

*Preventing Suicide: A Handbook
for Pastors, Chaplains and
Pastoral Counselors*

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Sobering Statistics on Suicide

Suicide is a national health problem. For every highly publicized story, thousands take their own lives in what can only be described as a tragedy. While the numbers below paint a grim picture, awareness of the problem is an important first step toward prevention.

- Throughout the developed world, self-harm is now the leading cause of death for people age fifteen to forty-nine, surpassing all cancers and heart disease.
- Every year since 1999, more Americans have killed themselves than the year before.
- In 2010, over thirty-eight thousand Americans took their lives.
- According to data from the National Survey on Drug Use and Health from 2008 to 2012, 8.6 million adults aged eighteen or older had serious thoughts of suicide in the past year.
- The majority of completed suicides in America involve firearms, and access to firearms is associated with a significantly increased risk of suicide.
- Over 90 percent of people who die by suicide have been diagnosed with mental illness.
- Access to mental health professionals is worse than for other types of doctors: 89.3 million Americans live in federally designated mental health professional shortage areas, compared to 55.3 million Americans living in similarly designated primary care shortage areas and 44.6 million in dental health shortage areas.
- The National Suicide Prevention Lifeline is a network of 163 crisis centers in forty-nine states. In the United States, call 1-800-273-8255.

Statistics compiled from the following sources:

Tony Dokoupil, "The Suicide Epidemic," Newsweek, May 23, 2013

Sarah Kliff, "Seven Facts about America's mental health-care system," Washington Post, December 17, 2012

American Foundation for Suicide Prevention, afsp.org

National Alliance on Mental Illness, nami.org

National Survey on Drug Use and Health, nsduhweb.rti.org

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Karen Mason (PhD, University of Denver) is associate professor of counseling and psychology at Gordon-Conwell Theological Seminary and a psychologist working in the mental health field since 1990. Before teaching at Gordon-Conwell, she managed the Office of Suicide Prevention for the Colorado Department of Public Health and Environment. She also delivers services to clients in a private practice. A member of the American Psychological Association, Mason is the author of *When the Pieces Don't Fit: Making Sense of Life's Puzzles*.

Suicide is an issue in the church: What can we do about it?

Many pastors, chaplains and pastoral counselors play a vital role as agents of hope to people who are struggling, but most of them feel overwhelmed and unprepared to prevent suicides. Informed by her work as a psychologist, Karen Mason's new guide, *Preventing Suicide*, will help proactive pastors find the tools and resources to work with suicidal individuals.

What made you want to write a book for pastors about the crisis of suicide?

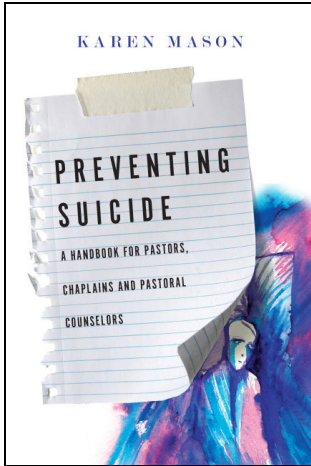
Karen Mason: I am passionate about suicide prevention and about supporting clergy in their key role in suicide prevention. I wrote the book because while there are books written for suicide survivors from a Christian perspective, there are very few resources for clergy focused on the larger task of suicide prevention particularly from a Christian perspective.

What role does the church have to play in suicide prevention?

Mason: Pastoral caregivers (pastors, chaplains and pastoral counselors) are needed in suicide prevention because of their unique and vital contributions of practical theology and the faith community. This idea is not distinctive. The US government recognizes the key role of faith-based leaders and faith communities in suicide prevention in the *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. What I hope to have contributed is the explication of all the ways that clergy work out this key role in terms of contributing to a theology of life, death and suicide, engaging directly the issue of suicide in their faith communities and offering community where support is offered and relationship skills are learned and practiced.

What do you hope church leaders can take away from your book?

Mason: I would like pastoral caregivers to feel empowered in the suicide prevention tasks they engage in. I hope they (1) challenge their own myths about suicide and understand that suicide exists in faith communities—perhaps in larger numbers than they expected—and that all ages and genders could be at risk, (2) develop a clearly articulated theology of suicide and particularly a commitment to help people develop lives worth living, (3) develop risk assessment skills, (4) develop postvention skills (what to do following a suicide) that prevent suicide contagion, and (5) understand their key role in suicide prevention.



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The Prevalence of Suicide in the Church

The phone rings at your home at 10:30 p.m. Jim is sobbing. Bit by bit he tells you that he plans to kill himself tonight because his wife has discovered his ongoing affair. He says he has disappointed God, his family and himself in an unforgivable way.

Jim is the last person in your congregation you would have expected to experience suicidal thinking. He's an involved member of your church, a committed Christian. He has never discussed any concerns about his marriage. And even if he had, he is upbeat and positive, and people describe him as "dependable" with "a winning personality." You wonder: If Jim is suicidal, are there others in your faith community who might be as well? Suicidal thinking and suicide are a lot more common than we often believe.

Is Suicide That Widespread?

The World Health Organization has found that for every death due to war in the world, there are three deaths due to homicide and five due to suicide. Closer to home in the United States, suicide was the tenth leading cause of death across all ages in 2010 (affecting 38,364 people), ahead of homicide (16,259 people) and HIV (8,352 people). Even as you read this chapter, there will be one US suicide every sixteen minutes. Suicide is a serious threat and must be taken seriously, especially because these numbers are underreported. Take this example from 1899 cited by Kushner: A 34 year-old woman inhaled gas but revived. She then swallowed morphine and lost consciousness, but again she recovered and showed improvement. She died five days later of pneumonia, which is listed as the cause of death on both the coroner's report and her death certificate in 1899.

Those who actually die by suicide are just the tip of the iceberg. Based on large national surveys, it is estimated that for every fourteen suicides per hundred thousand people each year, approximately five hundred people attempt suicide and three thousand think about it. Therefore, there's a significant chance suicidal thinking occurs in your faith community. Individuals in your pews, those who request counseling and even members of your governing board may at some point have thought about suicide or even attempted it. And you may experience a suicide death in your faith community.

Jim's story ended well. He called his pastor who talked about God's forgiveness (Rom 5:20-21) and prevented his suicide. But what happens when the Jim in your church doesn't call you? Is there a way to identify him and help him anyway?

Risk and Protective Factors: Researching Suicide

You may wonder how we answer this question about factors when "the chief source of information is no longer available." One method employed is psychological autopsy, which comprises in-depth interviews with family, friends and colleagues of the person who died by

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“Mental illness exists inside and outside of the church community. Christians struggle with depression and even suicidal thoughts. It does not make you less of a Christian. Just like heart disease or cancer does not dilute our Christianity, neither does mental illness. Nevertheless, we must stand committed to ‘creating space’ and providing ministry to those who struggle with depression and other mental illnesses. In partnership with medical professionals, the church of Jesus Christ can bring attention to this silent illness with grace, compassion and love. Karen Mason’s book provides such space. For at the end of day, suffering from mental illness is not a sin. Yet not addressing it may very well be.”

— Samuel Rodriguez,
president, Hispanic
Evangelical Association

suicide, as well as professionals who worked with him or her, in order to clarify intent to die.

Another method is epidemiology, which involves the study of patterns related to suicide deaths in order to identify risk factors (factors that increase the likelihood of suicide) and protective factors (factors that decrease the likelihood). Durkheim calls these factors the “coefficient of aggravation” and the “coefficient of preservation.” Epidemiology can also help quantify the amount of risk a factor adds—for example, researchers have found that almost six times as many people who have a diagnosis of alcohol abuse or dependence die by suicide compared to the general population. Based on these methodologies, researchers have identified the following risk and protective factors, which may be factors in Jim’s and Joan’s suicidal thinking.

Mental health factors. A prominent factor associated with suicide is the presence of a mental health problem. In a large national survey, a mental health disorder was present in 82 percent of people with suicidal thoughts, 94.5 percent of those who made a suicide plan, and 88.2 percent of those who had attempted suicide in the previous twelve months. Major depression was the most common disorder. The “big five” mental health disorders are of particular concern for suicide risk: borderline personality disorder (400 times higher suicide rate than that of the general population), anorexia nervosa (which increases suicide risk 23 times), major depressive disorder (20 times more risk), bipolar disorder (15 times greater risk), and schizophrenia (8.5 times greater risk). Joiner assumes that everyone who dies by suicide experiences at least some symptoms of a mental health problem. Mental health factors are important to know about because one in five Americans has a mental health problem and this may confer some suicide risk. For example, John, an unemployed contractor in his fifties, lived with depression and thoughts of suicide since his college days, experiencing a lifelong struggle with not meeting his father’s expectations. One in five members of your congregation may be at some risk of suicide because of a mental health disorder.

Circumstances. It’s a myth that people in difficult circumstances kill themselves as a matter of course. People survive great horror and do not kill themselves. Kushner contrasts Meriwether Lewis and Abraham Lincoln, who both suffered from depression and faced great challenges, but it was Meriwether Lewis who killed himself. In fact, suicide is never a normal response to difficult events. Circumstances are just one part of the story. Jim struggled with a circumstance—his wife’s discovery of his affair—but it was not the circumstance alone that affected his thinking. The circumstance occurred in the context of his theology that God could not forgive him. As a Centers for Disease Control report states, “Suicide is never the result of a single factor or event, but rather results from a complex interaction of many factors and usually involves a history of psychosocial problems.”



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Among adolescents, problems with parents play an important role in suicidal behavior, especially in younger adolescents. And as Miller and colleagues note, “Romantic difficulties are more common precipitants among older adolescents, while parent-child conflicts are more common among younger adolescents.” Other factors that confer suicide risk for adolescents include conflict with friends, disciplinary events and legal problems. In fact, in adolescents these stressful life events may contribute as much risk for suicide as a mental health problem.

But even as we point to these general risk factors based on population statistics, we must recognize that every suicide is unique and involves many factors. Styron wrote, “The greatest fallacy about suicide lies in the belief that there is a single immediate answer – or perhaps combined answers – as to why the deed was done.” Durkheim adds, “Each victim of suicide gives his act a personal stamp which expresses his temperament, the special conditions in which he is involved, and which, consequently, cannot be explained by the social and general causes of the phenomenon.”

For example, Sally died by suicide. She had struggled with depression and suicidal thoughts every day of her life. Her first suicidal thought was around three years old. Her father had fluctuated between neglecting her and abusing her and her siblings both sexually and physically. Though Sally begged her mother for help, she not only did not protect Sally but locked her in her room for days at a time. Sally was sexually assaulted and experienced domestic violence as a young woman. Before she died, she was living alone with little positive contact with family. She prepared for her death by taking out an insurance policy, then waiting the necessary years. She got used to pain by cutting herself. Sally is an example of the complexity of factors that contribute to suicide. Jim experienced several risk factors but he also had an important protective factor. He felt comfortable pouring out his heart to his pastor, who shared with him a theology of forgiveness.

Protective factors. Even if a person has several risk factors, protective factors can buffer the effects. These are “the mirror image of the risk factors,” meaning that they are the reverse of risk factors. A desire to live, fear of pain and suffering, and not having access to a firearm are protective factors.

Among adolescents, family cohesion (a feeling of togetherness in the family) and parental support, ethnic identity, and self-esteem have been found to be protective against suicidal thinking and behaviors as well as social support and connection to school.

* * * * *

How can pastors, chaplains and pastoral counselors use this information? One way is to realize that suicidal thinking, attempts and deaths are more common than you think. People in your faith community are struggling today. Another way is to realize that it’s difficult to



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predict who the Jim or Joan in your congregation is or will be. While it's possible to identify a person who may be at higher risk – such as a white middle-aged divorced male who just lost his job and is abusing alcohol – it is also possible that someone you least expect may attempt suicide. Surveillance and risk and protective factors are based on general population statistics and each suicide is a unique interaction among many factors and therefore in many ways unique and unpredictable. Despite all the information we have on suicide, human beings are not clairvoyant. We can in hindsight notice risk factors that were there, but to expect to predict suicide is unreasonable. McKeon writes, “Prediction of death by suicide was probably never a feasible goal.”

But prediction and prevention are different. While we struggle to predict suicide, we can help to prevent it. Pastoral caregivers can monitor a person's risk factors and are especially able to build protective factors that buffer vulnerabilities to suicide. In addition to encouraging involvement in religious activities, clergy also help strengthen people's reasons for living, giving them a place to belong and serve, teaching them how to build enduring marriages, strong cohesive families and identities and esteem founded on God's everlasting love.

One of the top ten causes of death in the United States is suicide. It can show up unexpectedly in people like Jim. Even though white middle-aged men have high vulnerability, people from every group die by suicide. People at higher risk are those with mental health problems such as depression who have developed the ability to harm themselves. Irving Selikoff is quoted as saying, “Statistics are people with the tears wiped away.” What is sad about these statistics is that they describe real people who have died. What is positive is that suicide is often preventable, as we saw with Jim when his pastor intervened.

As we have looked at the factors associated with people wanting to harm themselves, you may have found yourself wondering how a Christian gets to that point. For example, Jack was teaching at a Christian college and directing the choir at his evangelical church. Why did he kill himself? Myths about suicide abound – myths such as “Christians don't kill themselves,” and “Talking about suicide will give the person the idea,” and “If someone really wants to kill himself, there's nothing I can do.” Is there any truth to these? We'll look at these questions next.

– Adapted from chapter one, “Who Dies by Suicide?”