**Theological Musings from Dave's Laptop**
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I often listen to NPR when I'm driving, and this week I heard a short segment on suicide. The likely reason for the timing of the spot is that May is one of the prime seasons in which persons choose to take their own lives.

The psychologists who spoke to the subject were aware that suicide is strongly related to a loss of Hope, but I was sorry that they seemed either unaware or unwilling to acknowledge that the loss of Hope that can lead to suicide is more often than not a spiritual problem as well as a cognitive one.


It is hardly news to observe that **how we think about things matters**; and Thomas Oden, a pastoral theologian who recently crossed over into Glory, helped me when he pointed out that hope-less-ness might really be called "despair in three tenses."[1] Oden's idea is actually quite closely related to what I mean when I talk about our deep, fundamental human yearning for "A Life that Matters" and for "Relationships that Last."

When a Hope-*full* person looks at the **past**, she sees many experiences of faith-full relationships and meaningful accomplishments. And, where those are lacking, she sees both God's forgiveness and the forgiveness of significant others in her life covering the cracks and broken places.

When a Hope-*full* person looks at the **present**, he continues to see faith-full relationships, combined with a sense of efficacy and purpose connected to what God is doing in the world. He understands his life to be significant, to matter, both in time and in eternity. And when a Hope-*full* person looks at the **future**, she anticipates good things both in time and in eternity, the work of a personal God who is trust-worthy.

| HOPE | | |
|---|---|---|
| Forgiveness/faithfulness | Effectiveness/purpose | Trust/anticipation |
| **PAST** | **PRESENT** | **FUTURE** |
| Faithlessness/guilt/isolation | Meaninglessness/boredom | Anxiety/death |
| **DESPAIR** | | |

In stark contrast to these perspectives, when a Hope-*less* person looks at the *past*, he sees a trail of faithless relationships and meaningless activity steeped in unresolved and unrelenting guilt. When a Hope-*less* person looks at the *present*, she sees empty relationships, boredom, and meaninglessness. And when a Hope-*less* person looks at the *future*, he sees only isolation, anxiety, death, and meaninglessness. Is it any wonder that such a person would be overtaken by a life-destroying despair?

[1] Thomas Oden, *The Structure of Awareness* (Nashville: Abingdon, 1969).

It is into just such Darkness that God's Spirit speaks Words of Hope. One of my favorite verses is John 5:24, where our Lord says, "*I assure you, those who listen to my message and believe in God who sent me have eternal life. They will never be condemned for their sins, but they have already passed from death to life.*" Let's put those words into the Hope/Despair table above:

| PAST | PRESENT | FUTURE |
|---|---|---|
| "***have already*** *passed from death to life"* | "***have*** *eternal life"* | "***will never be*** *condemned for their sins"* |

Can you sense the HUGE difference that makes? It was of this transformation that Paul spoke when he wrote, "*Don't copy the behavior and customs of this world, but* ***let God transform you into a new person by changing the way you think****. Then you will know what God wants you to do, and you will know how good and pleasing and perfect his will really is*" (Romans 12:2).

Here's another angle from which to consider Hope and Despair. You will need to pay close attention, and you may have to read this several times, but once you understand this, it will be a Big Deal.

All of us try to explain and to understand our experiences and the events of our lives by attributing them to causes—by making what psychologists call "causal attributions."[2] And whether a person is Hope-*full* or Hope-*less* is determined in large measure by the ways in which these attributions are made.

Both Hope and Hopelessness are partially the result of these largely unconscious calculations of probability. Researchers have suggested that such Hope-related calculations of probability take place along three continua. These dimensions are (1) **locus of causality** (*Is the cause of this event internal or external to me*?); (2) **stability** (*Is this situation likely to change over time*?); and (3), **limits of the arena** (*Does this affect every bit of my life, or only some part of it*?).[3] Each of us tends to make these evaluations according to a predictable pattern. . . .


When **bad** things happen to us, despairing/Hope-less persons respond with the **internal-stable-global** style. A person with this style understands negative events to be caused by some personal failure (internal) which is characterological and not likely to change (stable), and that negatively affects life satisfaction in virtually every area (global). Such a person sees her or his situation as being the painful result of an irremediable deficit in her or his personhood.

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[2]Bernard Spilka, Phillip Shaver, and Lee Kirkpatrick, "A General Attribution Theory for the Psychology of Religion," *Journal for the Scientific Study of Religion*, 24 (1985), 2-3.

[3]Martin E. P. Seligman et al., "Depressive Attributional Style," *Journal of Abnormal Psychology*, 88 (1979), 242.

At the other end of the spectrum are those Hope-full persons whose response to "bad" things is **external-unstable-specific**. These persons tend to locate the origin of negative experiences outside of themselves (external, not characterological), considering these experiences to be transient (unstable) and situation-specific, not global. Thus Hope-full persons view negative experiences as temporary setbacks that can be adequately managed, and they are not afraid to consider adventurous solutions to them.

On the other hand, when **good** things happen, Hope-*less* and Hope-*full* persons again take opposite approaches. Hopeless persons understand positive events as external-unstable-specific, that is, as being related to chance, not character, unlikely to persist, and affecting only a tiny portion of their lives. Hopeful persons understand positive events as internal-stable-global, that is, as being related to their own activity and/or character, likely to persist, and affecting many or most dimensions of their lives.

While most of us fall somewhere between these two extremes, Christians are able to view our lives through these six lenses in even more positive ways:

1. **INTERNAL**: God has, through Jesus, completely changed my character. I am a new person! (2 Corinthians 5:17).
2. **EXTERNAL**: This transformation is all God's doing, and isn't dependent on my own strength or goodness (Romans 6:23).
3. **STABLE**: These God-made changes are guaranteed both for time and for eternity (Hebrews 9:12).
4. **UNSTABLE**: Whatever my faults today, God continues to work in my life to make me more like Himself (Ephesians 4:15).
5. **GLOBAL**: God gives me an abundant, overflowing, rich, and satisfying quality of life that is not dependent on my circumstances (John 10:10).
6. **SPECIFIC**: God's forgiveness and God's empowerment allow me to be fully present in each experience and with each person (James 2:14-17).

The diagram on the next page puts this all together. I urge you to read and ponder this until you see its powerful, transforming logic. Once we have made the choice to follow Jesus and have been born again by God's grace, God's indwelling Spirit begins these transformations at once, and that work is not complete until we have "*the mind of Christ*" (1 Corinthians 2:16). **We who follow Jesus are People of the Light. We are People of Hope.**


As People of Hope, we sometimes have opportunity to walk with those who are being overtaken by Despair. Walking with persons who are suicidal is intense and awesome, frightening, and potentially redemptive. I have attached some guidelines for how to approach such conversations, if they come to you.

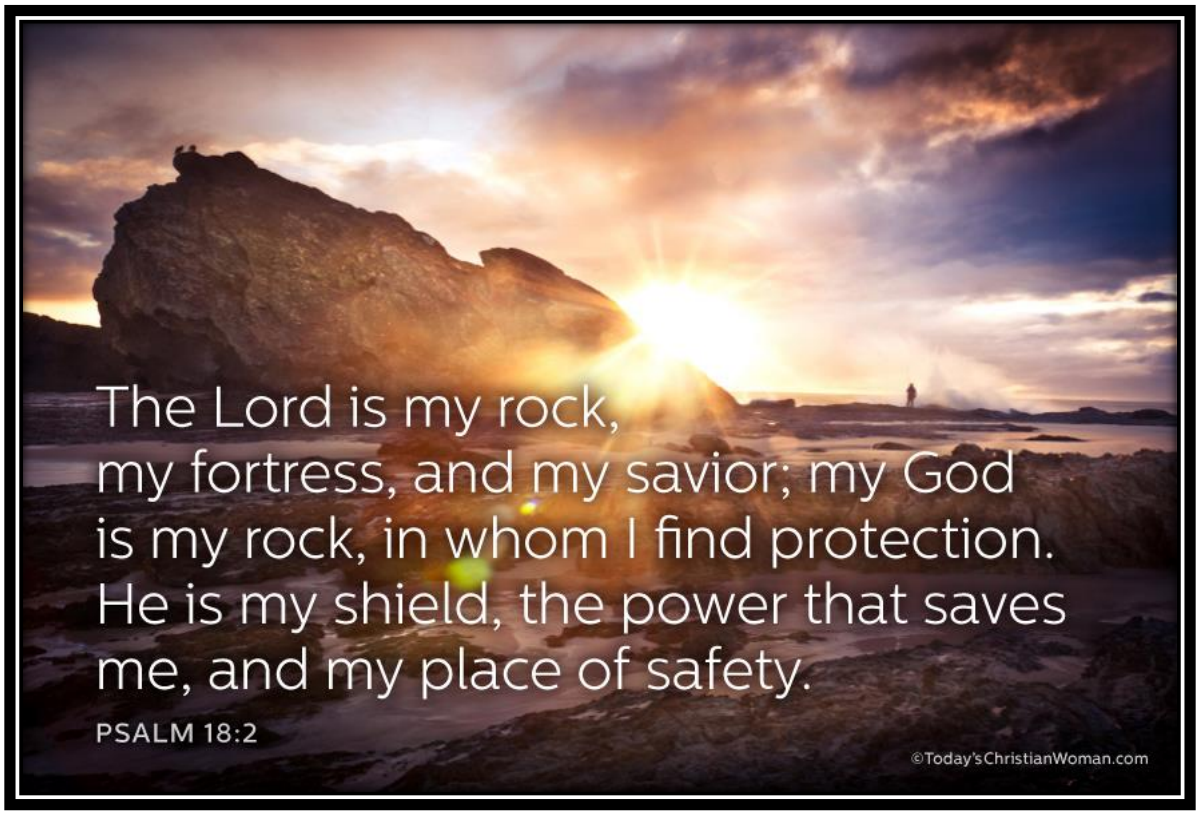
Trust Him who is our Hope.

Dave

# How We Think About Things Matters

| Christian Experience | Hopeful Response to Positive Events | Hopeful Response to Negative Events | Christian Experience |
|---|---|---|---|
| *True Inner Change* *2 Corinthians 5:17* | **INTERNAL** | **EXTERNAL** | *Comes from God* *Romans 6:23* |
| *Eternal* *Hebrews 9:12b* | **STABLE** | **UNSTABLE** | *Always Growing* *Ephesians 4:15* |
| *All of My Being* *John 10:10b* | **GLOBAL** | **SPECIFIC** | *THIS Person/Event* *James 2:14-17* |
| **Christian Experience** | Hopeless Response to Negative Events | Hopeless Response to Positive Events | **Christian Experience** |

Central diagram from Chris R. Brewin, "Depression and Causal Attributions: What is Their Relation?" *Psychological Bulletin*, 98 (1985), 297-309. Christian adaptation by David C. Stancil, Ph.D.



# MINISTRY IN SUICIDAL SITUATIONS

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## Introduction

Suicide is a leading cause of death in the United States. The highest months for suicide attempts are May and December, with the period between Thanksgiving and Christmas being an especially difficult time. Suicide is the result of a crisis of meaning in persons' lives, of a crisis of hope. Loneliness is often a major factor in suicide, especially existential aloneness—the perception that one is alone in the universe and that one's life has no meaning. Holiday times and springtime are especially difficult in this regard, since the joyfulness and celebration of others accentuates the feeling that one is truly alone.

Most persons who complete suicide are alone when they do, and most are at home. While women attempt suicide much more often than men (80% of suicide attempts are made by women), men complete suicide much more often than women. The rate of completed suicides for men is 300-400% greater than that for women. One contributing factor to this situation is that men use more lethal means for suicide, usually firearms, whereas women tend to use overdoses of medicine. These overdoses are often either with non-lethal medications, or else are discovered in time to be reversed.

The rate of suicide of persons 15-25 has increased nearly 300% since 1950, and is the leading cause of death in this age group. Teen and young adult suicides tend to be related to perceptions of failure (such as few friends, poor grades, loss of a relationship) or to the anticipation of punishment for some misbehavior. The rate of suicide for adults 25-65 is higher than that for young adults, and tends to be related to financial difficulties of one sort or another. The underlying inner perception, however, is still one of failure.

The highest rate of completed suicide is among senior adults, 65 and older. Senior adult suicides are often related to crises of meaning in life, feelings of loneliness and uselessness, and intractable illness. Approximately 4% of suicides are murder-suicides, with these concentrated in the 25-and-older range. Group suicides have become more prevalent in recent years, with the greatest occurrence in the month of February. A ripple effect seems to be operative with group suicides, with one incidence of group suicide tending to precipitate others within a space of several weeks.

## Warning Signs of Suicide

There are numerous warning signs of suicide, and almost never does a person complete suicide without exhibiting one or more of these signs.

1. **DEPRESSION**. The major precursor of suicide is depression. Depression originates in two primary processes. The first source of depression is biochemical, and there is convincing evidence that susceptibility to depression can be inherited. Biochemical, or endogenous, depression tends to be cyclic, with particular times of the day, month, or year tending to be depressive. The primary treatment for biochemical depression is pharmacological, since there is a need to compensate for the biochemical deficit that leads to the depression. The other principal source of depression is dysfunctional interpersonal relationships, especially primary relationships. It is commonplace among mental health professionals to view depression as the result of anger turned inward toward the self, rather than outward toward the person, persons, or system

that more correctly are the focus of the anger. The treatment for interpersonal, or dynamic, depression is psychotherapy, which explores the root causes of the anger and helps to find more effective ways of resolving interpersonal conflict. Assertiveness training is one aspect of such treatment. If dynamic depression is of sufficient intensity and duration, it can result in biochemical depression as well, which will require pharmacological treatment in addition to psychotherapy in order to see improvement.

2. **TALKING AND WRITING ABOUT SUICIDE**. Beyond being depressed, most persons who are contemplating suicide give some indication of this condition. There may be written notes, letters, or simply statements in conversation such as "I just don't think I can go on anymore," "Things aren't getting any better, and I don't think they will," "My family would be better off without me," "No one would miss me if I were dead," "My life doesn't count for anything," etc.. It is not uncommon for persons to be even clearer than this about their intent to take their own lives. As will be noted below in the suggestions about intervention, comments or notes that hint about or which speak clearly about suicide should always be taken seriously!

3. **GIVING AWAY PRIZED POSSESSIONS**. Persons who have already decided to commit suicide may sometimes give away objects or items that have previously been very dear to them. For example, it would be a warning sign of possible suicide if a person gave away a prized automobile, a cherished collection of stamps, music albums, a stereo, special clothing, etc., especially if the person has been depressed, and if there is no clear, logical reason for such action.

4. **RISK-TAKING AND OTHER SELF-ABUSIVE BEHAVIOR**. Persons who are contemplating suicide (even unconsciously) may become accident prone, or may take unusual risks such as driving while intoxicated, driving at unnecessarily high speeds, or taking up hazardous pastimes. Remarks about one's self may become more deprecating, with many put-downs. Numerous elective surgeries may be a form of suicide "by degrees."

5. **TURNING TO ALCOHOL OR OTHER DRUGS**. Attempts to ameliorate depression by chemical means are quite common. Much drug use originates in a desire to alter one's mood, especially when that mood is painful or disagreeable. Alcohol is one of the most readily available and socially acceptable drugs, particularly in the military. Alcohol is simply ether and water, functioning as an anesthetic—actually as a depressant. Drugs allow temporary escape from emotional pain, but they frequently have undesirable side effects and social consequences, and do nothing to solve the situation that led to the depression. Drug use might also be considered to be "suicide by degrees" or "by the ounce."

6. **OBVIOUS CHANGE IN PERSONALITY OR BEHAVIOR**. Any significant change in personality or behavior can be a warning sign of suicide. Some typical changes have already been mentioned; others could be imagined as well. Perhaps the most ominous change to be alert for is a sudden cheerfulness in a person who has previously been significantly depressed. Quite often such cheerfulness indicates a calm that follows the resolve to commit suicide. Another behavioral change to note would be an unusual interest in contacting significant persons—even those at some distance—as a form of ritualized leave-taking in which suicide may not even be mentioned.

7. **PREVIOUS SUICIDE ATTEMPTS**. Once a person has breached the invisible barrier that separates life from death, the line is more easily crossed in the future. Persons who have made previous suicide attempts (not just talking about it) are at significantly greater risk for suicide in the future.

## How to Minister to a Suicidal Person

Ministry with suicidal persons is not really very mysterious, though it is frequently awesome. One of the first things to bear in mind is that suicide is rarely a response to a single incident, and thus it is unlikely that any single attempt at help would "push someone over the edge" to suicide. The following are some of the major interventions to be made with suicidal persons.

1. **ASK ABOUT SUICIDE**. It doesn't ever make suicide more likely to ask a person whether they are thinking about it. Suicide is frequently, if not always, a cry for help or an angry statement that help was not forthcoming. The Number One Rule about suicidal work is to take suicide more seriously than the person who is contemplating it does. Making suicide speakable goes a long way toward reducing the isolation felt by the suicidal individual. This is not the place to lecture or to sermonize. It is *not helpful* to ask persons "Why in the world would you want to do that?" or "How could you!?" Simply ask, "Are you thinking about hurting yourself?" Other possible questions might be "Have you seriously considered taking your own life?" "Are you seriously considering suicide?" "It sounds as though you may be talking about or hinting about suicide. Is that correct?" Sometimes it is helpful to ask something like, "On a scale of one to ten, how close would you say that you are/have been to taking your own life?"

2. **ASK ABOUT THE PLAN**. If a person says that she has been thinking about suicide, ask whether she has a plan by which to carry it out. The existence of a plan—particularly a specific plan—increases the likelihood of a suicide attempt. The more specific the plan, the greater the danger. Ask about the plan, and determine whether the means to carry out the plan are at the person's disposal. Does the person already have a gun, the medicine, etc.?

3. **TRY TO GET A CLEAR NO-SUICIDE CONTRACT**.

   a) Ask the person whether he would be able and willing to make a contract or a covenant not to hurt himself (intentionally or accidentally) for a specified period of time. This period might be "forever," for a year, for six months, for a month, for a week, for a day, or for an hour. If he or she is willing, then ask the person to make this covenant out loud: "I promise that I will not harm myself, either intentionally or accidentally, until our appointment next week." After that, ask the person if he or she is a person who keeps promises!

   b) After the initial contract, attempt to get the person to agree to remove from easy access whatever means by which she had contemplated suicide. Ask her to give her medicine to a friend, who would then dispense it; ask her to get rid of her gun, or entrust it to a friend, etc.

   c) Try to secure a further covenant that if she begins to doubt whether she can—or will—keep the no-suicide contract, she will call to talk about it. Give your own name and telephone number, the number of your quarterdeck, a suicide hot line, etc.. The more personal the contact, the more likely that such a call will be made. Probably the approach most likely to succeed would be to give

either your own name and an on-call number (since you have an "established" relationship) or that of the Duty Chaplain.

d) Since, as noted above, physiology often is a major player in clinical depression, urge the person to seek a medical evaluation of her situation to determine whether pharmacological intervention is indicated.

e) Finally, if you are not a trained psychotherapist yourself, attempt to secure a contract that the individual will seek appropriate professional help. Some Chaplains may be qualified for such interventions. Otherwise, going to the Clinic or the Emergency Room is appropriate, depending upon the urgency of the situation. It is always appropriate to request a psychiatric consult in suicide situations.

4. **IF THE PERSON WILL NOT MAKE A CONTRACT, THEN TAKE ACTION**. If you are convinced that a person is suicidal, and if he or she will not make a contract, then you are not bound by confidentiality, and should tell the person so. The appropriate thing to do is to notify next of kin, if they are in the local area, apprise them of the situation, and urge them to seek hospitalization for the individual. Since in most cases family will not be available, it is appropriate to order the individual to seek medical attention. This might be done by calling the person's command and asking for an escort to the Emergency Room, or you might enlist another person and take the individual to the ER yourself. If a person is actively suicidal, and will not make a clear contract, then they should not be allowed to be alone unless seen and treated by a psychiatrist.

5. **DO NOT ATTEMPT "REVERSE PSYCHOLOGY" WITH SUICIDAL PERSONS**. While talking about suicide is always appropriate, it is NOT appropriate to make a paradoxical intervention such as "Well, perhaps that would be the best thing," or "You're right. I don't think anyone would miss you. You probably are no good."

## Suicide Intervention Follow-Up

While nearly all suicides can be prevented, in the final analysis, if a person is completely committed to taking her or his own life, the best that intervention can do is to postpone this event. Appropriate medical attention can be secured, needed medications can be prescribed, hospitalization can be enforced. Yet the time will come when the individual will be released, and suicide will still be possible. Persons working with suicidal individuals need to accept that this danger is inherent in such ministry.

Making suicide referrals does not relieve the helping person of responsibility. There remains the need to maintain contact with the suicidal individual, keeping lines of communication and support open. While it is important not to interfere with psychotherapeutic or medical interventions, it is also important to be available to the depressed person, offering appropriate assurances of continuing interest and encouragement. Referral is not a transfer of responsibility so much as it is a broadening of responsibility.

Recovery from suicidal depression requires at least two major decisions on the part of the depressed person. The first decision is the DECISION NOT TO DIE. This decision is foundational, but insufficient for recovery. The second decision is the DECISION TO LIVE. This decision involves not only treatment for the depression, but the recovery of hope and purpose in life. Hope and purpose are essentially spiritual concerns, which require spiritual attention. The help of a Chaplain or another minister is most useful at this point in treatment.

## Suicide Prevention and Suicide Follow-Up

The adage, “the best defense is a good offense,” is no less true for suicide work than it is in football. Command Religious Programs, Recruit Indoctrination Programs, Welcome Aboard Orientations, and Command Leadership Training Programs are wise to include suicide awareness and prevention lectures in their training plans. Basic awareness of suicide warning plans and front-line interventions is “all hands” information.

In the event that a completed suicide occurs, those who are survivors need ministry urgently. Because suicide is fundamentally an act of anger and despair, the grief and guilt experienced by family members is intense—generally much worse than that experienced after accidental death. Pastoral initiative will be needed to move toward such persons and families, allowing them opportunity to ventilate their emotions and offer mutual support, much as might be done after deaths of other sorts.

Because the experience of surviving suicide is so painful, however, and if sufficient bereaved persons are in the area, a “Survivors of Suicide Support Group” might be considered. In the military environment, “family” includes the decedent’s entire unit or company, and debriefing opportunities will likely be helpful in processing grief, guilt, and anger in the aftermath of suicide.