

THE ROLE OF FAITH COMMUNITIES IN PREVENTING SUICIDE

A REPORT OF AN
INTERFAITH SUICIDE PREVENTION DIALOGUE



SUICIDE PREVENTION RESOURCE CENTER

2009

The Role of Faith Communities in Preventing Suicide

A Report of an
Interfaith Suicide Prevention Dialogue
held March 12-13, 2008
Rockville, Maryland

Suicide Prevention Resource Center

Substance Abuse and Mental Health Services Administration

Suicide prevention is a very mainstream religious activity that builds from what the vast majority of congregations already want to do. They just don't tend to name the significance of what they are doing as suicide prevention.

Reverend Dr. Gary Gunderson, 2004

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Consensus Statement on Suicide and Suicide Prevention from an Interfaith Dialogue

The following statement was developed at an Interfaith Suicide Prevention Dialogue held March 12-13, 2008 in Rockville, Maryland. The dialogue was sponsored by the Suicide Prevention Resource Center and was funded by the Substance Abuse and Mental Health Services Administration. The participants included representatives from the Buddhist, Christian, Hindu, Jewish, and Muslim faith communities.

Life is a sacred gift, and suicide is a desperate act by one who views life as intolerable. Such self-destruction is never condoned, but faith communities increasingly support, rather than condemn, the *person* who contemplates or engages in suicidal behavior. They acknowledge that mental and substance use disorders, along with myriad life stressors, contribute significantly to the risk of suicide. And they reach out compassionately to the person who attempts suicide and to families and friends who have been touched by a suicide or suicide attempt. This increasingly charitable understanding finds agreement between the historic precepts of faith and a contemporary understanding of illness and health. It renders no longer appropriate the practice of harshly judging those who have attempted or died by suicide.

Life is a complex journey viewed through different lenses by different faith groups. But the varied eyes of all our traditions increasingly see the great potential of people of faith to prevent the tragedy of suicide. Spiritual leaders and faith communities—and now the research community—know that practices of faith and spirituality can promote healthy living and provide pathways through human suffering, be it mental, emotional, spiritual, or physical.

Faith communities can work to prevent suicide simply by enhancing many of the activities that are already central to their very nature. They already foster cultures and norms that are life-preserving. By providing perspective and social support to their members and the broader community, they compassionately help people navigate the great struggles of life and find a sustainable sense of hope, meaning, purpose, and even joy in life.

The time is right for the life-enhancing strengths that are the foundations of our most ancient faith traditions to find application in preventing suffering and loss from suicide. Suicide prevention will take a quantum leap forward as members of faith communities gain understanding and the necessary, culturally competent skills to minister to people and communities at heightened risk for suicide and to support the healing of those who have either struggled with suicide themselves or survived the suicide of someone they love.

The Role of Faith Communities in Preventing Suicide

When United States Senator and Mrs. Gordon Smith lost their twenty-two-year-old son to suicide, they were profoundly comforted by assurances from the head of their church that “Garrett was in the arms of his Heavenly Father and that his mind was now calm and clear.” As described in Gordon Smith’s book *Remembering Garrett*, knowing that Senator Smith was contemplating resigning from the Senate, another church leader “verbally grabbed me by the lapels and gave me a good shaking.” He told the Senator, “You need to fully grieve for Garrett and get back to work! You are needed, and your children ... need most to see your good example, especially now!”

Senator and Mrs. Smith have indeed provided a sterling example of how to transform a personal tragedy into a public good. Mrs. Smith began serving on the Oregon Task Force on Mental Health and on the board of SPAN USA, and Senator Smith was the driving force that ensured that Congress would pass the Garrett Lee Smith Memorial Act. Since 2005, this Act has provided funding for States, American Indian and Alaska Native tribes and tribal organizations, and colleges and universities to implement comprehensive suicide prevention programs. The Smiths have received tremendous support from friends and colleagues, and Senator Smith concludes his book with an affirmation of what else has enabled him to go on:

Lastly, there is one more thing that, if I could, I would give to all. It has sustained me throughout my wandering in mortality’s mist. It is the glue that held me together in grieving for Garrett. It does the same for others. That one thing is, simply, faith. (Smith, 2006, p. 176)

The Scope of the Tragedy

The loss of a single life to suicide is a tragedy, and the tragedy is multiplied many times over when the friends and family members of the deceased are counted. The Centers for Disease Control and Prevention reports that in 2005, 32,637 people died by suicide in the United States alone. That amounted to 89.4 people per day and accounted for 11 percent of the Nation’s deaths that year (www.cdc.gov/ncipc/dvp/Suicide). The World Health Organization reports that in 2000, throughout the world, approximately 1,000,000 people died by suicide—a global mortality rate of 16 percent, or one death every 40 seconds. This makes the number of deaths by suicide worldwide higher than the total number of deaths from war and homicide combined. In addition, it is estimated that there are ten to twenty times as many suicide attempts as suicide deaths (www.who.int/mental_health/prevention/suicide). It is estimated that for every suicide, there are at least six survivors, a number many consider to be a very conservative estimate. If it is accurate, approximately five million Americans became survivors of suicide in the last 25 years (www.suicidology.org).

Enlisting the Faith Community in Suicide Prevention

National Strategy Objectives

Much of the work of suicide prevention must occur at the community level, where human relationships breathe life into public policy. American communities are also home to scores of faith-based and secular initiatives that help reduce risk factors and promote protective factors associated with many of our most pressing social problems, including suicide.

--Dr. David Satcher, U.S. Surgeon General
National Strategy for Suicide Prevention, 2001

Beginning in the 1990s, public health agencies such as the World Health Organization, the office of the U.S. Surgeon General, and the Institute of Medicine issued calls to action to prevent suicide, and many have pointed to the unique position of faith communities to reach people in distress. For example, the *National Strategy for Suicide Prevention: Goals and Objectives for Action* (the *National Strategy*) sets forth eleven goals and 68 objectives, at least three of which relate directly to faith communities:

Objective 2.4: Increase the number of nationally organized faith communities adopting institutional policies promoting suicide prevention.

Objective 6.4: Increase the proportion of clergy who have received training in identification of and response to suicide risk and behaviors and the differentiation of mental disorders and faith crises.

Objective 7.5: Increase the proportion of those who provide key services to suicide survivors (e.g., emergency medical technicians, firefighters, law enforcement officers, funeral directors, clergy) who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors.

To further the progress of faith communities in preventing suicide, the national Suicide Prevention Resource Center (SPRC) convened an Interfaith Suicide Prevention Dialogue, which was supported by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA). Participants included representatives of the five largest faith groups in the United States: Christian, Jewish, Islamic, Buddhist, and Hindu. Christian denominations represented were Catholic, Baptist, Latter-day Saints, Lutheran, and United Methodist. Islam was represented by a member of the Sunni sect and a member of the Shiite sect. In addition to SAMHSA, Federal agencies represented included the Indian Health Service, the National Institute of Mental Health, and the Department of Veterans Affairs. Non-governmental organizations represented were the Rollins School of Public Health at Emory University, the National Alliance on Mental Illness, and SPAN-GA. *As the suicide prevention initiative expands throughout faith communities, it is expected that people from all faith groups, sects, and denominations will join the dialogue.*

The group included chaplains, college professors and other religious scholars, health and mental health practitioners and advocates, and family survivors of persons who had died by suicide. (See Appendix A for participants.)

Goals of the Dialogue

The goals of the dialogue were:

1. To build mutual understanding and respect among the SPRC staff, SAMHSA staff, and the leaders of different faith communities regarding their various attitudes, beliefs, and practices related to suicide and its prevention
2. To increase the knowledge and understanding of the SPRC staff and SAMHSA staff regarding attitudes, beliefs, practices, and opportunities for promoting suicide prevention in faith communities
3. To identify common areas of interests, beliefs, and opportunities across faith communities, and to prioritize potential faith-based suicide prevention activities for SPRC and SAMHSA
4. To identify readiness for, and challenges to, the development of suicide prevention efforts in faith communities and their various subgroups

The first morning consisted of a welcome to the participants, a presentation on suicide prevention efforts at SAMHSA, an introduction to the work of SPRC, and a presentation on a public health approach to preventing suicide. The afternoon of the first day and the morning of the second day were devoted to representatives of the faith groups sharing their perspectives regarding suicide and its prevention, and to establishing priorities for future actions.

Welcome

Ms. A. Kathryn Power, Director of SAMHSA's Center for Mental Health Services (CMHS), began the meeting by welcoming the participants as follows:

I am honored to be here this morning to welcome you to this Interfaith Suicide Prevention Dialogue. This meeting begins an essential partnership between the faith community and SAMHSA in a shared mission to promote sound mental health, create resilience, generate a sense of hopefulness, prevent suicide, and help people recover from mental illnesses. I am extremely grateful that I had the good fortune to have attended a college where a minor in philosophy and theology was a requirement for graduation, for this requirement provided me with an understanding of the human condition informed by great philosophers and theologians of all faiths.

At CMHS, we build hope and resilience in the American public by using a public health approach that embraces a continuum of care that includes the promotion of mental health, the prevention of mental illnesses, and effective, recovery-oriented treatment for people who already have mental illnesses. Part of the public health approach involves effective communication to decrease the stigma and discrimination against people with mental illnesses and to identify people at risk for suicide. No one is better positioned to do this than you—members of our faith communities.

As you know, there are prohibitions against talking about mental illness and suicide in some cultures, and we very much need a common language to address these issues. It's very difficult to establish a collective understanding and to frame a national suicide prevention campaign because the words people will respond to vary so greatly from one group to another, and indeed, from one person to another. Increasingly, members of faith communities have become sensitive to problems such as depression and substance abuse, both of which are often accompanied by suicidal ideation. For those of you who are leaders in your faith communities to become actively involved in mental health and suicide prevention activities would greatly increase the reach and effectiveness of our local, national, and international initiatives. I am delighted that you have come here to share your knowledge with us, and I know you will have a wonderful meeting.

Lest we lose our way in the darkness, the suicide must also be seen as an occasion to raise awareness in the community and most importantly, to reach out to the survivors with compassion and support...The parish can also be a place for education, not just about the risk factors for suicide, but also about mental health, thus helping to diminish the stigma associated with these conditions.

**Father Charles T. Rubey, Founder
Catholic Charities' LOSS Program**

The Suicide Prevention Initiative at SAMHSA

Dr. Richard McKeon, Special Expert in Suicide Prevention and Public Health Advisor at SAMHSA/CMHS, told the group about SAMHSA's existing suicide prevention initiatives as follows:

The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency within the U.S. Department of Health and Human Services. It is composed of three Centers: the Center for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), and the Center for Mental Health Services (CMHS). With SAMHSA's suicide prevention initiatives, we are responding to a key problem identified in the report of President Bush's New Freedom Commission on Mental Health when it says, "In this nation, suicide prevention has not been made the priority that it needs to be." We here at SAMHSA are striving to provide national leadership for suicide prevention that will advance the 11 goals and 68 objectives of the *National Strategy for Suicide Prevention*.

Dr. Terry Cline, SAMHSA's Administrator, has established a Suicide Prevention Matrix Working Group comprised of representatives from each of its Centers, as well as from the Office of the Administrator. The goal of this group is to set priority suicide prevention activities that cut across the entire agency. SAMHSA also participates in the Federal Suicide Prevention Working Group, a group that functions across departments and agencies to share knowledge and coordinate activities. I co-chair that group along with an officer from the Department of Defense. We're glad that representatives from three other Federal Working Group organizations are with us today: Jeni Cook from the Department of Veterans Affairs, Jane Pearson from the National Institute of Mental Health, and Wilbur Woodis from the Indian Health Service. Other

Federal agencies and departments that are part of this working group are the Centers for Disease Control and Prevention, the Department of Justice, and the Department of Education.

Since 2001, CMHS has been SAMHSA's lead Center for suicide prevention activities. In 2004, CMHS was responsible for only two major projects: SPRC and the National Suicide Prevention Lifeline. By the time of this meeting, our portfolio contains over 100 grants, contracts, and cooperative agreements. It currently funds the following:

- *Suicide Prevention Resource Center (SPRC):* The mission of this national technical assistance center is to promote the implementation of the *National Strategy* and enhance the nation's mental health infrastructure by providing states, government agencies, private organizations, colleges and universities, suicide survivors, and mental health consumer groups with access to the science and experience that can support their efforts to develop programs, implement interventions, and promote policies to prevent suicide (www.sprc.org).
- *National Suicide Prevention Lifeline:* This "hotline" provides a 24-hour toll-free telephone number (800-273-TALK) that is accessible from anywhere in the United States. Calls are routed to the Lifeline network crisis center nearest the caller. In collaboration with the Veterans Administration, the Lifeline now has the ability to route calls from veterans to a special crisis center designed just for them. It is also working with the Trevor Project to make seamless connections to that organization's hotline for lesbian, gay, bisexual, transgender, and questioning youth (www.thetrevorproject.org).

The Lifeline receives about 40,000 calls a month. It has developed standards for suicide risk assessment and has taught crisis workers in most of its 120 crisis centers how to meet those standards. It's now working on comparable standards for emergency interventions. We need the standards and training very much because crisis workers need to know how to dispatch an ambulance immediately. We find this to be a significant need, especially on the veterans line. The crisis centers are basically self-supporting. SAMHSA provides a modest stipend, but they really have to look elsewhere for funds.

The Lifeline also needs additional language capacity. Currently, only assistance in [English and] Spanish is available. Callers can select a message in Spanish, and calls are routed to an around-the-clock Spanish-speaking sub-network of crisis centers. The Lifeline uses a universal translation service, but it is not fully adequate for many people who are in crisis and who don't speak English. This is a big problem, and we're open to suggestions for adding fluent speakers of more languages who are also trained to be crisis workers (www.suicidepreventionlifeline.org).

- *State/Tribal Youth Suicide Prevention Grant Program:* This program was initially funded in 2005 by the Garrett Lee Smith Act. As of today, this program has awarded grants to 31 states and seven American Indian/Alaska Native tribes or tribal organization. The grantees develop and implement suicide prevention programs for young people ages 10 to 24.

- **Campus Suicide Prevention Grant Program:** This program is also funded by the Garrett Lee Smith Act. As of today, we have awarded grants to 55 colleges and universities to build campus infrastructure for suicide prevention.
- **Linking Adolescents at Risk for Suicide to Mental Health Services Grant Program:** This program evaluates existing voluntary school-based practices that focus on identifying high school youth at risk for suicide or suicide attempts, the processes by which these youth are referred to appropriate mental health treatment and/or other services, and the outcomes of these processes. Eight grants were awarded in 2005 and receive funding for three years.
- **Native Aspirations:** This contract provides training and technical assistance to help Tribal communities use existing social and educational resources to develop and implement comprehensive, collaborative, community-based prevention plans to reduce violence, bullying, and suicide among American Indian/Alaska Native (AI/AN) youth. The contractor, Kauffman & Associates, Inc., is now providing assistance to 24 AI/AN communities.

There is a tremendous need to evaluate suicide prevention activities, and we are strongly committed to evaluating the effectiveness of our programs. The first evaluation of the Lifeline was conducted by researchers from Columbia University and Rutgers University. It documented reductions in callers' suicidal intent and hopelessness during crisis calls and at a two-week follow-up. SAMHSA and the National Institute of Mental Health (NIMH) are currently funding an evaluation of a modified version of the *ASIST* program, which is being used by crisis center workers throughout the Lifeline network. *ASIST* stands for *Applied Suicide Intervention Skills Training*, and it is fairly widely used in the suicide prevention world, along with another program, *QPR*, which stands for *Question, Persuade, and Refer*.

My fondest hope is that our preventive strategies will eventually make the question of suicide more and more irrelevant. I want to encourage people of faith to enter the suicide prevention process earlier and talk more about promoting living—what life has to offer. I'm confident this would help invigorate a person's life so that it has meaning and purpose and that people do not feel hopeless, despondent, and alone. The best suicide preventive approach is a life worth living.

Suicide Prevention Resource Center

Dr. Lloyd Potter, then Director of SPRC, described SPRC as follows:

As early as 2001, the *National Strategy for Suicide Prevention* called for a federally funded national resource center to advance the goals and objectives it sets forth. In response, Congress provided resources for SAMHSA's Center for Mental Health Services to fund SPRC. Our mission at SPRC is to promote the implementation of the *National Strategy* and enhance the nation's mental health infrastructure. We do that by providing states, government agencies, private organizations, colleges and universities, suicide survivors, and mental health consumer groups with access to the science and experience that can support their efforts to develop programs, implement interventions, and promote policies to prevent suicide.

One of our first activities was to conduct regional conferences to help interested States establish statewide suicide prevention plans. In 2002, only seven or eight states had developed such plans, but now at least 48 states have done so. Following the passage of the Garrett Lee Smith Memorial Act in 2004, in addition to pursuing our mission as a national technical assistance center, we began to provide technical assistance (TA) to SAMHSA's State/Tribal and Campus grantees. At SPRC, we have staff known as "Prevention Specialists" who provide customized TA by means of telephone calls and site visits to individual grantees, as well as through webinars, conference calls, and other online services.

SPRC is also responsible for identifying and disseminating best practices in suicide prevention. Best practices generally include effective mechanisms for responding to someone with suicidal ideation, core values that reflect a public health approach, noncompetitive collaborative partnerships, cultural sensitivity, and seamless services.

We have developed a number of suicide prevention resources, such as:

- *Assessing and Managing Suicide Risk*, a curriculum for mental health clinicians that has been adapted for college counseling center staff and employee assistance professionals
- *Strategic Planning for Suicide Prevention*, a curriculum for community leaders
- juvenile justice curricula
- suicide prevention training for first responders
- online courses addressing suicide prevention
- a webinar discussion series
- an online library of information, tools, and resources
- *The Weekly Spark*, a free weekly e-newsletter providing research and samplings from the news media
- customized information for a wide range of stakeholders: substance abuse counselors, clergy, college students, co-workers, corrections staff, employers, law enforcement, media, nurses, physicians, school health workers, survivors, teachers, and teens

Documents that the faith community finds especially useful are *Customized Information for Clergy* (www.sprc.org/featured_resources/customized/clergy), *After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances* (www.sprc.org/library/aftersuicide.pdf) and *Safe and Effective Messaging for Suicide Prevention* (www.sprc.org/library/SafeMessagingfinal).

SPRC is currently collaborating with the National Association of State Mental Health Program Directors to develop a resource guide for the public sector response to suicidality among people with severe mental illness [completed in March 2008: www.sprc.org/library/SeriousMI.pdf]. We are also collaborating with the State and Territorial Injury Prevention Directors Association to develop recommendations for suicide prevention in rural areas [completed in April 2008; www.sprc.org/library/ruralyouth.pdf], and we are developing a white paper on suicide and suicide prevention among lesbian, gay, bisexual, and transgender youth.

A Public Health Approach to Suicide Prevention

It is not impossible to dream of thousands of congregations working alongside public health, sharing an understanding that health is a seamless whole: physical, mental, social, spiritual; that poverty and illiteracy and addiction and prejudice and pollution and violence and hopelessness and fatalism are forms of brokenness, diseases that require the deployment of both their assets in building whole, healthy communities.

--Dr. William Foege, 1999, Senior Fellow, Bill and Melinda Gates Foundation
Former Director, Centers for Disease Control and Prevention, The Carter Center,
The Center for Child Survival at Emory University, and The Global Health
Initiative at the Bill and Melinda Gates Foundation

Dr. Potter described the public health approach to suicide prevention as follows:

We at SPRC and our colleagues at SAMHSA follow the recommendation of the *National Strategy* and take a public health approach to suicide prevention. Public health is the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society. It is the approach that has decreased rates of smoking and increased rates of seatbelt use, and it is widely regarded as the approach that is mostly likely to produce significant and sustained reductions in suicide.

The public health approach is a scientific approach that comprises five basic, systematic steps:

1. Define the problem (Surveillance)
2. Identify causes and/or risk and protective factors
3. Develop and test interventions in “controlled” settings
4. Implement interventions in the “real world”
5. Evaluate interventions, and use the findings to improve them

These steps may be sequential, or they may overlap.

Attempts to *define the magnitude of the problem of suicide* have been underway since the first National Vital Statistics System (NVSS) was implemented in 1933. Over the years, NVSS has allowed us to know that, after the high suicide rates during the Great Depression declined, the rates have remained fairly stable. It has further let us know that males have a higher suicide completion rate, but females have a higher attempt rate, and that firearms are most often used in a completed suicide, followed by suffocation (usually by hanging) and poisoning. Currently, the majority of suicides are by working-aged adult males, but the highest rates are among white males over the age of 84.

Determining that suicide is the cause of a death is often a difficult process; and suicide statistics for all age groups are likely to be underestimated. For example, no one really knows how many single-occupancy car crashes are suicides. Some state laws require a suicide note or some other indisputable evidence for coroners to declare that a death is caused by suicide. Uniform guidelines for coroners exist, but how well the coroners are trained and whether they follow the

guidelines are difficult to gauge. In many localities, coroners are elected, and families often go to great lengths not to have suicide listed on death certificates. Destigmatizing mental conditions such as depression might enable coroners to report more accurately when a death is a result of suicide.

The next step in the public health approach is to try to *identify causes* of the problem. However, we know that suicide is a very complex behavior with no single cause, so we have to look at the *risk and protective factors* that *correlate* with suicidal behavior. Well-known risk factors include mental illnesses and stressful events such as losses that result in humiliation, shame or despair. Key protective factors include social support networks and access to mental health care. People who attempt suicide typically have a combination of risk factors, but there is often one precipitating factor that leads the person to make an attempt. I can't emphasize enough the importance of protective factors. A person with many risk factors may *not* attempt suicide *if* his risk factors are sufficiently balanced by protective factors. We know that being a part of a faith community is a powerful protective factor, so you see why all of you gathered here today are so important to the national suicide prevention initiative.

Clergy people may be most aware of their role as a protective factor for friends and family following a suicide. We know that suicide victimizes the friends and family and that grief reactions are often very complicated. Many people who die by suicide leave a letter in which they try to explain where their hearts and minds are and try to absolve the family of responsibility. This sometimes helps. However, many friends and family members never stop bearing responsibility for not knowing the level of distress the person was in and for not stopping the suicide. Rabbis, ministers, and others in faith-based communities are invaluable in helping people find hope and meaning in life after such a painful tragedy.

The third step in the public health approach is to *develop and test interventions*. Now the development of an intervention is far more complicated than most of us think. Our common sense might tell us one thing, but hard data might tell us something else. For example, we might think that if we had more mental health professionals, we could decrease the suicide rate, and maybe we could. We haven't tested that hypothesis to know for sure. We do know, however, that *not all strategies for prevention are clinical*. Many strategies are actually laws and public policies. For example, there is some evidence that many who take their lives would not have died without the use of a firearm, so we might argue for stricter gun control laws. However, the evidence is equivocal—there is no absolute correlation between gun laws and suicide rates. Be that as it may, almost everyone would agree that the lethal nature of a firearm in the hands of a depressed individual speaks for itself. We have to consider the implications of multiple factors as we develop our programs and policies, and we have to make sure they are age-specific, developmentally appropriate, and culturally sensitive.

Now consider the questions you in the faith community must ask as you develop programs and policies regarding suicide. I think it's safe to say that, by and large, more faith groups are becoming less judgmental and more sensitive toward what a suicide victim may have been going through. There is more of a belief that God must know the suffering this person endured and will forgive him. Unlike beliefs in the past, many people now believe that the person will not necessarily go to hell. But the public health approach demands that we ask the tough questions.

Will removing the fear of punishment, stigma, and hell toward those who take their own lives deter them from doing so or encourage them? Horribly depressed elderly people have said that their faith prevented them from taking their own lives, especially the conviction that they would go to hell. The notion of a judgmental God has changed among many Catholics and other groups toward a God of grace who will forgive the person who dies by suicide. Does lowering this barrier potentially make it easier for some of these depressed people to take their lives? We have to think carefully about how accepting to be without actually encouraging suicides. Do we publicize school suicides or keep them quiet? Will big assemblies on the subject encourage copycat suicides? Does being too accepting communicate an implicit suggestion that suicide is an acceptable behavior?

Once we have considered all relevant factors we can think of and have developed our programs and policies, we have to test them in what is known as “efficacy” or “formative” research under more or less “controlled” conditions to ensure that they are safe, effective, ethical, and feasible. This research enables us to make necessary revisions and maximize our chances of success before we implement the program on a broad scale.

Once we’re pretty sure we have a sound program or policy, we can proceed to the next step in the public health approach, *widespread dissemination*. A key issue here is *fidelity of implementation*. It is extremely important to implement the entire program as it was originally designed and tested. Minor adaptations may be made for a particular community or cultural group, but it is best to do these adaptations only in consultation with the developer of the program. The principles of the program absolutely must remain intact, as well as many other elements such as the number, frequency, and intensity of intervention (or dosage).

The fifth and final step in the public health approach is to *evaluate the effectiveness* of our policies and programs in the “real world.” Evaluation involves setting realistic goals and objectives that are specific, measurable, attainable, relevant, and time-based, and it needs to be a part of the initial development of the program or policy. We want our interventions to be safe, ethical, feasible, and effective, and only good evaluations can tell us if they are. *Unfortunately, most interventions that are presumed to prevent suicide, including some that have been widely implemented, have not yet been adequately evaluated.*

These same five steps can be used when a death by suicide is averted to determine the best life-affirming treatment to help individuals and families heal and restore mental well-being. Churches and faith based organizations are ideally suited for providing encouragement to guide people to better paths. The crisis may generate opportunities for proactive interventions such as school and community gatekeeper training, screening programs, peer support networks, and suicide prevention education. Whatever we do, we want to make sure it works.

(Additional information about the public health approach can be found at <http://www.sprc.org/library/phasp.pdf> and at <http://www.hsph.harvard.edu/hicrc/nviss/documents/Suicide%20Brochure%20FINAL1.pdf>.)

Faith Community Perspectives on Suicide

Ten days before the meeting, participants were sent the following questions, which they then addressed at the meeting:

1. With respect to those who adhere to your faith perspective:
 - What are the predominant views with regard to suicide and its spiritual consequences?
 - What are some of the commonly understood explanations for why people of your faith end their lives?
 - What are commonly held opinions of people of the faith who attempt or complete suicide?
 - What are some of the predominant attitudes with regard to
 - a. Whether suicide is preventable,
 - b. Whether the faith community should focus on preventing suicide, and
 - c. Whether the faith community should engage with the community at large to prevent suicide?
2. Are there any official or unofficial position statements regarding suicide or suicide prevention available from leaders in your faith?
If yes, what do they say and what, if any, effect do you think these position statements have in shaping attitudes, beliefs, and practices by the majority of those who share your beliefs?
3. What attitudes, beliefs, subgroups, or structures within your faith group could either help or present significant barriers to preventing suicide among adherents of the faith?

Dr. David Litts, Associate Director for Prevention Practice at SPRC, facilitated the discussion of these questions. ***Each participant stressed that, within his or her particular faith group, people hold a wide variety of beliefs about suicide and its prevention.*** They then presented *generally held teachings and beliefs* of their respective groups.

Judaism

I call heaven and earth to witness against you this day, that I have set before thee life and death, blessing and cursing: therefore choose life, that mayest live, thou and thy seed.

--Deuteronomy 30:19

Jewish Publication Society Bible

Representing the Jewish faith were Rabbi Gary Greenebaum, U.S. Director of Interreligious Affairs for the American Jewish Committee, and Dr. Kalman Kaplan, Professor of Clinical Psychology, Department of Psychiatry, University of Illinois in Chicago (UIC) and Director, Program in Religion, Spirituality, and Mental Health, sponsored by the John Templeton Foundation at UIC. Key points they made are as follows.

Among the major Jewish congregations—Reform, Conservative, and Orthodox—the *predominant views regarding suicide* are no different either in law or tradition. The Book of Deuteronomy makes clear what we should do when it says, “I call heaven and earth to witness against you this day, that I have set before thee life and death, blessing and cursing: therefore choose life, that mayest live, thou and thy seed.” (Deuteronomy 30:19, Jewish Publication Society Bible)

Judaism teaches that how we are born and how we die are in God’s hands. Life belongs to God, not to the individual, and it is a gift to be treasured. The Biblical basis for the injunction against suicide has been derived from the Noahide laws: “For your lifeblood too, I will require a reckoning.” (Genesis 9:5, Jewish Publication Society Bible) This statement has been seen as a prohibition not only against suicide, but also against any form of self-mutilation. (*Baba Kamma* 91b) The Hebrew Bible contains several additional prohibitions with regard to self-mutilation. For example, “Ye are the children of the Lord your God: Ye shall not cut yourselves, nor make any baldness between your eyes for the dead.” (Deuteronomy 14:1, Jewish Publication Society Bible) Taking a single life is seen as taking the life of the entire world; saving a single life is seen as saving the entire world.

Our definition of suicide requires intent, full wits, non-deficiency in behavior, and non-inebriation. (*Yorah Deah*, 345) Taking your own life is viewed as a very serious violation of your responsibility to God and society if you are in your right mind, in part because it denies you the opportunity to repent. In Jewish law, there is no right to self-mutilation or suicide since you are only “renting” your body from God. People who die by suicide cannot be buried inside a Jewish cemetery; spaces for them are reserved just outside the cemetery.

It is important to note that the Jewish law against suicide is only one narrow aspect of the far wider and more important idea that God loves man without qualification and indeed created man uniquely in His own image. The *Torah* is thus given to man as a *guide for living* rather than merely as a preparation for death: “Ye shall therefore keep My statutes and Mine ordinances, which if a man does, he shall live by them: I am the Lord.” (Leviticus 18:5, Jewish Publication Society Bible) This same idea is constant throughout the Bible and Rabbinic writings.

Jewish teachings never condone suicide, but Jews tend not to blame the person who dies by suicide. However, Jewish communities feel a profound sense of tragedy and loss when someone takes his own life. They try to understand the death and not be judgmental toward the victim. The suicide is condemned, but not the person.

Regarding the spiritual consequences of suicide, Judaism does not have a strong sense of punishment such as hell. It assumes an afterlife but does not provide a lot of details as to what that would be, and many rabbis don’t like to talk about it. Jews customarily say a particular prayer for the dead, the Kaddish, for 11 months following a death. For a death by suicide, the Kaddish is recited for 12 months to give that person additional assistance in the afterlife. The Kaddish speaks of the wonderful nature of God as an entity who is good, caring, and compassionate and who will provide for whatever the afterlife will be.

Judaism does not teach a doctrine of original sin; people are not born into sin and do not need to be baptized or saved. In Hebrew, the word for “sin” means “an arrow that misses the mark”; it is

not fraught with intention or lack of intention. “Responsibility” is the important concept for Jews, not “sin.” Jewish life is considered to be “this worldly” in its emphasis. Our role is in this world. Although we are not required to complete the work of creation, we are not free to desist from doing what we can to better the world. Attitudes regarding death are generally practical. There is a strong sense that people have free choice, and many Jews support the right to die movement. It is widely held that “pulling the plug” to end suffering does not offend God or violate our responsibility to promote life.

Some commonly understood explanations for why Jewish people end their lives include severe depression or other psychological problems and major life stresses. Jews generally attribute responsibility for a suicide to these conditions and try to help the survivors. They believe that suicide is not an act against God when the victim’s psychological state prevents him from being in full control of his capacities. There’s a lot of understanding of pressures and stresses, and many people feel responsible for their failure to see the pain the person was enduring. The suicide victim is regarded as acting out a personal psychological reality that no one knew existed.

In general, Jews believe that most suicides can be prevented. Suicides are seen as psychologically based, so Jews usually search for ways to intervene in time. It is important, for example, to take actions such as giving a person food and water, personal affirmations, and physical comfort, and to get the person the care he needs.

Jews are likely to be quite willing to participate in suicide prevention efforts. Orthodox Jews are more insular than Reform or Conservative Jews, but they would still participate in outside efforts to prevent suicides.

Key opportunities for participation in suicide prevention include education for rabbis and youth group leaders, activities at Jewish summer camps, and working with Jewish social services agencies. We also need to develop better approaches to the family survivors, especially if we can find ways to help them translate their loss into some sort of life-affirming and charitable contexts that may help others who are suffering.

The key barrier to the Jewish faith community’s engaging in suicide prevention activities is that proper access to materials and training is lacking. Rabbis and Jewish seminarians often are not aware of the seriousness of the problem and do not know how to access materials that could be helpful in preventing suicide.

There are always two parties to a death; the person who dies and the survivors who are bereaved . . . the sting of death is less sharp for the person who dies than it is for the bereaved survivor. This, as I see it, is the capital fact about the relation between the living and the dying. There are two parties to the suffering that death inflicts; and in the apportionment of the suffering the survivor takes the brunt.

—Arnold J. Toynbee, *Man's Concern with Death*, 1968

Islam

Nor kill (or destroy) yourselves: for verily Allah hath been to you Most Merciful!
The Quran, An-Nisa (The Women) 4:29

Verily in the remembrance of Allah do hearts find tranquility and rest.
The Quran, Ar-Raad (The Thunder) 13:28

Come back to your Lord – well pleased (with Him) and well pleasing unto him.
The Quran, Al-Fajr (The Daybreak) 89:28

Dr. Abdul Basit, former Professor of Psychiatry at Northwestern University and Editor-in-Chief, *Journal of Muslim Mental Health*, and Mrs. Najah Bazy, Transcultural Registered Nurse Specialist and Health Ministry Liaison at the Islamic Center of America in Michigan represented the Islamic faith. Dr. Basit is a practicing Sunni, and Mrs. Bazy represented both the Sunni and Shia perspectives. Key ideas they presented are as follows.

There is no gender inequity in Islam, and the *Quran* makes it clear that, for all of humanity, life is a struggle. There are good days and bad days, but the *Quran* also reassures us that there is no shame associated with having to struggle. Islam is proactive and preventive with regard to avoiding trouble and averting crises. The teachings of Islam discourage people from “falling off the straight path” of lifestyle choices. Toxic substances such as cocaine and alcohol are not allowed, nor are high-risk activities such as gambling. Our clergy tell us to stay away from these and other vices. Suicide is often seen as the result of the person’s not being obedient to the rules of God and “falling off the straight path” by engaging in harmful behavior.

Mrs. Bazy told about an incident in which a man who lost a lot of money gambling, thereby endangering the well-being of his family, took his own life and the lives of his wife and children. These deaths were deeply painful for the families and shook the community to its core. However, after this tragedy, the community saw an opportunity to reinforce adherence to Islamic teaching. In addition, the Muslim community determined to save other people from these disasters, and it created anti-gambling and suicide prevention initiatives primarily through more open dialogue with the community, especially at the level of clergy and social support networks.

In general, the predominant view of suicide among Muslims is that suicide takes away the gift of life that God gave us, and we definitely do not condone it. The *Quran* says to trust God, have faith in the mercy of God, support the family, have patience, and do not destroy life. Despite the teaching that one should not destroy life, Muslims generally do not condemn the individual who dies by suicide. They believe that the death is a personal matter between the victim and God. Often it becomes evident that the victim had suffered emotionally or had a mental illness that the community was unaware of. The victims are buried with the rest of the community.

Regarding the spiritual consequences of suicide, Muslims believe that the soul is eternal, that it never dies. It is a gift of intellect and discernment, that is, a gift of choice. The issue of choice makes suicide a difficult discussion. If you take your own life, you are choosing to sin against God. Muslim suicide is often associated with the sins of drinking and gambling, which further

complicates the issue, for God has warned humanity to stay away from such vices. Quantity of life is as important as quality of life because all moments are sacred. To take a life prematurely would almost be equivalent in some respects to aborting a life, which is looked upon unfavorably in Islam. Muslims believe that those who take a life unjustly, be it their own or another, is the equivalent of taking all of humanity. Likewise, to save a life is the equivalent of saving all humanity.

In addition to the spiritual framework, there is a physical component as well. Muslims are not permitted to mutilate their bodies. The body gives us dignity in life, so the body in turn deserves its own dignity in death, and the individual will be called into question about how the body was treated. The body cannot be cremated. Rather, it must be buried for the soul would suffer deeply to see that the “carrying case” (i.e., the body) has been mutilated or burned.

Muslims generally understand that suicide results from psychological illnesses and severe life stresses. In the United States, many Muslims are scholars and doctors who see suicide as a result of depression and not as a sin. Similar to Judaism, there is an understanding that such a person is in some way not in control; something has short-circuited in the brain. It could have been depression, or perhaps something went wrong physically and/or chemically that fostered a sense of hopelessness. There is sympathy and a search for reasons to explain why the suicide happened. Our role ought to be to make sure that suicide does not happen. We never condone it. We don't want to create a perception of giving permission, nor should it ever be glorified.

Mrs. Bazy stated, “In Detroit, we are currently working closely with Muslim divorcees who have attempted suicide. We have a large refugee population. Many Iraqi refugees suffer from post-traumatic stress disorder, a sense of desperation about all they have lost, a tremendous amount of hopelessness as the war continues, and fear for their families still in Iraq, as well as from the repercussions of being separated from loved ones. They constitute a very high-risk population. Core counseling includes a tremendous emphasis on spirituality because they are deeply devout and God-conscious people.”

From a theological perspective, *Muslims would certainly agree that most suicides could be prevented.* We are encouraged to think about the verses in the *Quran* and what they mean. There is a saying, “God gives a soul no more than it can bear.” This is a message of healing, especially if someone is on the edge, such as surviving family members. Mrs. Bazy noted that she leans on that saying to help people who are feeling a sense of hopelessness. She added, “The clergy will say, ‘God is testing you.’ I try to redirect or reconstruct the way that is said to mean ‘God will reward you for your patience and struggle.’ I try to encourage clergy to reconstruct the way they say that.” Another problem is that clergy who speak English as a second language may not be communicating clearly; they may inadvertently use the wrong words and thereby convey the wrong message.

Our clergy are beautifully trained in religious theology, which almost allows them to be *de facto* social psychologists. However, many are not trained to identify a more practical solution to problems that stem from serious depression, and many may just tell the person to pray harder. They are not able to pull out what ails people and how to help them when they are severely depressed. The clergy teach us to never lose hope or faith in God to resolve inner turmoil. “God

is the last refuge,” they will say, hoping that individuals with suicidal ideation will change their minds and not take their lives.

The Muslim community would be enthusiastic about *engaging with the community at large to prevent suicide*. A major opportunity that would help engage Muslims is based on one of our core beliefs – in Islam, we are all *interdependent*. Few outside the Muslim culture understand the nuances of how we view our interdependence on one another, and more importantly, on God.

Major barriers to Muslims’ participating in suicide prevention efforts are stigma and lack of access to care. Women are hesitant to walk into their mosque for a formal appointment with the Imam, who may not be as scholarly and trained as other Imams and less educated about psychological problems. We need to sit down with our Imams, especially those who are less familiar with western culture and pressures, and help to educate them about available resources. In addition, even if adequate culturally appropriate mental health services exist, sometimes fear of stigma prevents many Muslims from seeking treatment in a mental health clinic. Muslims believe that it is important to protect family integrity, to protect and honor the family name, and not to bring shame on the family. While mental health is gaining ground in terms of community education, more resources are needed to continue this journey.

Hinduism

You must not use your God-given body for killing God’s creatures, whether they are human, animal or whatever.

Yajur Veda, chapter 12, verse 32

Nonviolence is the highest duty. Ahimsa paramo dharmaha.

Mahabharata, Anushasana Parva, chapter 115, verse 1

Representing the Hindu faith were Dr. Jeffery Long, Chairman of the Department of Religious Studies at Elizabethtown College in Pennsylvania, and Arun Gandhi, Founder and President of the Gandhi Worldwide Education Institute. Key ideas they presented are as follows.

Hinduism is not really a “religion.” It is not formalized or organized like Islam, Judaism, or Christianity. We do not have to be baptized or belong to one particular temple. There is no established creed, no centralized institutions, no congregational praying. There is not even a single authoritative scripture. While the *Vedas* are universally revered among Hindus, they are very rarely read, and even less frequently understood. Portions of them are typically chanted during ceremonial events. They have traditionally been the preserve of the priests. Unlike scriptures in Western religious traditions, it is not expected that most Hindus will read daily from the *Vedas*.

The philosophy of the *Vedas* is commonly communicated through popular literature like the *Mahabharata* and the *Ramayana*. A portion of the *Mahabharata*, the *Bhagavad Gita*, has become especially popular in the modern period and was a particular favorite of Mahatma Gandhi. But it is by no means seen as universally authoritative. Not all Hindus are familiar with

it, and some Shaiva Hindus even reject it. Whenever one speaks of the “Hindu scriptures,” therefore, one is referring to a vast body of literature, including, but not limited to, the *Vedas*, the *Mahabharata*, the *Ramayana*, and numerous legal and philosophical texts, such as the *Manusmriti* and the *Yoga Sutra*. Some Hindus regard particular portions of this literature as more sacred than others, while other Hindus focus on other portions of it, with the *Vedas* being more universal in their appeal (with the qualifications already noted).

Despite the lack of formalization, Hindus do have duties to perform and rituals to practice during a lifetime. The role of Hindu priests is to carry out the rituals; they are not pastoral. In times of crisis, some people turn to their families and communities, while others turn to their spiritual leaders or gurus, not to Hindu priests. Hindus believe that the divine reality can be approached in a variety of ways: as an impersonal principle, or as a personal deity which takes numerous forms. These forms are the deities of Hinduism and of all the world’s religions. All are seen as forms of the one supreme Reality.

With regard to suicide in the Hindu faith, Hindu scriptures say little regarding suicide or the spiritual consequences of suicide. The *Isha Upanishad* contains the following controversial verse: “All who kill the self go after death to demonic worlds that are cloaked in blind darkness.” (*Isha Upanishad*, verse 3) It appears to be a straightforward condemnation of suicide, asserting that the next rebirth of one who commits suicide will be in an unpleasant, hellish state. But the phrase “kill the self” has been taken by most of the commentators to refer to the eternal self, the *atman*, which, of course, is divine and cannot be killed. So “kill the self” is taken to refer to denial of the reality of the *atman*. The verse thus becomes more of a condemnation of atheism than of suicide.

Other Hindu writings make a distinction between a “dishonorable” suicide and an “honorable” giving up of one’s life. On the one hand, suicide undertaken out of passion (due to despair, anger, and so on) is condemned in passages from the *Laws of Manu* such as, “No ritual of libation should be poured out for those who...have taken their own lives.” (*Manusmriti*, chapter 5, verse 89) On the other hand, the same text commends giving up of one’s life when one has reached a high spiritual state: “When he has gradually abandoned all attachments in this way and is freed from all duality, he is absorbed directly into the ultimate reality.” (*Ibid*, chapter 6, verse 81) Examples of “honorable” suicides would be when an elderly person with an incurable disease or an ascetic who has dedicated himself to a monastic life stop eating and drinking and “let nature take its course.” Such people are admired for being calm as they die, knowing they have fulfilled the purpose of their lives.

Hindus have a lot of confidence in the immortality of the soul, so there is little fear of death. But a *human* rebirth is rare and precious. Even though there are other forms besides human that your soul can take in your next incarnation, your current human form is particularly rich with possibilities and should not be wasted. The attitude toward suffering, as in other religions, is that it builds character. In Hinduism, the soul and the body are not the same; we separate the spiritual from the physical. So disease is only happening to the physical body. We should only identify with the soul, and let go of the body.

Let him not desire to die, let him not desire to live; let him wait for his appointed time, as a servant waits for the payment of his wages.

Manusmriti, chapter 6, verse 45

The concept of *karma* is a law of cause and effect, analogous to the laws of physics inasmuch as it is universal and impersonal. It is thus different from the concept of divine judgment found in the Abrahamic religions. The same concept is also present in Buddhism. It holds that certain actions have certain inevitable effects. The lifespan-karma destiny from birth to death includes an expectation of duties to perform. Suicide is a premature death.

Many traditional Hindus believe that the *spiritual consequence of suicide* is that one becomes a ghost, an unquiet spirit, until the spirit reaches the originally-destined age for death. In some villages in India, people often perform rituals to keep the ghost “happy” until it reaches its destined age and can then continue on to its next existence.

There are about two million Hindus in America, and they generally do not hold these beliefs. As with many Jews and Muslims, American Hindus tend to believe that suicide is a very sad tragedy and a terrible loss for the community. They grieve, extend sympathy to the family, and do activities to honor the person and acknowledge the loss, but there is not really a sense of shame surrounding a suicide. The *Mahabharata* states, “Nonviolence in thought, word, and deed toward all creatures, compassion, and generosity constitute praiseworthy behavior.” (*Mahabharata, Shantiparva*, chapter 124, verse 65) These are the three main virtues in the Hindu tradition. Nonviolence is the basis for the Hindu rejection of suicide, and compassion is the basis for the non-condemnation of the person who commits it.

Hindus would agree that *suicide is preventable*. In India, many suicides have been linked to economic difficulties. It is estimated that two to three farmers take their lives each day because they can no longer make a living. In the United States, suicides among Hindus are more often socially and/or psychologically driven. For example, suicides among Indian students in the States are often linked to intense pressures to excel. In addition, some Indian men who came to America to study when they were young became involved with American women. Some even married these women without telling their families in India. Many actually returned to India and went through with an arranged marriage to an Indian woman. When they returned to the States with their Indian wives, some treated these women as slaves or abandoned them. Being too humiliated to tell their families, many of these women took their own lives. The Indian community in the U.S. is now reaching out to help those women gain hope for a new life.

Hindus in America believe that we must tackle the compulsions and eliminate the hate, negativity, prejudice, and exploitations that may cause the suicides. We believe that there are so many walls, labels, and barriers that prevent us from treating one another as human beings. We need to work harder to achieve a harmonious society and break down the walls we have created around us.

The Hindu *community would engage with the community at large to prevent suicide*, but probably not through traditional Hindu clergy and temples. Hindu priests are only trained in how

to perform rituals, not in human relations. They would only quote the scriptures to someone in distress. There's an interesting paradox here. While the American culture is individualistic, mosques and churches are where people seek community. In India, people are very community-oriented in their daily lives, but when they go to a temple, it is to be alone, to seek solitude and spirituality. Indian Hindus are individualistic only in regard to religion, and the priest is there to help with prayer.

Gurus and spiritual leaders have a pastoral role similar to monks and nuns. Also, networks for assistance exist in Hindu communities; everyone is there to help, especially close family and friends. There are festivals and other ways to reach the Indian communities, which are well organized. For example, the Hindu American Foundation is a strong advocacy group that provides education for leaders in public policy, academia, media, and the public at large about issues concerning Hindus—religious liberty, the portrayal of Hinduism, hate speech, hate crimes, and human rights, for example. Its goal is to promote the Hindu and American ideals of understanding, tolerance and pluralism, and it takes a firm stand against hate, discrimination, defamation, and terror. This organization might well help carry the message about suicide prevention to the larger Hindu community.

American Hindus are comfortable with science and accept modern medicine and psychotherapy, but there is also shame and stigma around seeking psychiatric help. The difference between the stigma in Hindu communities versus that in Islamic and Jewish communities is that the latter never condone suicide, but Hindus take a more neutral, situational, and nonjudgmental attitude. They probably would not ask, "How will the gods feel?" but rather, "How would your Hindu mother feel?" They believe that the fear of stigma is in the person's mind, not in or on the minds of the community. It is necessary to have a continuing dialogue in the suicide prevention community on how to balance not attaching a stigma to suicide but simultaneously not condoning the act.

Buddhism

*How swiftly the days pass! It makes us realize how few are the years we have left.
Friends enjoy the cherry blossoms together on spring mornings, and then they are gone,
carried away like the blossoms by the winds of impermanence, leaving nothing but their
names. Although the blossoms have scattered, the cherry trees will bloom again with the
coming of spring, but when will those people be reborn? The companions with whom we
enjoyed composing poems praising the moon on autumn evenings have vanished with the
moon behind the shifting clouds. Only their mute images remain in our hearts. Though
the moon has set behind the western mountains, we will compose poetry under it again
next autumn. But where are our companions who have passed away? Even when the
approaching tiger of death roars, we do not hear and are not startled.*

--Nichiren

Mr. Lee Wolfson, a psychologist and lecturer at the University of Pittsburgh Medical School represented Buddhism. Among his key comments were the following.

Buddhism began in about 600 B.C. with one human being, Siddhartha, who came to be called the Buddha. The Buddha asked the question many have struggled with: “Why do we suffer, and how do we end the suffering?” The first teachings that the Buddha espoused were the Four Noble Truths. In popular culture, there is a lot of misunderstanding about what he was really talking about. For example, the Pali word *dukkha* was translated into English as *suffering*, so people commonly say that the Buddha’s first truth is “All life is suffering.” But a more accurate translation of *dukkha* is *unsatisfactoriness*, and the first truth is better translated as “All life is unsatisfactory.” This moment is just never good enough. It is an idea that expresses the unsatisfactory nature of human existence.

As a good physician, the Buddha wanted to diagnose the problem. He said the cause of suffering or dissatisfaction is desires. However, this is not to be understood to mean that we must eradicate desires. The Buddha was much more specific. This moment is unsatisfactory because of cravings for pleasant experiences and an aversion to unpleasant experiences. This moment is unsatisfying because we want to be anywhere but where we are, either because of what we desire to have more of, or because we are trying to escape from something that is unpleasant.

Buddhists believe that the solution to the unsatisfactory nature of life is *nirvana*. *Nirvana* does not necessarily mean the absence of desire. Rather, when someone achieves *nirvana*, he experiences a state of liberation where he can be at peace and in harmony with his aversions and desires. He is not ruled by or attached to them. He does not try to avoid undesirable experiences or to hold onto pleasurable experiences. From this belief, Buddhism then extrapolates the *Eightfold Path to Nirvana—Right View, Right Intention, Right Speech, Right Action, Right Livelihood, Right Effort, Right Mindfulness, and Right Concentration*. Out of these paths come what are metaphorically referred to as the 80,000 teachings. Not all of these teachings were preached by the Buddha. Many were articulated later on, but they are believed to reflect the true spirit of the Buddha and are widely accepted. Among the most universal of these teachings is the *Lotus Sutra* which expounds that Buddhahood is accessible to all people, regardless of class, gender, or capacity for learning. It also expounds the eternal nature of Buddhahood and of life itself.

Most American Buddhists were not born into Buddhism; they come to it because they are seeking something. They usually find Buddhist practices such as mindfulness and meditation helpful, even though these practices do not actually “clear” or “discipline” the mind. Rather, they train and cultivate the capacity to be whatever you are at the moment, wherever you are, without judgment. There are also Buddhists who practice a more “devotional” form of Buddhism and attend gatherings at temples where priest perform rituals. I am a member of the Soka Gakkai International (SGI). Our form of practice involves chanting in front of a Mandala that represents the essence of the *Lotus Sutra*. For Buddhists, the path and the destination are really the same. Living a virtuous life is the goal; we’re not trying to get somewhere. The challenge is to keep people motivated to find the time to continue to meditate and progress psychologically.

In communicating with people already on the edge who are considering suicide, we have to carefully frame our message. Many who contemplate or attempt suicide think they know what they should be doing with their life but have decided they will never live up to the scriptures and beliefs of their faith. They believe they are “just not good enough” and that they don’t have

enough control to be better. It is these subtleties that religious leaders need to be sensitive to when trying to counsel someone in a suicidal frame of mind. They need to stress that Buddhism teaches virtuous precepts; it does not issue commandments. The precepts are something to aspire to, knowing we may never fully achieve them. For example, despite our teachings against not taking a life, including the life of an animal, not all Buddhists are vegetarians, but that does not mean they are “failures.”

The predominant views with regard to suicide among Buddhists are twofold: the historical view grounded in Buddhist teachings and the more contemporary view, neither of which condone suicide, although there is some academic discussion about circumstances where the Buddha may have condoned suicide. Buddhism teaches that one should not take a life, and it is a delusion to think that suffering will end with suicide. We suffer because we are deluded about the true nature of ourselves, our life, and our inner connectedness with all living beings and the world at large.

Historically, Buddhists believed in two kinds of illnesses: -illnesses of the body and illnesses of the mind. They believed that mental illnesses were really karmic illnesses that could not be cured by medical means. This reinforces stigma with regard to seeking professional help with depression. A major problem with the old thinking about depression and suicide is its judgmental mindset, though a core practice of Buddhism is not to be judgmental, even toward yourself. But the human tendency to judge is very powerful, and some Buddhists still believe that something has gone wrong with a suicidal person’s practice. I believe this is common in most faith communities.

When someone attempts suicide, the Buddhist attitude is that every life event is an opportunity for the individual, the community, and the family to grow and heal. There is sensitivity within my Buddhist community to make sure that the individual and his/her family are not shunned or condemned. Rather, they are embraced within a wonderful Buddhist concept of “changing poison into medicine.” When someone dies by suicide, the outcome cannot be changed, but the survivors can transform the tragedy from a negative into a positive by creating a meaningful narrative.

A suicide creates many doubts within a Buddhist community. Very often, no one can explain satisfactorily why an individual would take his own life, but the community still rallies around the family members and helps them find a deeper meaning in the tragedy. One doctrine in the Buddhist belief system is that obstacles will appear as the practitioner advances along his life’s path. One of these is the obstacle of death (*mrityu-mara*), the hindrance arising from the premature death of oneself or another practitioner. This doctrine helps to inoculate the Buddhist community from a sudden death and to maintain their commitment to their own awakening. Ultimately the death is reframed to provide an opportunity that enables everyone to grow and deepen their faith, to find a deeper level of meaning in, and appreciation for, their own lives.

The second, more modern view of suicide is widely held by Buddhists in America. This group tends to be well educated, to be more accepting of modern medicine and psychological explanations for suicide, and to embrace contemporary concepts regarding mental health issues. They feel that referring people to a mental health specialist is perfectly legitimate. Interestingly, mental health practitioners have begun to embrace the Buddhist practice of mindfulness

meditation. There is a growing body of literature to support the notion that mindfulness practices are efficacious in reducing stress, depression and anxiety. In the past, many academic and research circles dismissed faith and/or religion as irrelevant to mental health. But that began to change in the 1990s when psychologist Dr. Marsha Linehan and others began to incorporate Zen concepts of mindfulness and “radical acceptance,” along with contemplative spirituality from Western traditions, into psychotherapy. Some say that mindfulness is a fad, but it’s hard to categorize a form of mind training that has been around for 2000 years as a fad.

Be that as it may, some Buddhists still believe that Buddhism offers all the answers to life’s problems. There will always be those who stand up and say they were once diagnosed with bipolar disorder or depression and that through their Buddhist practice they were able to “cure” themselves. I have witnessed such transformations in some individuals, but I have also seen others who found a temporary solution in their Buddhist practice, only to find themselves in the grips of depression in spite of their devotion. The Buddhist community is now open to being educated and informed about depression and suicide prevention, but there is still work to be done to overcome the stigma of mental illness.

Regarding *the spiritual consequences of suicide*, some Buddhist traditions embrace the idea of reincarnation, perhaps not as literally as in Hinduism, but they do conclude that you are not going to resolve your suffering by taking your life. A wonderful psychologist, Dr. David Rosen, who has written numerous books on depression and suicide, will say to someone who is suicidal, “Something needs to die, but maybe it is not you.” That is a very Buddhist way of thinking; there is some suffering here that needs to go away, but it is not “I” who needs to go away.

By and large, most Buddhists, at least in America, *believe suicide is preventable*. More Buddhists are now able to say that, because of their practice of Buddhism, they knew enough to know they needed help and were able to reach out and ask for it. Or they were spiritually and physically in the right place at the right time when a wonderful doctor, psychologist, or therapist appeared in their life, and they were able to receive help when they really needed it. In the past 10 to 15 years, more and more Buddhists have been willing to acknowledge that they had mental health problems and saw a convergence between the compatibility of their Buddhist faith and practices and their seeking professional medical help. In the context of this complementary relationship, their faith and religion impelled them to seek help.

*Thousands of candles can be lit from a single candle,
and the life of the candle will not be shortened.
Happiness never decreases by being shared.*
--Sutta Nipata, Shakyamuni Buddha

Regarding the Buddhist faith community’s engaging with the community at large to prevent suicide, I must admit that Buddhist temples in America are no more organized than the Hindu temples. Moreover, the Buddhist community is small and highly fragmented. Only one percent of the U.S. population identifies as Buddhists, and there are many different Buddhist sects. The Soka Gakkai group which embraces Nichiren Buddhism is the largest and most organized here in the USA. Tibetan Buddhism, while generally united under the Dalai Lama, has a variety of sects.

Within the Zen community, lineage is emphasized, and transmission of the teachings is from one teacher to the next. There is no one overarching organization under which they would all identify. This fragmentation into various sects is the “karma” of Buddhism throughout its history. We have a unique opportunity in the US because, for the first time, all of these traditions are practicing in the same geographic area. However, you can see that without a central “church,” efforts to educate our communities will be more challenging.

Buddhist temples may not actively engage in suicide prevention efforts, but at the grassroots level, there would be a lot of acknowledgement of the need and interest in doing something. For example, Buddhist community centers around the country do outreach, and they may offer opportunities for working in suicide prevention. There are Zen centers in many cities that are very active and would be good contacts. Several of the Soka Gakkai International centers have mental health support groups that meet monthly to discuss issues such as depression and anxiety. This affords people the opportunity to discuss their struggles with other Buddhists with similar issues.

In addition to activities at community centers, temples, and retreat centers, most Buddhists read certain publications such as *The Tricycle* and *Shambhala Sun* that would offer opportunities for suicide prevention education. Also, Soka University of America in Los Angeles is an accredited university based on Buddhist values. The graduates are idealistic and passionate, and their dedication and hard work to achieve their ideals are inspiring. Naropa University in Colorado may also provide a base for disseminating awareness about suicide prevention. Other opportunities for community involvement include the Internet, Zen publications, and through the Dalai Lama. There may be opportunities to reach out to communities of recent immigrants from countries that have large Buddhist populations. For example, the Lowell Community Health Center in Lowell, Massachusetts serves a large Cambodian community with many refugees suffering from post-traumatic stress disorder. It has partnered with the local Buddhist center to develop programs to deal with violence and gang problems. Meditation rooms in the health center are used to teach meditation and help people develop non-violent coping skills.

Christianity

The Black Christian Church

Bishop William Young of the Healing Center Full Gospel Baptist Church in Memphis, Tennessee began the discussion of Christianity and suicide by addressing issues related to the Black church.

Reverend Otis Moses of Cleveland's Olivet Institutional Baptist Church once said:

“Have you ever thought about the fact that, without a psychiatrist, we withstood things that send most people to insane asylums? We didn't have the benefits of psychiatric counseling at the point of death, but the black preacher at the funeral service became the psychiatrist, without fee. The black church kept the black race from committing suicide.”

To a large extent, this is true. However, suicides still do occur among black churchgoers, and we are gradually coming to address it.

The Black church experience from slavery to the present includes many denominations—Pentecostal, Baptist, Catholic, United Methodist, Mormon, and African Methodist Episcopal (AME) to name a few. Generally speaking, though not exclusively, these churches teach that the person who dies by suicide is lost spiritually for eternity – i.e., he goes to hell. God is supreme, and suicide is considered to be an act against God. It is unforgivable because the person has no opportunity to repent. For many, this stigma is based on their Christian beliefs. Many preachers are uncomfortable when they have to preach at a funeral for someone who has died by suicide. They don't know what to say. They talk about everything else but the deceased. The preacher has already prejudged that the person is in hell.

The general perception in the Black community is that Black people who are in touch with their culture do not take their own lives. Suicide is considered to be a “white thing.” There is a denial that black men take their own lives. A woman whose husband took his life formed an organization named “Black Men Don't Commit Suicide” to try to dispel this myth. A lot of these myths are hard for people to give up. A lot of these cultural mores have been passed down for generations and are very difficult to change.

Some deaths that are likely suicides are referred to as “Suicide by Cop.” Hopeless youth may set themselves up to be shot by police officers rather than take their own lives. Some interpret this behavior as a weakness and an inability to take responsibility, but others see these youth as trying to die with dignity: “I stood up to the cops. I'm a man.” These youth know their behaviors will get them killed, but they feel like victims nonetheless. Many Black churches won't use the words *suicide*, *despair*, *hopelessness*, or *drive-by shooting*. There is a need for a different language.

Some pastors will say there is no suicide in their churches. When people need help and become suicidal, they say, the congregation comes together to pray over them, and the church takes care

of the problem then and there. These pastors completely deny a role for mental health treatment and maintain that prayer alone helps people.

Fortunately, many Black congregations are beginning to see that prayer alone may not be adequate to deal with issues prevalent in the African American experience and that mental health counseling is not just a need but a necessity. Incest and child molestation, depression, unresolved grief and trauma, the effects of fatherlessness, the self-hatred of violent crime, teen mothers with illegitimate babies at an alarming rate, and the culture of silence and denial threaten the core of our society. In Tennessee, we now have a coalition among mental health societies, the State, and churches to set up community-based mental health services known as “Emotional Fitness Centers,” many of which are domiciled in local churches. The Centers help prevent suicides by dealing proactively with problems such as depression and anger. In addition, churches recruit and train Peer Advocate Liaisons (PALs) to help members gain access to health care for both emotional and physical problems. We try to send a message that it is okay to care of yourself mentally, physically, and spiritually. This model has proven successful, and it is a good venue to promote total health for the African American population.

Churches are your richest resources if you can get them the right information. But in many cases, the information and the thinking need to change. Some pastors are also therapists, and an informed pastor/therapist listens rather than preaches when interacting with an individual in distress. But there is still a tremendous need to convince other pastors that both prayer and medicine are often needed to permit a person to sleep, to concentrate, and to recover from depression. This effort takes time. One of our projects in Memphis is a radio talk show with both mental health professionals and pastors that reaches a thousand people every Sunday morning. We’re able to provide correct information repeatedly to our listeners. These pastors and mental health professionals have tapped into another network of around four hundred churches. Views are changing little by little, and it does take a team approach to prevent suicides.

The Healing Center Full Gospel Baptist Church Mission Statement
...to build God’s kingdom and address spiritual, emotional, mental, and social needs of people through the preaching and teaching of the Word of God. It is our aim to utilize counseling and various other ministries designed to enhance the lives of people of all ages.

The Catholic Church

Ms. Jean Beil, Senior Vice President for Programs and Services at Catholic Charities USA, discussed commonly held views among Catholics:

The Catholic Church teaches that everyone is responsible for his life before God, that suicide contradicts the natural inclination of the human being to hold onto life, that it violates natural law, and that it is “gravely contrary to the just love of self.” It also violates the love of one’s neighbor and breaks the ties of solidarity with family and community to which we have obligations.

The Catholic Church teaches that there are two types of sins. *Venial sins* such as lying weaken grace in a person's soul and damage but do not destroy his relationship with God. *Mortal sins* such as murder are more serious because, by their very grave nature, they destroy our relationship with God. In order for a sin to be mortal, it must be a sin of *grave matter*, committed with *full knowledge and deliberate consent* of the sinner. The person knows the act is inherently evil, but he deliberately decides to do it anyway.

In the past, suicide was considered a mortal sin. However, in 1983, the Roman Catholic Church removed suicide from the list of mortal sins. Post-Vatican II thinking acknowledges that grave psychological disturbances, anguish, or a great fear of hardship, suffering, or torture can diminish the responsibility of the person who dies by suicide. We should not despair of the eternal salvation of those who have taken their own lives. We believe that only God knows whether the person repented between the time the wound was inflicted and the time of death, and people who die by suicide now can be buried in Catholic cemeteries. The second edition of the *Catechism of the Catholic Church*, 1994, 1997, details the current Roman Catholic teaching on suicide. (See Appendix B.)

Vision of Catholic Charities

Believing in the presence of God in our midst, we proclaim the sanctity of human life and the dignity of the person by sharing in the mission of Jesus given to the Church. To this end, Catholic Charities works with individuals, families and communities to help them meet their needs, address their issues, eliminate oppression, and build a just and compassionate society.

The Church of Jesus Christ of Latter-day Saints

Ye have heard that it hath been said by them of old time, and it is also written before you, that thou shalt not kill, and whosoever shall kill shall be in danger of the judgment of God.

Book of Mormon, 3 Nephi 12: 21

Dr. Brent Scharman, Assistant Commissioner of LDS Family Services with headquarters in Salt Lake City, Utah, provided the following comments relevant to the LDS (Mormon) view of suicide:

The Church of Jesus Christ of Latter-day Saints has a lay ministry through which most active members offer time and resources to their church and community and share the gospel through missionary efforts worldwide. In so doing, members are responding to their callings from God to inspire others to live higher and better lives. A Mormon might respond to his or her calling by teaching Sunday School, being a leader in our Young Men and Young Women programs, providing leadership or teaching to adults, or being a leader in a ward or a stake (i.e., a congregation). Many adult women respond to their callings by being actively involved in our Relief Society, whose purpose is to provide "relief of the poor, the destitute, the widow and the orphan, and for the exercise of all benevolent purposes."

All adults are encouraged to participate in our Home or Visiting Teaching program, where pairs of men or women visit the homes of three to five families monthly to provide support and encouragement. The goal of active church involvement and regular visitation of members is to prevent problems and provide a structure whereby support can be made available quickly when needed.

The LDS Church is very concerned about suicide prevention and about assisting family members when a suicide has taken place. Our booklet, *Identification and Prevention of Suicidal Behavior*, is available to all at no charge. A weekly newspaper supplement entitled *Church News* periodically publishes relevant articles such as one entitled *Surviving the Loss of a Loved One to Suicide*. In addition, the *Ensign* is a magazine published monthly with articles such as *Keeping Mentally Well* and *Mental Illness: In Search of Understanding and Hope*.

The LDS doctrine states that it is wrong to take a life, even one's own. However, it further acknowledges that a person who commits suicide may not be responsible for his or her acts. Only God can judge such a matter. Leaders should counsel and compassionately console the family members of a person who has committed suicide. The family, in consultation with the bishop, determines the place and nature of a funeral service for a person who has died under such circumstances. Church facilities may be used. A person who has seriously considered suicide or has attempted suicide should be counseled by his or her bishop and may be encouraged to seek professional help. (See Appendix C for a more complete statement of the LDS Church regarding suicide and its prevention.)

God has said, "You leave this to me." We're not wise enough to make judgments in such matters. We don't know enough. We did not walk with Karl in that dark night. As much as we have known him and as much as we have loved him, we have not been able to imagine what Karl must have been thinking. Because we can't and because God can, He has said, "You leave this to me."

--Elder Jeffrey R. Holland, speaking at the funeral of a good friend who died by suicide, 2001

The Lord was the only one who knew our genetic makeup, our state of mind, our emotional and intellectual capacities, the understanding we had of the gospel, and our physical and mental health, and he would take all things into consideration when He judged our actions on earth.

--Elder M. Russell Ballard, 2000

Suicide consists in the voluntary and intentional taking of one's own life, particularly where the person involved is accountable and has a sound mind...Persons subject to great stresses may lose control of themselves and become mentally clouded to the point that they are no longer accountable for their acts. Such are not to be condemned for taking their own lives. It should also be remembered that judgment is the Lord's; He knows the thoughts, intents and abilities of men; and He in His infinite wisdom will make all things right in due course.

Mormon Doctrine, second edition, p. 771

The Evangelical Lutheran Church in America (ELCA)

The church is the inn and the infirmary for those who are sick and in need of being made well.

--Martin Luther

Jerry and Elsie Weyrauch, survivors of the 1987 suicide death of their thirty-four-year-old daughter Terri Ann Weyrauch, MD, offered their thoughts on the ELCA perspective, based on their many years of membership in the ELCA.

Martin Luther, the priest who broke with Catholicism and started the Protestant Reformation in 1517, once said that “the church is the inn and the infirmary for those who are sick and in need of being made well.” The ELCA view of suicide is similar to many already discussed. In general, Lutherans believe suicide is a sin, but they also believe that a gracious and loving God does not judge a life by the way a person dies. On November 14, 1999, the Church Council of the ELCA adopted “A Message on Suicide Prevention,” which is reprinted in its entirety in Appendix D.

The United Methodist Church

...the General Conference of The United Methodist Church strongly urges the employment of major initiatives to prevent suicide, following the guidelines of the National Strategy for Suicide Prevention issued by the U. S. Department of Health and Human Services.

The Book of Resolutions of the United Methodist Church 2004

#157 Amended and Readopted

The United Methodist perspective was presented by Mr. Niels French, Director of the Interfaith Health Program at Methodist LeBonheur Healthcare in Memphis, Tennessee, and Dr. Jim Clemons, retired minister and founder of OASSIS (Organization for Attempters and Survivors of Suicide in Interfaith Services).

Many of us find comfort in the statement by St. Paul when he said, “Nothing can separate us from the love of God,” and that includes suicide. Despite this, historically, the Methodist perspective has been similar to that of most Protestants: if you take your life, you go to hell.

At its General Conference every four years, the United Methodist Church approves official statements on social issues, known as our *Social Principles*. The following is our statement on suicide from the 2005-2008 quadrennium:

Paragraph 161. The Nurturing Community

N) Suicide - We believe that suicide is not the way a human life should end. Often suicide is the result of untreated depression, or untreated pain and suffering. The church has an obligation to see that all persons have access to needed pastoral and medical care and therapy in those circumstances that lead to loss of self-worth, suicidal despair, and/or the desire to seek physician-assisted suicide. We encourage the church to provide education to address the biblical, theological, social, and ethical issues related to death and dying, including suicide. United Methodist theological seminary courses should also focus on issues of death and dying, including suicide.

A Christian perspective on suicide begins with an affirmation of faith that nothing, including suicide, separates us from the love of God. (Romans 8:38-39) Therefore, we deplore the condemnation of people who complete suicide, and we consider unjust the stigma that so often falls on surviving family and friends. We encourage pastors and faith communities to address this issue through preaching and teaching. We urge pastors and faith communities to provide pastoral care to those at risk, survivors, and their families, and to those families who have lost loved ones to suicide, seeking always to remove the oppressive stigma around suicide. The Church opposes assisted suicide and euthanasia. (2004 Book of Discipline of the United Methodist Church, ¶161N)

In 1980, the United Methodist Church published its first official statement on suicide prevention in the *Book of Resolutions*. It set forth strong guidelines for what we as a church should do to prevent suicide. (See Appendix E for complete statement.)

Methodist Le Bonheur Healthcare Mission Statement

Methodist Le Bonheur Healthcare, in partnership with its medical staffs, will be the leader in providing high quality, cost effective health care to benefit the communities we serve. Services will be provided in a manner which supports the health ministries and social principles of The United Methodist Church.

Methodist Le Bonheur Healthcare Interfaith Health Program Mission Statement

To build the capacity for collaboration between faith groups and health structures contributing to the health and wholeness of communities. The Interfaith Health Program seeks to align the Faith & Health movement through integrated action strategies among public health entities, hospital systems, seminaries and denominational & interfaith religious structures.

Common Themes

Recurrent themes throughout the discussions were as follows:

- **All faith groups have a strong reverence for life.** Regardless of what might happen after a person dies, this life is precious and a gift to be treasured.
- **A wide range of opinions and beliefs about suicide exist among people in all faith groups.** While most agree on the destructive and painful aspects of suicide, there is an increasing understanding that the decision to take one's own life is influenced by many variables including mental illnesses. Judgment is often tempered by compassion and by the belief that the individual will ultimately be judged by God who understands the full intent of one's heart. However, within each faith group, some people are still judgmental and believe the person who died by suicide simply did not hold onto the beliefs or pray and practice the rituals of his faith diligently enough.
- **Except in the case of Hindu "honorable" suicides, suicide is not condoned by any faith group.**
- **Most suicides can be prevented.** We are responsible for each other, and we need to be proactive in promoting hope and meaning in life for people in distress.
- **Suicide is a tragedy and a terrible loss for the victim's friends, family, and community.** However, it is also an opportunity to "change poison into medicine" by spurring people into action to promote connections with others and prevent high-risk behaviors such as drinking and gambling.
- **The causes of any suicide are multiple and complex.** However, a person who takes his own life often has a number of risk factors, such as mental illnesses and substance use disorders that are not offset by protective factors such as caring relationships with friends and family and a strong connection to a faith community.
- **Stigma, lack of culturally acceptable "language," and lack of culturally appropriate mental health services prevent many people from seeking help.**
- **Except for Hindu and Buddhist priests whose roles are mainly ceremonial, most clergy are likely to agree to be involved in suicide prevention efforts.** Within the Hindu and Buddhist communities there are many other people and organizations that would welcome the opportunity to engage in suicide prevention.
- **Clergy and other leaders in faith-based communities need training and access to sound information regarding mental health, mental illnesses, and suicide prevention.**
- **Many perspectives in addition to those represented at this small meeting would contribute in important ways to this dialogue.**

Priority Opportunities for Interfaith Initiatives

Although faith communities appear to have limited resources relevant to the complex issues of suicide, participants noted that a great deal of their normal work of creating, affirming, and nurturing connections among people is directly and powerfully related to the continuing life of those who may consider hurting themselves. While faith communities take on many difficult issues such as poverty and hunger, suicide prevention is a natural part of their life as a connected people. Faith groups can enhance the effect of their naturally relevant activities by focusing on those suicide prevention initiatives likely to have the most benefit. To determine what those initiatives might be, participants broke into five working groups where they identified opportunities for activities. When the large group reassembled, participants prioritized the possible activities by voting. They developed the following list in priority order:

- 1. Develop and disseminate accurate information to clergy and other leaders in faith communities that amplifies their existing wisdom with the intelligence of the public health approach via:**
 - a. Written documents,
 - b. Online courses,
 - c. Gatekeeper training, and
 - d. Presentations to be delivered at meetings of clergy, lay people in faith communities, and mental health professionals.

- 2. Encourage the many growing collaborative partnerships between mental health clinicians and clergy.** Clinicians typically are taught how to develop a therapeutic alliance devoid of judgment, how to understand why people sometimes see suicide as their only option, and how to talk effectively with someone who is suicidal. Clinicians could help clergy and others working in a faith-based community, such as parish nurses, to develop these skills. Without these skills, clergy (or anyone, for that matter) may become anxious when dealing with someone who is suicidal and may inadvertently sound judgmental or resort to messages that may or may not be helpful.

On the other hand, clergy could help mental health clinicians better understand the role of religion and spirituality in their clients' lives. Just as some clergy distrust mental health professionals as being "too secular," some mental health professionals distrust organized religions and do not appreciate the active, positive role of faith in many of their clients' lives. Some are outright hostile toward religion. A movement to integrate psychology and spirituality has begun, but it does not always involve clergy directly. Participants agreed that direct, visible collaborations between clergy and mental health professionals would be extremely beneficial because they would enhance and extend each other's credibility and accessibility to those they serve.

- 3. Develop culturally acceptable language and culturally competent services.** We must find the appropriate words to use with different people and groups in order to break the silence about suicide and reduce stigma while at the same time keeping the taboo against suicidal

acts themselves. Many clergy need access to resources and advice on appropriate language for funerals of those who die by suicide. Tailor messages to specific communities. Use language to increase awareness by linking mental health to emotional fitness and by shifting from prevention of death to the promotion of life.

4. **Develop an initiative to prevent suicide among the clergy.**
5. **Help faith organizations develop “Hope for Tomorrow” days which acknowledge survivors and provide mental health promotion activities such as stress management and other activities such as depression screening.**
6. **Collect accurate information related to suicide prevention in faith communities.** A web-based survey of clergy suicide prevention experiences, comfort level in dealing with suicidal persons, and preferred way to receive additional training is available from the QPR Institute. (Paul Quinnett, Ph.D., President and CEO, QPR Institute. Phone: (509)-235-8823, E-mail: pquinnett@mindspring.com.)

Participants further noted that they would like to be able to evaluate the effectiveness of any activity they undertook.

Possible Stakeholders *within* Individual Faith Communities

Participants divided into groups which contained other members of their faith community to identify possible organizations *within their faith group* that could help with suicide prevention activities. They identified the potential roles and impact of each organization, its readiness to undertake these activities, and other considerations as follows.

Hindu & Jain				
Organizations	India Association	Hindu American Foundation	Ramalerishna Mission/Vedanta Society	Jain Association in North America
Potential roles	Promoting awareness; identifying the problem	Promoting awareness	Promoting awareness; trainees	Promoting awareness; identifying the problem
Potential impact	Substantial within the Indian community	Uncertain	Could have impact on membership	Large
Readiness	Initiation	Preplanning	Vague awareness; preplanning	Preplanning
Other considerations	There will be sympathy for the issue, but it has not yet emerged as a major topic of discussion.			

Buddhist	
Organization	Soka Gakkai International U.S.A.
Potential roles	Education and information dissemination within community and at large
Potential impact	Numbers would be small
Readiness	Vague awareness
Other considerations	Limited resources and personnel to commit

Jewish (Part I)				
Organizations	Central Conference of American Rabbis	Rabbinical Assembly	Union For Reform Judaism	United Synagogue of Conservative Judaism
Potential roles	Training Rabbis; lead to training seminarians	Training Rabbis; lead to training seminarians	Youth groups, schools, older members	Youth groups, schools, older members
Potential impact	Training	Training	Reaching through lifespan	Reaching through lifespan
Readiness	Open; need knowledge	Open; need knowledge	Open; need knowledge	Open; need knowledge
Other considerations				

Jewish (Part II)			
Organizations	Men's Group	B'nai B'rith	Lay Sunday School Teachers
Potential roles	Outreach to isolated men	Catalyst for full congregation involvement	Identify kids at risk
Potential impact	Reduction in male suicide	Significant culture change	Early intervention
Readiness	Denial/Vague awareness	Preplanning	Preplanning
Other considerations	Need excellent facilitation	Need for resources	Flashback/denial; conflict about gatekeeper role

Islam				
Organizations	Muslim Mental Health or Refugee Center	Mosque educational programs	Muslim youth groups in Mosques and on campuses	Muslim humanitarian relief organizations (ISNA, ICNA, Zaman International, ACCESS, Muslim Healthcare Clinics)
Potential roles	Training, treatment, rehabilitation	Spiritual support and human values counseling	Awareness, intervention, peer support	Awareness, education, responsiveness, umbrella organization
Potential impact	Direct intervention, teaching, training	Direct contact, individual/family support, grief/funeral education	Awareness campaign, campus support, peer mediation	Educational material, wide outreach, networking
Readiness	Preparation; Initiation; Stabilization; Professionalism	Vague Awareness; Some Preplanning; Some Denial	Tolerance; Vague Awareness	Preparation; Initiation; Professionalism
Other considerations	Community-based support; grant funded; more orientation to subject	Lack of formalized awareness; no funding; lack of interest	Ready to go, just need awareness	Possible public shyness; reluctance; pushback

Latter-day Saints (LDS)				
Organizations	Church News Publishing	Publishing suicide packet	LDS Family Services	LDSMentalHealth.org
Potential roles	Updated article	Updated packet	Convey accurate information through a presentation	Update Web site
Potential impact	Accurate information to subscribers	Accurate information to leaders	Accurate information to leaders and members	Accurate information to Web site visitors
Readiness	Professionalization	Institutionalization	Confirmation/expansion	Professionalization
Other considerations	Approval likely	Approval likely	Approval likely	Approval likely

Catholic (Part I)				
Organizations	Catholic Charities Agencies	Catholic Charities USA Interest Section	Ministering Together	Seminaries/Catholic Colleges
Potential roles	Resource to clergy and the community	Championing suicide prevention	Promoting collaboration	Preparing next generation of leaders
Potential impact	Referral route	Development/dissemination of training vehicles	Greater reach to larger Catholic community	Greater success of suicide prevention activities
Readiness	Confirmation/expansion	Confirmation/expansion	Vague awareness	Vague awareness
Other considerations	Clergy already expect agencies to do this	Looking for topics of focus	Current board member	

Catholic (Part II)	
Organizations	Bishops' Conference USCCB
Potential roles	Official Statement
Potential impact	Clarifying position and encouraging action and compassion
Readiness	Preparation
Other considerations	CCUSA has already been asked to work on this

Black Church		
Organizations	Pastors, Mental Health Professionals, The Black Church and Suicide Conference	Congregational Health Network
Potential roles	Educate the Black community on emotional health	Aftercare following hospitalization
Potential impact	Prevent violence; lower suicide rates; help youth and adults	Increase longevity
Readiness	Confirmation	Confirmation
Other considerations	Decrease emergency room visits. Provide a model for wellness with domestic violence victims.	Decrease emergency room visits. Create a team approach to health care. Remove stigma against need for mental services. Gain greater accessibility to services.

United Methodist Church				
Organizations	General Boards & Agencies	Publications & Other Media	Colleges & Seminaries	Leadership
Potential roles	Dedicate and/or create staff and programs	Reach eight million members	Education	Raise awareness
Potential impact	Address stigma	Change perceptions	Educate	Suicide prevention task force
Readiness	Expansion	Development	Preparation & Developmental	Developmental/Initiation/Creation
Other considerations	Hard to change	Relatively easy to implement	How to add to an already full curriculum?	Who? Council of Bishops? General Conference?

Veterans Affairs Administration				
Organizations	Chaplains	Suicide Prevention Coordinators	Center of Excellence (VISN2)	Dept. of Veterans Affairs
Potential roles	Build awareness; teach	Teach; provide support	Develop, disseminate, and evaluate curriculum; provide support	Mandate training
Potential impact	Local/national	Local/national	Local/national	Local/national
Readiness	Preplanning	Initiation	Stabilization	Initiation
Other considerations	Systems issues; workload restraints; facility expectations and assumptions	Systems issues; workload restraints; facility expectations	Cost of training; compliance	Compliance with national priorities

Meeting Adjournment

SPRC and SAMHSA staff members thanked participants for so graciously giving of their time, for sharing their knowledge, and for their commitment to the process of improving suicide prevention efforts in their respective faith communities. Participants expressed their desire for ongoing communications, data collection, and continued action with other members of the group.

Appendix A

Participants

Abdul Basit, Ph.D.

Assistant Professor of Psychiatry
Northwestern University, and Editor-in-Chief,
Journal of Muslim Mental Health
Chicago, IL

Najah Bazy, RN

Transcultural Nurse Specialist
Islamic Center of America, and Health Ministry
Liaison
Zaman International
Canton, MI

Jean Beil, M.S.W., M.A.

Senior Vice President for Programs and Services
Catholic Charities USA
Alexandria, VA

Chaplain Jeni Cook, D.Min.

Department of Veterans Affairs
National Chaplain Center
Hampton, VA

Niels French, M.A.

Methodist Healthcare
Memphis, TN

Arun Gandhi

Rochester, NY

Rabbi Gary Greenebaum

U.S. Director of Interreligious Affairs
American Jewish Committee
New York, NY

Kalman J. Kaplan, Ph.D.

Professor of Clinical Psychology
Department of Psychiatry
U. of Illinois in Chicago College of Medicine

Mimi Kiser, RN, M.P.H., CHES

Associate Director, Interfaith Health Program
Rollins School of Public Health
Emory University
Atlanta, GA

Arlene Krohmal

Director of Administration
NAMI, The National Alliance on Mental Illness
Arlington, VA

David A. Litts, O.D., FAAO

Associate Director, Prevention Practice
Suicide Prevention Resource Center
Macatawa, MI

Jeffery D. Long, Ph.D., R.A.

Associate Professor of Religion and Asian
Studies, and Chair, Department of Religious
Studies
Elizabethtown College
Elizabethtown, PA

Richard McKeon, Ph.D., M.P.H.

Public Health Advisor
SAMHSA/CMHS
Rockville, MD

Lloyd Potter, Ph.D., M.P.H.

Director, Institute for Demographic and
Socioeconomic Research
University of Texas at San Antonio
San Antonio, TX

Brent Scharman, Ph.D.

Assistant Commissioner
LDS Family Services
Salt Lake City, UT

Margaret (Peggy) West, Ph.D., M.S.W.

Senior Advisor
Suicide Prevention Resource Center
Seattle, WA

Jerry and Elsie Weyrauch

Founders, SPAN USA and SPAN-GA
Marietta, GA

Lee K. Wolfson, M.Ed.
Psychologist/Lecturer
University of Pittsburgh Medical School
Pittsburgh, PA

Wilbur Woodis, M.A.
Management Analyst

Other Participants

Jose Bermea
Communications Specialist
SAMHSA/CMHS
Rockville, MD

Jim Clemons, Ph.D.
Gaithersburg, MD

Mike Costigan
Senior Advisor to the Administrator
Office of the Administrator, SAMHSA
Rockville,

Wendy Cyprien, M.P.A.
Prevention Specialist
Suicide Prevention Resource Center
Newton, MA

Nancy Davis, Ed.D.
North Bethesda, MD

Capt. Maria Dinger, B.S.N., M.S.N.
Branch Chief, Suicide Prevention Branch
SAMHSA/CMHS
Rockville, MD

Division of Behavioral Health
Indian Health Service
Rockville, MD

Bishop William Young
The Healing Center
Memphis, TN

Avi Goldgraber
Confidential Assistant to the Administrator
Office of the Administrator, SAMHSA
Rockville, MD

Jane Pearson, Ph.D.
Division of Services and Intervention Research
National Institute of Mental Health
Bethesda, MD

Hyden S. Shen, J.D.
Special Assistant to the Director
Center for Substance Abuse Prevention
SAMHSA
Rockville, MD

Anne Mathews-Younes, Ed.D.
Director, Division of Prevention, Traumatic
Stress, and Special Programs
SAMHSA/CMHS
Rockville, MD

Eileen Zeller, M.P.H.
Special Advisor, Suicide Prevention
SAMHSA/CMHS
Rockville, MD

Appendix B

Roman Catholic Church Statement Regarding Suicide and Suicide Prevention

Roman Catholic Teaching on Suicide

Taken from *Catechism of the Catholic Church*, 2nd ed., 1994, 1997

In the section on the fifth commandment:

2280 Everyone is responsible for his life before God who has given it to him. It is God who remains the sovereign Master of life. We are obliged to accept life gratefully and preserve it for His honor and the salvation of our souls. We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of.

2281 Suicide contradicts the natural inclination of the human being to preserve and perpetuate his life. It is gravely contrary to the just love of self. It likewise offends love of neighbor because it unjustly breaks the ties of solidarity with family, nation, and other human societies to which we continue to have obligations. Suicide is contrary to love for the living God.

2282 If suicide is committed with the intention of setting an example, especially to the young, it also takes on the gravity of scandal. Voluntary co-operation in suicide is contrary to the moral law.

Grave psychological disturbances, anguish, or grave fear of hardship, suffering, or torture can diminish the responsibility of the one committing suicide.

2283 We should not despair of the eternal salvation of persons who have taken their own lives. By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own life.

In summary...

2325 Suicide is seriously contrary to justice, hope, and charity. It is forbidden by the fifth commandment.

Appendix C

Church of Jesus Christ of Latter-day Saints Statement Regarding Suicide and Suicide Prevention

Members of the Church of Jesus Christ of Latter-day Saints believe that it is wrong to take a life, even one's own. They realize that a person who commits suicide may not be responsible for his or her acts due to various factors including mental illness. Only God can judge such a matter. LDS leaders are encouraged to compassionately console the family members of a person who has committed suicide. Together, family members and ecclesiastical leaders determine the place and nature of a funeral service for a person who has died under such circumstances. Church facilities may be used. The funeral should be a setting where the life of the deceased individual can be reflected upon appropriately and an uplifting gospel message be given. A person who has seriously considered suicide or has attempted suicide should be counseled by his or her church leader and may be encouraged to seek professional help.

Quote from an LDS Church Handbook

Appendix D

Evangelical Lutheran Church in America (ELCA) Statement Regarding Suicide and Suicide Prevention

A Message on Suicide Prevention

*Adopted by the Church Council of the Evangelical Lutheran Church in America
on November 14, 1999*

Each year more than 30,000 persons in the United States take their own life. Suicide is the eighth leading cause of death and the third leading cause among persons who are 15 to 24. More persons die by suicide than by homicide. Each year nearly 500,000 persons make a suicide attempt serious enough to receive emergency room treatment. Millions have suicidal thoughts.

These numbers, we know, speak of individuals whose stories and relationships are unique. They speak of persons with whom we live in our families, congregations, neighborhoods, and workplaces. Some of us have attempted suicide, and others of us have made sure a relative or friend who is threatening suicide gets help. Many of us have mourned and anguished over the suicidal death of a loved one, and others of us will some day experience such unspeakable grief and suffering.

Suicide testifies to life's tragic brokenness. We believe that life is God's good and precious gift to us, and yet life for us ourselves and others sometimes appears to be hell, a torment without hope. When we would prefer to ignore, reject, or shy away from those who despair of life, we need to recall what we have heard: God's boundless love in Jesus Christ will leave no one alone and abandoned. We who lean on God's love to live are called to "bear one another's burdens and so fulfill the law of Christ." (Galatians 6:2) Our efforts to prevent suicide grow out of our obligation to protect and promote life, our hope in God amid suffering and adversity, and our love for our troubled neighbor.

Increasingly, suicide is being viewed as a serious and preventable public health problem. Suicide and its prevention are complex and multi-dimensional and need to be approached openly and comprehensively. Suicide prevention requires concerted and collaborative efforts from all sectors of society. Let us in the Evangelical Lutheran Church in America contribute to these efforts. With this message, the Church Council encourages members, congregations, and affiliated institutions to learn more about suicide and its prevention in their communities, to ask what they can do, and to work with others to prevent suicide.

Becoming Aware

Suicide occurs in all social groups. It occurs among young, middle-aged, and older people; men and women; rich, middle class, and poor people; all ethnic and religious groups; married and single people; the employed and unemployed, and the healthy and the sick.

Yet statistics indicate that suicide is more prevalent among some groups than others:

- White males account for nearly three-fourths of all completed suicides.
- While there are four male suicides for every female one, women attempt suicide twice as often as do men.
- The highest suicide rates are found among white men over 50, who represent 10 percent of the population and who are responsible for 33 percent of the suicides. Suicide rates for men over 65 are on the increase after a steady decrease from 1950-1980.
- Since 1950 the suicide rate for young men aged 15-24 has tripled, and for young women, it has more than doubled.

- Although suicide among children is a rare event, there has been a dramatic increase in the reported suicide rate among persons aged 10-14.
- Suicide rates for American Indians and Alaska Natives are well above the national average, with a disproportionate number of suicides among young men.
- Suicide among young African American males, once uncommon, has increased sharply in recent years.
- Suicide rates among some professions, such as police, farmers, dentists, and doctors, have been found to be higher than the national average.
- Attempted suicide rates among youth struggling with questions about their sexual orientation are higher than among others of the same age.
- Nearly 60 percent of all suicides are carried out with a firearm. People living in a household with a firearm are almost 5 times more likely to die by suicide than people who live in gun-free homes.

While there is no one cause of suicide, researchers tell us that suicidal behavior is associated with a number of risk factors that frequently occur in combination. These include:

- Clinical depression and other mental illnesses. More than 60 percent of all people who complete suicide suffer from major depression. If one includes people who abuse alcohol and are depressed, the figure rises to 75 percent. Almost all people who take their own life have a diagnosable mental or substance abuse disorder or both.
- Alcohol and substance abuse. Alcoholism is a factor in 30 percent of all completed suicides.
- Adverse life events. Such events may be confusion about one's personal identity or a feeling of being cut off from others among young people; a family crisis like death or divorce; the loss of one's livelihood, perhaps caused by rural economic crisis, business downsizing, a cutting off of government programs, or addictive behavior; chronic, acute, or terminal illness; or the effects of a natural or social disaster. For most people, adverse life events do not lead to suicidal behavior. They may contribute to suicidal behavior in the context of mental illness and substance abuse.
- Familial factors, such as a family history of suicide, of mental illness and substance abuse, of violence and sexual abuse.
- Cultural or religious factors, such as beliefs that suicide is a noble resolution of a personal dilemma, or the destruction of a people's traditional culture that may lead to feelings of disconnectedness from the past, isolation, and hopelessness.
- Prior suicide attempt, firearm in the home, incarceration, impulsive or aggressive tendencies, and exposure to the suicidal behavior of others (by family members or peers, or through inappropriate media coverage or fiction stories). Suicides among young people sometimes occur in clusters and may even become an epidemic. Young people are particularly susceptible to imitating behavior leading to unintended suicide.

"All persons who express suicidal ideas while exhibiting symptoms of depression, alcohol abuse, drug abuse, or schizophrenia should be evaluated promptly by a qualified health professional." In: *Clergy Response to Suicidal Persons and Their Family Members*, ed. David C. Clark (Chicago: Exploration Press, 1993), p. 183. Clark directs the Center for Suicide Research and Prevention, Rush-Presbyterian-St. Luke's Medical Center, Chicago. This book is a valuable resource for pastors and congregations. In it, ELCA pastor and theologian Herbert Anderson writes on "A Protestant Perspective on Suicide."

Looking at Attitudes

Certain social attitudes form obstacles to suicide prevention. One such set of beliefs says that nothing can be done. "If it's going to happen, it will." "It's not worth trying to help, because these people have such huge problems that nothing can be done." "Suicide has been around forever; we're not going to change that fact." "Let them alone. If they want to kill themselves, that's their business."

Punitive attitudes form another obstacle to suicide prevention. These attitudes are eager to punish suicidal behavior and often blame the living for suicidal deaths. They create an environment in which suicidal behavior is concealed and persons with suicidal thoughts are reluctant to talk. Punitive attitudes are a carryover from the time when suicide was considered a crime and an unpardonable sin, and when those who completed suicide were denied Christian burial.

Failure to understand major depression as an illness also obstructs suicide prevention. Some misguided attitudes view serious depression as a character deficit, a human weakness, or a rare, untreatable, and permanent condition. These convey to depressed people that they should "tough it out" or be embarrassed or ashamed by how they feel. In truth, clinical depression is a disease involving changes in brain chemistry. It is one of the most common diseases, and can happen to people who have no apparent reason "to be depressed." Although clinical depression often goes untreated because it is not recognized, it is a very treatable mental illness. Depressed people cannot treat themselves, but they can be helped by professionals through medication or therapy, or a combination of the two. Suicide is not an inevitable or acceptable outcome of depression.

Experts speak of common misunderstandings that stand in the way of suicide prevention:

- Myth: Persons who talk about suicide rarely actually complete suicide; they are just wanting attention and should be challenged in order to "call their bluff." The truth is that persons who talk about suicide are serious and may be giving a clue or warning of their intentions. They should not be challenged but given assistance in obtaining professional help.
- Myth: A person who has made a serious suicide attempt is unlikely to make another. The truth is that persons who have made prior attempts are often at greater risk of completing suicide. A suicide attempt is a cry for help and a warning that something is terribly wrong and should be taken with utmost seriousness.
- Myth: The suicidal person wants to die and feels there is no turning back. The truth is that suicidal persons often feel ambivalent about dying. They often go through a long process in which they try various ways to reduce their profound emotional pain. The balance between their contradictory desires to live and to die shifts back and forth, even up to the time of taking their life.
- Myth: Most people who take their life have made a careful, well-considered, rational decision. The truth is that persons considering suicide often have "tunnel vision": in their unbearable pain they are blind to available alternatives. Frequently, the suicide act is impulsive. When their suffering and pain are reduced, most will choose to live.
- Myth: Asking about suicidal feelings will cause one to attempt suicide. The truth is that asking a person about suicidal feelings provides an opportunity to get help that may save a life. The listener should ask if the person has formulated a plan and has access to the means to carry it out. If the intent, a plan, and the means are there, the suicidal person should not be left alone but be helped to get treatment immediately, by calling 911 if necessary.

Suicide Prevention Helpcard

If someone you know:

- threatens suicide
- talks or writes about wanting to die

- appears depressed, sad, withdrawn, hopeless
- shows significant changes in behavior, appearance, mood (either from being "normal" to being depressed or the reverse)
- abuses drugs, alcohol
- deliberately injures himself or herself
- says he or she will not be missed if gone
- gives away treasured belongings...

You can help:

- stay calm and listen
- take threats seriously
- let him or her talk about his or her feelings
- be accepting; do not judge
- ask if he or she has suicidal thoughts
- ask how intense and frequent these thoughts are
- ask if he or she has a plan
- ask if he or she has a means to carry out the plan
- don't swear secrecy—tell someone
- assure the person it is okay and necessary to get help...

Get help: You cannot do it alone

Accompany the person to your:

- hospital emergency room
- mental health services
- police
- family, friend, relative
- clergy, teacher, counselor
- family doctor
- or call your crisis line

Call your 911 number for emergency assistance or check the inside front cover page of your telephone book for local crisis services. The National Crisis Helpline is 1-888-284-2433 (1-888-SUICIDE). The National Youth Crisis Helpline is 1-800-999-9999.

For information on the nearest ELCA social ministry organization providing non-emergency counseling for suicidal persons, call Lutheran Services in America (LSA), 800-664-3848. You may visit LSA online at www.lutheranservices.org.

Adapted from The Suicide and Information Center

Receiving and Giving Help

"The church," Martin Luther once wrote, "is the inn and the infirmary for those who are sick and in need of being made well." Luther's image of the Church as a hospital reminds us who we are, a community of vulnerable people in need of help; living by the hope of the Gospel, we also are a community of healing. At the same time vulnerable and healed, we are freed for a life of receiving and giving help. In the mutual bearing of burdens, we learn to be persons who are willing to ask for healing and to provide it.

Whoever among us experiences suicidal thoughts should know that the rest of us expect, pray, and plead for them to reach out for help. "Talk to someone. Don't bear your hidden pain by yourself." The notion is all too common that one should "go it alone": Persons are not supposed to be vulnerable, and when they are, they should conceal it and handle things on their own. In the Church, however, we admit that we all share the "need of being made well." There is no shame in having suicidal thoughts or asking for help. Indeed, when life's difficulties and disappointments threaten to overwhelm our desire to live, we are urged and invited to talk with trusted others and draw upon their strength.

When, on the other hand, a loved one talks to us of suicide or we sense that something is seriously amiss, we are called to be our brother's or sister's keeper. The experience may be frightening, and we may want to deny or minimize the suicidal communication. We may want to shy away because we feel unprepared to help someone with suicidal thoughts or think that we may make matters worse. Yet our responsibility is to listen, to encourage the person to talk, and to get him or her appropriate help. Beyond the crisis situation, we will want that person to hear the healing comfort of the Gospel and receive the care of the congregation. That care might, for example, involve creating an ongoing support network for a person and his or her family.

Pastors have unique opportunities to minister with suicidal persons, in part because many people are often more willing to approach clergy than other caregivers. Chaplains in hospitals and nursing homes, colleges and universities, the military, and prisons as well as counselors in church agencies are called upon to counsel suicidal persons. Their concern is to explore the suffering that motivates the person's thoughts and behavior and to comfort the person through his or her anguish. Drawing upon their pastoral wisdom, pastors may seek to discern to what extent the person's suffering is spiritual or has other sources. They will refer (and often accompany) suicidal persons to professional health care and mental health providers for other forms of intervention and assistance. The pastoral response will bring God's Word to bear on the situation with compassion, competence, and willingness to collaborate with other care providers.

When a suicide does occur, congregations and pastors minister to the bereaved and deceased through Christian burial and their loving support. Funerals are not occasions either to condemn or idealize an act of suicide, but times to proclaim that suicide and death itself do not place one beyond the communion of saints. Because of Christ's death and resurrection for us, we entrust a troubled person to God's love and mercy with the promise that "whether we live or whether we die, we are the Lord's." (Romans 14:7) Pastor and congregation need to offer intentional and sensitive care for the family and loved ones of the deceased for some time and offer them the opportunity to become part of a support group for survivors.

Preparing to Act

Suicide prevention is broader than responding to a crisis situation. Prevention efforts also aim to reduce or reverse risk factors and to enhance protective factors before vulnerable persons reach the point of danger. They go together with efforts to prevent drug and alcohol abuse as well as violence. Protective factors include:

- Effective and appropriate clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal methods of suicide
- Family and community support
- Support from ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts.

What can we do in our congregations and communities to prevent suicide? The following is intended to stimulate discussion, reflection, and action.

Let us first recognize that the day-to-day preaching, teaching, and living of the Christian faith in congregations contribute to suicide prevention in indirect yet significant ways. In the community of the baptized, we come to know that we belong to God and to one another. There we give thanks to God for life and for our new life in Christ, and we are empowered to persevere during adversities and to hope in God when all else fails. We learn that human life is a sacred trust from God and that "deliberately destroying life created in the image of God is contrary to our Christian conscience." We are equipped to empathize with others in their suffering and joy and are prepared to act for their well-being. We are given a reason to live, forgiveness to start anew, and confidence that neither life nor death can separate us from "the love of God in Christ Jesus our Lord." (Romans 8: 38) How, we might ask, do we do such things better?

When discussing love for others in confirmation classes, could we talk about what to do if a friend hints at suicide? How does our congregation ensure that all members are known and none are invisible? How do we

become more attentive to changes in a person's participation that may indicate personal distress or depression? How do we strengthen the bonds of community with persons going through stressful periods in their lives and with older persons living alone so they do not feel isolated and abandoned? Might we begin or further develop congregational health ministries, such as a parish nurse program or Stephen Ministry?

How do we honor the vocation of members who are social workers, psychologists, doctors, nurses, counselors, and other caregivers who often work with suicidal persons? How do we find ways to assure them that when a person they are helping takes his or her life, they are not responsible for not "saving a life?" We also can draw upon these caregivers as well as upon survivors and advocates for suicide prevention to help educate other members about suicide.

What in our community, we should ask, are the cultural and social dynamics that lead to isolation and hopelessness? How do we address them? What are the resources in our community to respond to suicidal behavior? Do members know how to access them? We can join with other churches and community groups to help ensure that adequate treatment resources are available. What about our schools? Is suicide prevention a part of their programs that focus on mental health, substance abuse, aggressive behavior, and coping skills? Are there peer counseling or ministry programs in our schools and congregations?

What about the firearms in our homes? Most gun owners reportedly keep a firearm in their home for "protection" or "self-defense," yet 83 percent of gun-related deaths in these homes are suicide, often by someone other than the gun owner. Are our homes really safer with guns in them? we might ask.

How do we counter the stigma often associated with mental illness? Should not the crucial role of untreated depression in suicidal behavior be an important consideration in debates on insurance coverage for mental illnesses? What might we do as citizens to promote accessible and affordable mental health services to enable all persons at risk for suicide to obtain needed substance abuse and treatment services?

We can encourage, use, and learn from suicide prevention programs in our social ministry organizations and at our colleges and universities. What, we should ask, could our church-related day schools do to prevent suicide? How are our seminaries preparing pastors to minister with suicidal persons? Should suicide prevention be a part of continuing education for rostered persons? Could we create opportunities at events for youth, women, and men and in our camping and retreat programs to learn about suicide and its prevention?

The Church Council urges synods to support members, congregations, and affiliated institutions in their efforts to prevent suicide. It directs the governing bodies of churchwide units to evaluate their programs in light of this message, calling upon this church's educational and advocacy programs to make suicide prevention an important concern in their ministries. It directs the Department for Ecumenical Affairs to share this message with churches with whom we are in full communion and to express our willingness to work with them to prevent suicide. The Church Council welcomes the Surgeon General's call for a comprehensive national strategy for suicide prevention.

Before we go in peace from worship to serve the Lord in the trials and joys of the coming days, we receive the Benediction:

"The Lord bless you and keep you,
The Lord make His face shine on you
and be gracious to you.

The Lord look upon you with favor and give you peace."

"Amen," we sing. We are not alone, abandoned, and without hope. The Lord's name is " 'Emmanuel,' which means, 'God is with us.' " (Matthew 1:23)

<http://www.elca.org/What-We-Believe/Social-Issues/Messages/Suicide-Prevention.aspx>

National Suicide Prevention Organizations

(Note: The author of this report updated the contact information for the following organizations as needed.)
Most state health departments also have resources on suicide prevention and mental health.

American Association of Suicidology (AAS)
5221 Wisconsin Avenue, NW
Washington, DC 20015
Phone: (202) 237-2280
Fax: (202) 237-2282
www.suicidology.org

American Foundation for Suicide Prevention
120 Wall Street, 22nd Floor
New York, New York 10005
Toll-Free: (888) 333-2377
Phone: (212) 363-3500
Fax: (212) 363-6237
inquiry@afsp.org
www.afsp.org

National Alliance on Mental Illness (NAMI)
2107 Wilson Boulevard, Suite 300
Arlington, VA, 22201-3042
Toll-Free: (800) 950-6264
Phone: (703) 524-7600
Fax: (703) 524-9094
www.nami.org

National Center for Injury Prevention and Control, Division of Violence Prevention
Centers for Disease Control and Prevention
Mailstop K60, 4770 Buford Highway
Atlanta, Georgia 30341-3724
Phone: (770) 488-4362
DVPINFO@cdc.gov
www.cdc.gov

National Depressive and Manic-Depressive Association
730 North Franklin Street, Suite 501
Chicago, IL 60654-7225
Toll-Free: (800) 826-3632
Fax: (312) 642-7243
www.ndmda.org

National Institute of Mental Health (NIMH)
6001 Executive Boulevard
Rm. 8184, MSC 9663
Bethesda, MD 20892-9663

Phone: (301) 443-4513
Fax: (301) 443-4279
nimhinfo@nih.gov
www.nimh.nih.gov

Mental Health America
2000 N. Beauregard Street, 6th Floor
Alexandria, VA 22311
Phone: (703) 684-7722
Toll-free: (800) 969-6642
TTY Line: (800) 433-5959
www.nmha.org

National Organization of People of Color Against Suicide (NOPCAS)
P.O. Box 75571
Washington, DC 20013
Phone: (202) 549-6039
info@nopcas.org
www.nopcas.org

SAVE – Suicide Awareness Voices of Education
8120 Penn Ave. S., Suite 470
Bloomington, MN 55431
Phone: (952) 946-7998
www.save.org

Suicide Prevention Action Network USA (SPAN USA)
1010 Vermont Avenue NW, Suite 408
Washington, DC 20005
Phone: (202) 449-3600
Fax: (202) 449-3601
info@spanusa.org
www.spanusa.org

Yellow Ribbon Suicide Prevention Program
P.O. Box 644
Westminster, CO 80036
Phone: (303) 429-3530
Fax: (303) 426-4496
ask4help@yellowribbon.org
www.yellowribbon.org

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Appendix E

United Methodist Church Statement Regarding Suicide and Suicide Prevention

Suicide: A Challenge to Ministry

The Apostle Paul, rooted in his experience of the resurrected Christ, affirms the power of divine love to overcome the divisive realities of human life, including suicide:

For I am convinced that neither death, nor life, nor angels, nor rulers, nor things present, nor things to come, nor powers nor height, nor depth, nor anything else in all creation will be able to separate us from the love of God in Christ Jesus our Lord. (Romans 8:38-39)

Paul's words are indeed sources of hope and renewal for persons who contemplate suicide, as well as for those who grieve the death of friends and family members who have committed suicide. These words affirm that in those human moments when all seems lost, all may yet be found through full faith.

A Christian perspective on suicide thus begins with an affirmation of faith: Suicide does not separate us from the love of God.

Unfortunately, the church throughout much of its history has taught just the opposite: that suicide is an unforgivable sin. As a result, Christians, acting out of a sincere concern to prevent suicide, often have contradicted Christ's call to compassion.

For example, victims have been denounced and presumed to be in hell, and families have been stigmatized with guilt and inflicted with economic and social penalties.

The purpose of this statement is to challenge and guide our caring ministries to reduce the number of suicides and to share God's grace so that the lives of those touched by suicide may be enriched, dignified and enabled for ministry to others.

Demography of Suicide

Suicide is the eleventh leading cause of death, claiming 30,000 lives each year or one every 18 minutes. More than 4,000 of those who commit suicide annually are under age 25. Because suicide occurs at all ages, it is the fifth leading cause of lost potential life, according to the U.S. Centers for Disease Control and Prevention (CDC). Furthermore, it is estimated that between 500 and 1,500 people seek care in emergency rooms each day for suicide attempts. Research indicates that in any given year 20 percent of all high school students seriously consider suicide.

Suicide rates vary by age, gender and ethnicity but it affects all peoples, regardless of education or socioeconomic status. The highest rate of suicide generally occurs among white males in later life. Among some Native American and Alaskan Native groups, however, rates among youth are several times higher than that of the U.S. population as a whole. About 80 percent of those who commit suicide are male, but females are much more likely to attempt suicide.

"It is generally agreed that not all deaths that are suicides are reported as such. Deaths may be misclassified as homicides or accidents where individuals have intended suicide by putting themselves in harm's way and lack of evidence does not allow for classifying the death as suicide. Other suicides may be misclassified as accidental or undetermined deaths in deference to community or family." (*National Strategy for Suicide Prevention*, 2001; p. 32)

Risk and Protective Factors of Suicide

Specific groups in society appear more vulnerable to suicide than others, especially if they experience certain precipitants (events in their lives such as disease, loss of family, friends, job, severe trauma, or other stress factors) and have easy access to a method for ending their lives, that is, if they are in an enabling environment. Studies show that 90 percent of those who die by suicide suffer from a diagnosable mental illness, substance abuse, or both. These factors—vulnerability, precipitating events, enabling environment—must be recognized and addressed if there is to be any reduction to the suicide rate.

Youth experience alienation and rejection by society, family, and the church when dealing with sexual-identity issues, including homosexuality. For many youth, the only perceived way out is suicide.

Social interconnections, social support and life skills are shown to provide protection from suicide. These methods can be learned, and youth training, such as that taught annually by the Arkansas Youth Suicide Prevention Commission, is a major force for suicide intervention and prevention.

Societal Attitudes

The prevailing attitudes of society, both secular and religious, have been to condemn the victim and ignore the victim's family and friends.

There are always two parties to a death; the person who dies and the survivors who are bereaved . . . the sting of death is less sharp for the person who dies than it is for the bereaved survivor. This, as I see it, is the capital fact about the relation between the living and the dying. There are two parties to the suffering that death inflicts; and in the apportionment of the suffering the survivor takes the brunt.

—Arnold Toynbee, from *Man's Concern with Death*

Churches have denied funerals and memorial services to bereaved families. Victims' remains have been banned from cemeteries. Medical examiners have falsified records for families so they can receive economic aid. Federal and state surveys of attitudes toward suicide confirm a broad spectrum of responses ranging from fear, denial and resistance to widespread support for suicide prevention. Social and religious stigma is widespread. One report told of a longtime teacher of church youth who lost her son to suicide. When she returned to her class a few weeks later, she was told that because her son had taken his life, she was no longer to teach. In contrast, several denominations have in recent years adopted informed and more compassionate statements on suicide for their members. Frequently mentioned are the needs to remove social stigmas that discourage youth and others from seeking the help they need and to provide mental health opportunities for those who suffer from depression and suicidal ideation. The understanding support of family and friends as a major factor in providing such effective support is now more widely appreciated.

The Church's Response

Recognizing that the church's historical response to suicide includes punitive measures intended to prevent suicide and that there is no clear biblical stance on suicide, the General Conference of The United Methodist Church strongly urges the employment of major initiatives to prevent suicide, following the guidelines of the National Strategy for Suicide Prevention issued by the U. S. Department of Health and Human Services. Additionally, the General Conference recommends to the boards, agencies, institutions, and local churches of The United Methodist Church that the ministry of suicide prevention should receive urgent attention. Survivors of loss through suicide and suicide attempts should also receive priority concern in the overall ministry of the Church. Harsh and punitive measures (such as denial of funeral or memorial services, or ministerial visits) imposed upon families of suicide victims should be denounced and abandoned. The church should participate in and urge others to participate in a full, community-based

effort to address the needs of people at risk and their families. Each annual conference and local church should respond to issues of ministry related to suicide prevention and family-support services.

It must be emphasized that suicide increases in an environment or society that does not demonstrate a caring attitude toward all persons. The church has a special role in changing societal attitudes and harmful social environments of individuals and families. To promote this effort, the church should do the following:

1. the General Board of Discipleship shall continue to develop curriculum for biblical and theological study of suicide and related mental and environmental health problems and promote the programs recommended by the American Association of Pastoral Counseling and the use of scientific research of the Centers for Disease Control and Prevention, the National Institutes of Health, and other credible institutions in the private sector, such as organizations within the National Council of Suicide Prevention;
2. the General Board of Higher Education and Ministry shall develop materials for United Methodist-related seminaries to train church professionals to recognize treatable mental illness associated with suicide (e.g., depression) and to realize when and how to refer persons for treatment; it shall ensure that all pastoral counseling programs include such training and strategies for ministry survivors of suicide loss and suicide attempts; and seek attention to suicide in courses in Bible, Christian Ethics, Preaching and Religious Education as well as Pastoral Care;
3. the General Board of Church and Society shall continue to support public policies that: (a) promote access to mental health services for all persons regardless of age, (b) remove the stigma associated with mental illness, and (c) encourage help-seeking behavior;
4. embrace all persons affected by suicide, including young children, in loving community through support groups and responsive social institutions, call upon society through the media to reinforce (following published guidelines for reporting suicide and related matters) the importance of human life and to advocate that public policies include all persons' welfare, and work against policies that devalue human life and perpetuate cultural risk factors (i.e., nuclear armaments, war, racial and ethnic prejudice);
5. affirm that we can destroy our physical bodies but not our being in God, and affirm that a person stands in relationship to others, but in our efforts to be more compassionate and care giving, avoid glamorizing the deaths of those who take their lives, especially young people. The loss of every person is a loss in community;
6. support the United Methodist childcare institutions that provide treatment for emotionally disturbed children, youth, and their families and retirement communities that are home for those where suicide rates are highest; and
7. strengthen the youth ministries of the local church, helping the young people experience the saving grace of Jesus Christ and participate in the caring fellowship of the church.

Conclusion

"The church is called to proclaim the gospel of grace and, in its own life, to embody that gospel. It embodies that gospel when it is particularly solicitous of those within its number who are most troubled, and when it reaches beyond its own membership to such people who stand alone." (Dr. Philip Wogaman, Professor of Christian Social Ethics, Wesley Theological Seminary).

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Appendix F

FaithNet NAMI

www.nami.org

FaithNet NAMI is a network composed of members and friends of NAMI (National Alliance for the Mentally Ill). It was established for the purposes of:

- facilitating the development within the Faith Community of a non-threatening, supportive environment for those with serious mental illness and their families,
- pointing out the value of one's spirituality in the recovery process from mental illness and the need for spiritual strength for those who are caretakers,
- educating clergy and congregations concerning the biologic basis and characteristics of mental illness, and
- encouraging advocacy of the Faith Community to bring about hope and help for all who are affected by mental illness.

FaithNet NAMI is not a religious network but rather an outreach to all religious organizations. It has had significant success in doing so, because all the major religions have the basic tenets of giving care and showing compassion to those in need.

FaithNet NAMI respects all religious beliefs. It also recognizes the expression by the majority of those affected by mental illness of the importance of the role of their spirituality in their ability to cope with having one of these no fault disorders themselves or in caring for an ill friend or family member.

FaithNet NAMI encourages all those who are affected by a mental illness, who are also members of a faith community, to talk to their clergy person about mental illness and the role their faith is playing in their lives. This is done for two purposes.

- By telling their clergy person their story, he or she becomes personally involved and personal involvement is the best method of education. Understanding requires not only the attention of the ears and eyes, but also the heart.
- By speaking to their clergy person, they have the opportunity to gain spiritual support. Sadly, at present, many shy away from speaking with their clergy person because of the effect the stigma of mental illness has had on their lives. They needlessly feel ashamed and fear rejection.

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Education Development Center, Inc.
55 Chapel Street
Newton, MA 02458
www.sprc.org