situation that is beyond our PFA psychological and emotional support scope - it is our role to offer to connect them with a mental health clinician or other trained mental health or medical professional. It may be appropriate to “Link” people with social or clinical support in your region.

Anytime a PFA provider is confused about or unsure of how to offer care to someone, it is our role to connect with others who know more. When in doubt, consult.

When might additional support be needed, beyond what one can provide through PFA? It is cause for concern if someone displays or discloses some of the following:

- Unresponsiveness to verbal questions or commands
- Significant withdrawal - change in behavior
- They have been harmed or abused and thus may need protection and medical care

- They have not been able to sleep for the last week, or they are confused and disorientated – unable to focus
- They have no food, water or a place to sleep
- They are so distressed that they are unable to function normally and care for themselves by, for example, not eating or keeping clean despite food and washrooms available
- A loss of control over their behavior and behave in an unpredictable or destructive manner
- A threat to harm themselves or others, expresses suicidal ideation (more on this later in the training)
- A new habit of excessive use of drugs or alcohol

For those who need more care than we can provide through PFA, it is recommended that your community maintain a list of crisis and other clinical resources, with contact information. This list should include safety and crisis numbers. For example, in the USA 911 is the general emergency number and 988 is the mental health crisis number. If a person appears to be an immediate danger to themselves or others, these crisis or emergency personnel should be contacted immediately.

At times, someone may be so distressed that their behavior may become challenging. They may refuse to follow directions or stated rules and social norms, they may experience loss of control or become agitated, they may even become threatening.

Please keep in mind, this behavior is usually not personal. This may be a person's reaction to a highly distressing situation, or it could be related to a mental illness. It likely has nothing to do with you.

If someone is agitated or behaving in a manner that is disruptive to others, and if it is safe to do so, attempt to de-escalate. As Catholic Christians we strive to remain kind and compassionate in all our encounters with others. Being kind, calm, and compassionate can also help to de-escalate someone's distress and challenging behaviors. Other points to keep in mind in these situations:

- Be sure everyone involved is safe and has a clear exit from the area
- If anyone's safety is at risk, call an appropriate mental health or safety professional
- Express patience and compassion in your words and manner, reflect the love of Jesus
- Speak in a calm and soft tone of voice, using simple language and short sentences
- Remain courteous and respectful, do not argue or threaten
- Remind the person you are there to help them and that they are safe, if it is true
- Do not argue with someone who may be experiencing hallucinations or delusions
 - Do not pretend that the delusions or hallucinations are real, instead try to relate to the person's feelings
 - If they are experiencing frightening delusions or hallucinations, try to empathize

with the emotions of fear and worry, and offer to pray with them

- If they are experiencing religious delusions, you might say that it is good that they are close to God
- If the person's behavior in a Church setting is disruptive but not threatening, you could quietly talk to the person and invite them either to the back of the Church/room or outside to talk
- If the situation cannot be resolved, if de-escalation is not possible, call an appropriate professional or law enforcement if necessary

What if someone threatens to harm themselves, what if he or she expresses suicidal ideation? If someone is expressing suicidal ideation contact a mental health professional right away or call a crisis or safety line.

If you worry someone may be experiencing suicidal ideation, but you are not sure, ask them directly. Ask: "Are you thinking about suicide?" or "Are you thinking about killing yourself?" It is a myth that asking someone about suicide will put the idea of suicide into their head.

Asking these questions directly gives the person the opportunity to share if they are feeling this way, and having a conversation about this can bring them relief. Having this conversation in a clear and direct manner can allow you to connect the person to potentially life-saving help.

In the "Link" step of the PFA action plan, remember, if you are in doubt about whether you can offer the care that seems to be needed by someone, consult others. You may need to consult someone with more spiritual knowledge and authority than you or you may need to consult someone with more physical health or mental health knowledge and expertise than you.

The way we can be most helpful to others in offering the CMHM model of PFA is to acknowledge and stay within the limitations of what we are called to do. We are called to listen, to be a compassionate presence, to accompany, and to pray. If someone needs more care and support than this, our role is to "Link" them to those who have the specialized or professional knowledge and training required. . PFA is not used to diagnose mental illness, to offer any other type of clinical mental health care, nor to offer advanced spiritual care.

The Importance of Self-Care in Offering PFA

Offering Psychological First Aid to someone in distress can be taxing. It takes effort and energy to practice the "Look, Listen, and Link" action steps. Particularly if someone shares very distressing details about their situation or suffering with us, it can make an impact. For these reasons, we must attend to our own self-care when offering – or considering offering – PFA.

Our first opportunity for practicing self-care is to pause, even before the “Look” action step, and ask ourselves if we have the time, the energy, and the health to be able to offer PFA to someone. It is best for everyone involved for us to be self-aware, and to be sure we are in the right place personally, to be able to offer this gift.

Some components to keep in mind as part of your self-care are:

- Check your own readiness
- Understand your role and stay within your scope of care
- Engage your own resiliency and your own support system
- Use support resources that may exist in your community
- Expect to need a recovery period after offering PFA

Providing Psychological First Aid to people in distress can be difficult, both physically and emotionally. It can be difficult to be present to, and to communicate and pray with, people in distress. Often, even though you strive to offer the best help you can, you may still be left with a feeling that you did not do enough.

Psychological First Aid has limitations, just like physical first aid. It is help that can reduce someone’s distress, but PFA on its own is unlikely to be able to address or ‘fix’ all of a person’s challenges. This is why “Link”ing to other sources of help is such an important PFA skill. You are not expected to know about all the resources and support that may be available, or how to handle any kind of reaction on your own. When you are in doubt, consult someone with more expertise.

Remember, in offering PFA we are called to “Look, Listen, and Link”. We are not called to be saviors; Jesus Christ already fills that role.

Leaning on your other mental health ministry and/or Catholic parish and community members, and the other self-care supports you have, is an important component in your PFA self-care.

Consider some of these practices as part of your self-care routine:

- Share thoughts with people you trust
- Eat a healthy diet and avoid coping with substances
- Seek opportunities for gratitude
- Maintain a regular routine and good sleep habits
- Be physically active and enjoy time outdoors
- Access the sacraments as well as other spiritual and meditative practices

It is also critical to set and maintain boundaries. Know what you are and are not comfortable sharing or offering to someone to whom you are offering PFA. It is necessary to take care of yourself, to keep healthy and well, in order to be able to help others.

Lesson 6-II Reflection Questions (optional small group discussion if in a live virtual or in-person setting):

What are your top takeaways from the content covered?

1. What new information have you learned?
2. Have you gained confirmation of something you had already learned or experienced? If yes, please explain.
3. What next steps will you take as a result of what you have learned?

COURSE ASSESSMENT

Directions: Select the best answer to each question from the listed options. The answer key is provided on the page following the assessment.

1. What ethical considerations should lay ministers be aware of when serving on a Mental Health Ministry Team?
 - A. *Lay ministers should provide mental health treatment to parishioners.*
 - B. *Lay ministers should adhere to the diocese's Standards of Conduct and maintain appropriate ministerial boundaries.*
 - C. *Lay ministers should ignore any professional ethical and legal obligations they may have.*
 - D. *Lay ministers should involve themselves in individual accompaniment for parishioners.*

2. Why is it important for mental health ministers to have the right motivation for entering lay ministry?
 - A. *To feel superior to others and boost their self-esteem.*
 - B. *To ensure they can provide professional mental health treatment.*
 - C. *To help others selflessly out of love for God, as exemplified by St. Francis and St. Clare.*
 - D. *To avoid any form of emotional involvement with parishioners.*

3. What characterizes anxiety as a mental illness rather than a normal human experience
 - A. *Feeling nervous or jittery before a big event*
 - B. *Persistent feelings of apprehension and body tension dominating most days*
 - C. *Occasional feelings of sadness*
 - D. *Experiencing joy and excitement most days*

4. Which of the following is a risk factor for developing depression?
 - A. *Regular physical exercise*
 - B. *High self-esteem*
 - C. *Genetics (ie, heredity as well as genetic vulnerabilities that may influence neurotransmitter function)*
 - D. *Positive social interactions*

5. Which of the following is a common symptom of schizophrenia?
 - A. *Visual and auditory hallucinations*
 - B. *Consistent and coherent speech*
 - C. *Stable and rational beliefs*
 - D. *Normal cognitive processing*

6. What does the diathesis-stress model propose about the risk of schizophrenia?
 - A. *Schizophrenia is caused solely by genetic factors.*
 - B. *Schizophrenia is unrelated to family history.*
 - C. *Schizophrenia is caused by a single environmental factor.*
 - D. *A biological risk for schizophrenia is inherited and may be triggered by environmental or other stressors.*

7. What characterizes a manic episode in Bipolar I disorder?
 - A. *Stable mood and energy levels*
 - B. *Mild mood changes lasting a few hours*
 - C. *Highly elevated or irritable mood lasting at least one week, with high energy levels*
 - D. *Consistent feelings of sadness and low energy*

8. Which of the following is true about people with Bipolar I disorder?
 - A. *They rarely have other mental disorders.*
 - B. *They do not experience depressive episodes.*
 - C. *Their risk of suicide is lower than the general population.*
 - D. *They frequently have other mental health disorders such as anxiety, substance use disorders, and ADHD.*

9. Which of the following is NOT a long-term behavioral change that may follow a traumatic event?
 - A. *Avoidance of reminders of the traumatic event.*
 - B. *Social isolation.*
 - C. *Increased activity level.*
 - D. *Alcohol and substance abuse.*

10. What is a primary risk factor for developing post-traumatic stress disorder (PTSD)?
- A. *Experiencing a traumatic event.*
 - B. *Regular physical exercise.*
 - C. *Positive social interactions.*
 - D. *Stable and supportive childhood.*
11. Who should be trained in, and practice, the CMHM model of Psychological First Aid (PFA)?
- A. *Only members of the clergy*
 - B. *Only professional mental health clinicians*
 - C. *Only medical professionals*
 - D. *Any adult can be trained in, and practice*
12. In the CMHM model of Psychological First Aid, we are trained to do which of the following:
- A. *Diagnose mental illnesses*
 - B. *Treat mental illnesses*
 - C. *Look, Listen, and Link*
 - D. *Give advice about medications or therapies for mental illness*
13. The CMHM model of Psychological First Aid is one tool that a Catholic parish or community can use to offer community and spiritual support for those who are affected by mental health challenges.
- A. *True*
 - B. *False*
14. How many action steps are included in the CMHM model of Psychological First Aid?
- A. *Two*
 - B. *Three*
 - C. *Five*
 - D. *None of the above*

15. When offering the CMHM model of Psychological First Aid, you should tell a person anything they wish to hear and that makes them feel better, whether it is true or not.
- A. *True*
 - B. *False*
16. When engaging in Active Listening, these are some practices to include:
- A. *Sharing that you are concerned*
 - B. *Interrupting to share about a similar experience in your life*
 - C. *Offering statements or questions that are open-ended, inviting the person to share more*
 - D. *A and C*
 - E. *All of the above*
17. Every person has gifts to be shared, gifts needed in our Catholic communities, regardless of their experience with mental illness.
- A. *True*
 - B. *False*
18. When should the “Link” action step be used?
- A. *When someone has a spiritual problem that would benefit from a clergyman’s advanced knowledge and training*
 - B. *When someone has a psychological or emotional problem that would benefit from a certified/licensed/clinical mental health or medical professional’s advanced knowledge and training*
 - C. *When someone has basic unmet needs such as for food or housing that other ministries or agencies may be able to supply*
 - D. *When someone is in danger*
 - E. *All of the above*
19. Over-spiritualization can occur when a person with a mental illness is told that his or her mental illness could be cured if he or she would “Just have more faith”. This could result in someone feeling that their experience of their mental illness is being minimized or dismissed.
- A. *True*
 - B. *False*

20. What are some components of your recommended self-care when offering the CMHM model of Psychological First Aid?
- A. *Maintain a regular routine and good sleep habits*
 - B. *Eat a healthy diet and avoid coping with substances*
 - C. *Avoid setting and maintaining boundaries*
 - D. *A and B*

ANSWER KEY

1. Correct answer: B
2. Correct answer: C
3. Correct Answer: B
4. Correct Answer: C
5. Correct Answer: A
6. Correct Answer: D
7. Correct Answer: C
8. Correct Answer: D
9. Correct Answer: C
10. Correct Answer: A
11. Correct Answer: D
12. Correct Answer: C
13. Correct Answer: A
14. Correct Answer: B (ie, Look, Listen, and Link)
15. Correct Answer: B (False. One should only give accurate information about what you and/or your community may be able to offer. Do not offer platitudes, false hope, or false promises.)
16. Correct Answer: D
17. Correct Answer: A
18. Correct Answer: E
19. Correct Answer: A
20. Correct Answer: D

REFERENCES

- American Psychiatric Association (2025). *What are bipolar disorders?*
https://www.psychiatry.org/patients-families/bipolar-disorders/what-are-bipolar-disorders#section_0
- American Psychological Association. (2018). *APA dictionary of psychology*.
<https://dictionary.apa.org>
- Association of Catholic Mental Health Ministers (2025). *Listen with the ear of the heart*.
https://learning.catholicmhm.org/home.aspx?pagename=ext_product_cmhm&PID=118943
- California Catholic Conference. (2018). *Hope and healing: A pastoral letter from the Bishops of California on caring for those who suffer from mental illness addressed to all Catholics and people of goodwill*. Retrieved from
https://www.cacatholic.org/hope_and_healing
- Callahan, W. J. & Martinez, P. (Eds.). (2023). *Catholic mental health ministry: Guidelines for implementation (2nd Ed.)*. University of San Diego.
- Housel, J. (2023). Mental health ministers self care & continuing education. In W. J. Callahan & P. Martinez (Eds.), *Catholic mental health ministry: Guidelines for implementation* (2nd ed., pp. 155-166). University of San Diego.
- Minnesota Department of Health. (2025). Psychological First Aid: A Minnesota Community *Support* Model. [PowerPoint slides].
- National Council for Behavioral Health. (2015). *Mental health first aid USA* (1st ed.).
- Roman Catholic Diocese of San Diego. (2025). *Mental health ministry*. San Diego Catholic. Retrieved January 10, 2025, from Mental Health Ministry - Catholic Diocese of San Diego
- Substance Abuse and Mental Health Services Administration. (2014). *Concept of trauma and guidance for a trauma informed approach*.
<https://www.nctsn.org/resources/samhsas-concept-of-trauma-and-guidance-for-a-trauma-informed-approach>
- World Health Organization. (2008). *Task shifting: Global recommendations and guidelines*.
https://iris.who.int/bitstream/handle/10665/43821/9789241596312_eng.pdf
- World Health Organization. (2011). *Psychological first aid: Guide for field workers*.
<https://www.who.int/publications/i/item/9789241548205>

