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The Suicidal Person and Pastoral Care

Donald Wunrow
Concordia Seminary, St. Louis, ir_wunrowd@csl.edu

THE SUICIDAL PERSON AND PASTORAL CARE

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by

Donald N. Wunrow

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Approved by:_____
Advisor

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CHAPTER I

INTRODUCTION

The scope of the problem of suicide can only be gauged by the large number of persons who decide that life is no longer worthwhile and end it by self-destruction, and also by the scars left on families and communities. Suicide presents a problem in many areas -- legal, moral, ethical, and philosophical.

A recent feature article in Time magazine entitled "On Suicide" stated:

> "There is only one truly serious philosophical problem," wrote Albert Camus, "and that is suicide." In other words, what is it that makes life worth living? Religion's answer to that question today is still powerful, but far more muted than it used to be. Most men take their answers from the self-evident pleasure of being alive and, even in despair, from stubborn hope and a dimly realized sense of duty to the miracle of life.[1]

This paper comprises an examination of the problem of suicide, particularly the dynamics operative in the potentially suicidal individual, and the dynamics operative in a pastoral approach to suicide prevention. Attention will be given to the recognition of presuicidal behavior and to the role which the pastor assumes to prevent the individual from acting out his self-destructive communication.

The question of the legality of suicide is not within the particular scope of this study. The legal approach to suicide varies in different countries. For example, within the United States there are three states which maintain that attempted suicide is a crime:

New Jersey, North Dakota, and South Dakota.[2] Nor does this study pursue the moral question: whether or not the individual who committed suicide was a Christian; whether or not he died in grace; whether or not he should be given a Christian burial. In addition, this paper does not treat the ethical or philosophical debates on the question of suicide. Rather, it is confined to the factors leading to self-destructive thoughts so that the potential suicide may be recognized and helped.

Chapter II is an examination of the general problem of suicide. An evaluation of the available facts is made to determine the scope and frequency of suicide. Attention is given to the attitudes that society has had toward suicide and to the misconceptions still perpetuated. Two representatives from the fields of psychology and sociology are consulted: Karl Menninger and Emile Durkheim respectively. Also this chapter examines more recent theories concerning the dynamics of suicidal behavior.

Chapter III examines the role of the pastor within the area of suicide. Attention is given to the recognition of presuicidal behavior patterns on the part of the pastor and to the information necessary for an evaluation of the suicidal risk. This chapter also elucidates the pastor's use of supportive counseling in the prevention of suicidal action.

Chapter IV focuses on the role which the pastor assumes with both the presuicidal person's family and the post-suicidal person's family.

In Chapter V attention is given to the Suicide Prevention Centers, which are a relatively new innovation, and the role which

the pastor may assume with these agencies.

Chapter V comprises the conclusion of the study.

FOOTNOTES - CHAPTER I

[1]"On Suicide," Time, Volume 88, Number 22 (November 25, 1966), 48.

[2]Edwin S. Shneidman, "Suicide," Taboo Topics, edited by Norman L. Farberow (New York: Atherton Press, 1966), p. 46.

CHAPTER II

THE PROBLEM OF SUICIDE

Statistics

It is difficult to comprehend accurately the frequency of suicide. Records available are wholly inadequate and incomplete, but they do give an idea of the large number of successful suicidal attempts. Andrew F. Henry and James F. Short in Clues to Suicide write:

> More than 17,000 persons decided life was no longer worth living and committed suicide in the United States in 1950, producing a suicide rate of 11.4 per 100,000 population.[1]

For the year 1964 The World Almanac places the figure at 20,588 suicides.[2]

These figures do not include deaths that resulted from the complications of suicide attempts, such as where the attempt at suicide resulted in another condition which led to the patient's death. Neither do these figures include deaths resulting from alcoholism, drug addiction, drowning and car accidents which may have been suicide. For example, increased attention is being given to certain car accidents as noted in a recent article in Time magazine entitled "Autocide":

> Four cars in four years have smashed into Bridge 238 on the Kansas Turnpike near Topeka. In each case, the driver was the lone occupant, and he was killed. In each case turnpike police made the same notation on their report: daylight, clear, road dry, level and straight, no skid marks. "Cause: improper driving." Or was it suicide? No one can know for sure, but more and more police and traffic experts suspect that "autocide," as one expert

calls it, is an important cause of traffic deaths.[3]

Another reason why the available figures on suicides are inaccurate is pointed out by Edwin S. Shneidman in Taboo Topics:

> Certifications of obviously suicidal deaths as natural deaths or accidental deaths by physicians and coroners often occur in rural and urban areas throughout the world.[4]

When filling out death certificates, physicians and coroners may be tempted to put down another cause of death rather than suicide. This may be influenced by the stigma which suicide carries for the survivors and for the memory of the person who committed suicide. While the available statistics, therefore, do not reflect the accurate number of suicides, they are indicative of the immensity of the problem facing society today.

Characteristics

Although suicide occurs among all types of people and among all social classes, there are certain characteristics which may make one prone to suicide; the most important of these is relationship. The individual who has meaningful and significant relationships with others is less likely to attempt suicide than is the individual who has no significant relationships with others. Immigrants, for example, show a high rate of suicide.[5] This is because they have left all friends and families in their homelands, arriving in their new country knowing no one.

Marital status represents another kind of relationship influencing suicide. Erich Lindemann and Ina Greer, authors of "A Study of Grief: Emotional Responses to Suicide" state:

> Widows and widowers commit suicide more frequently than do members of an existing marital partnership; single men and women kill themselves more frequently than do married people; and divorced individuals show the highest rate of all.[6]

Marriage involves a significant relationship which reduces the suicide potential.

Studies further indicate that suicide rates are higher in central, disorganized sections of cities than in the outlying residential districts and rural areas. An individual in the city is easily lost among the masses. Moreover, he is likely to be more dependent upon himself rather than on others. The result is fewer relationships. On the other hand, the farmer in a rural area tends to belong to a closely knit group consisting of family and friends. Therefore, he has more meaningful relationships and, consequently, a lower suicide rate.

Relationships, however, are not the sole factor in suicide -- age, sex, social conditions, and even the time of the year affect the suicide rate. The rate is higher for older people than for the young. More women attempt suicide, while more men succeed. The rate for divorced males is three times that of divorced females. Also more wealthy people attempt suicide than do poor people. In addition, there are fewer suicides during a declared state of war, while the rate climbs once again during periods of peace, depression, and unemployment. Also suicide occurs most often in the spring of the year, especially in April and May, than in any other months of the year. Perhaps the lonely person becomes more conscious of his "aloneness" during the spring when others are elated by the season. The most vulnerable people are top executives, artists and professional

people. For example, the suicide rate for medical doctors is two in one hundred and even psychiatrists have a high rate.[7]

In brief, however, it is difficult to determine an overall pattern of suicide. Regarding the various causes, Samuel Southard in "The Minister's Role in Attempted Suicide" writes:

> Some people who attempt suicide are mentally ill, some are making a neurotic gesture for attention, some are emotionally deprived, and some are depressed because of some personal crisis.[8]

Thus, the causes culminating in suicide are manifold and the only feature common to all suicides is that the act itself represents a cry for help. Nonetheless, many individuals consider self-destruction as a solution. Lindemann and Greer write:

> A study of two hundred university students revealed that eighty percent of them had entertained the thought of self-destruction and thirty-nine of fifty so-called "normal, healthy individuals" admitted to having considered this solution to life and its difficulties.[9]

Yet society still views suicide with suspicion and fear.

Attitudes of Society

The study of suicide has been hindered by the fear and taboos of society. Regarding this Edwin Shneidman states:

> The history of suicide reveals that it has been viewed with varying attitudes by society. Some primitive and some recent cultures have accepted and approved of suicide. But by far the most prevalent attitude, especially in Occidental culture, has been negative, and suicidal behavior has been met with hostility, censure and condemnation. Suicide falls directly in the middle of the taboo area and thus encounters all the blind prejudices and resistances which encrust proscribed topics.[10]

The simple cultures and civilizations of primitive people and

those with established mores fear suicide as that which is considered unnatural. The early Greeks considered suicide as an offense to the gods. Later, under the influence of Stoicism and Epicureanism suicide was honorable in that it provided a means of gaining independence for the soul. Following the example of St. Augustine, Christianity considered suicide as murder and in the Middle Ages some Christian countries allowed the body to be mutilated and the person's property confiscated.[11] In the Eighteenth Century, especially in the western world, a new view came into being -- that a person could do what he wanted with his life. This resulted in the demise of previously held sanctions.

In the Twentieth Century suicide is regarded as a taboo topic and various misconceptions have arisen about it and are still being perpetuated. The most common misconception is that those who threaten suicide or talk about it will not attempt it. Yet studies have noted that seventy-five percent of those who committed suicide had either previously attempted it or threatened or both.[12] Therefore, any verbalization about potential suicide must be taken seriously. A second misconception regarding suicide is that it happens suddenly and without warning. In reality, however, the suicidal person generally gives a number of clues and warnings. Another misnomer is that the suicidal risk declines in proportion to the improvement following a suicidal crisis. But studies have found that one-half the suicides took place within ninety days following an emotional crisis.

A fourth misconception is that depression and suicide are synonymous. While depression is the best indication of possible suicide,

there are other factors also leading to suicidal action, for example, anxiety, psychoses, or an organic impairment. In addition, society generally believes that those who commit suicide are insane. Yet among older people, for example, the suicides are logical and rational and not psychotic. The sixth misconception in society is that suicide is a single disease, but this is not the case. Suicide occurs in many forms and shapes, among all classes of people of all ages and in both sex groups. A seventh generalization society makes is that suicide is immoral. In some suicides this is true and in others it is not. The truth of this statement depends upon where and when one is living. The eighth misconception is that legislation can control suicide. However, this would no doubt result in an increase of suicide rates. The person contemplating suicide will make sure that his attempt is successful so that he is not punished for attempted suicide, or if he isn't successful in his attempt he will be fearful of seeking help and medical attention. No evidence has so far been found to support the misnomer that the tendency toward suicide is inherited. The final universal misconception, especially by the middle class, is that suicide is the curse of the poor and the disease of the rich. Controlled studies indicate that all classes contribute to the suicide rate.[13]

Society has had many attitudes toward suicide and still retains various misconceptions which hinder a real understanding of the problems involved in suicide. While society has been perpetuating its misunderstandings, the applied sciences of psychology and sociology have been endeavoring to discover the causes of self-destruction.

Psychological Aspects

Karl Menninger, after observing suicide in its various manifestations, concurs with the Freudian theory of the death instinct as the cause for the self-destructiveness in the world. In Man Against Himself Menninger states:

> According to this concept, [the death instinct] there exist from the beginning in all of us strong propensities toward self-destruction and these come to fruition as actual suicide only in exceptional cases where many circumstances and factors combine to make it possible.[14]

Therefore, from a psychological perspective, the cause of suicide is complex and it is possible to discern the existence of various elements. The first of these aspects is murder. The suicidal person is at one and the same time a murderer and the murdered. Not only does he kill, but he is also the object of the killing. In addition to these two aspects, the wish to kill and the wish to be killed, there is also a third -- the wish to die. All of these must be present before the suicide is actually complete.

The wish to kill arises from the inner aggression which an individual has. Concerning the desire to kill, Menninger states:

> All of us have such impulses, such wishes; this is not abnormal. But most of us can resist them and no matter what sophistry is invoked to attempt to justify or glorify suicide the fact remains that it is a murder, a climax of destruction, and has purposes, motives and consequences related to that inescapable fact.[15]

If all people have such wishes and yet all do not attempt suicide, there must be other factors which explain why only some attempt suicide. A second element which Menninger proposes is the wish to be killed.

One of the ways in which the life instinct -- Freud's idea of

the desire to live -- finds satisfaction is in suicide. When an individual kills himself he still retains for himself the idea of omnipotence in that he is the master of life and death. On the other hand, should he wait to die of some other cause he would not be in control of his destiny. This wish to be killed presupposes a certainty of a future life, a reincarnation. Therefore the victim does not interpret his suicide as a real death.[16] In addition to the wish to kill and the wish to be killed, Menninger proposes an element which must be present before the suicidal person can carry his act to completion.

This third element which must be present is the wish to die. Unless this aspect is present, either consciously or subconsciously, the individual will probably not attempt suicide. An illustration of this wish to die is the woman who turned on the gas stove half an hour before her husband was expected home. Subconsciously she had timed the act so that her spouse would reach home in time to find her before she actually died. Of course, the husband may have unfortunately been late that particular evening. This absence of the wish to die is also seen in the people who have attempted suicide, failed, and then pleaded with the doctor to save them.

Karl Menninger, representative of the field of psychology, therefore proposes three elements which must be present for the completion of the suicide act: the wish to kill, the wish to be killed, and the wish to die. But an individual does not live in isolation. Rather he lives in a society which influences his psychological drives. Therefore, attention must be given to the role of society in the suicidal act.

Sociological Aspects

Emile Durkheim, the renowned French sociologist, complements Menninger by attempting to analyze the relationship of the psychological drives to the social factors which influence those drives. Durkheim developed three categories of suicide -- egostic, altruistic, and anomic.

On the basis of a study of marriage and the family, political and national communities, and religious affiliation, he developed the theory of egostic suicide, which results from a lack of integration of the individual into society. George Simpson, in the introduction to Durkheim's book Suicide, states:

> The stronger the forces throwing the individual into his own resources, the greater the suicide rate in the society in which this occurs. With respect to religious society, the suicide rate is lowest among Catholics, the followers of a religion which closely integrates the individual into the collective life. Protestantism's rate is high and is correlated with the high state of individualism there.[17]

Durkheim believes that religion thwarts suicide, not because of its teachings per se, but rather because it integrates the individual into a society.

The same holds true for the social unit, the family. It has already been noted that married individuals are less likely to attempt suicide than are the single, widowed, or divorced. The more integrated a family is, the more restraints there are against suicide.

Likewise there is more integration in the rural areas than in the urban community and the suicide rates vary accordingly. Simpson further states:

> Having established the variation of the suicide rate with the degree of integration of social groups, Durkheim is led to consider the fact of suicide in social groups where there is comparatively great integration of the individual, as in lower societies. Here where the individual's life is rigorously governed by custom and habit, suicide is what he calls altruistic; that is, it results from the individual's taking his own life because of higher commandment, either those of religious sacrifice to unthinking political allegiance. This type of suicide Durkheim finds still existent in modern society in the army where ancient patterns of obedience are rife.[18]

Therefore, Durkheim's second category of suicide -- altruistic -- results from an extreme integration to the point of regimentation. Thus an individual who is so much a part of society will commit suicide if it is the socially acceptable thing to do. In addition to these two categories, egostic and altruistic, Durkheim developed another classification.

This third category in Durkheim's approach to suicide is what he calls anomic suicide which results from a lack of regulation of the individual by society. Simpson continues:

> The individual's needs and their satisfaction have been regulated by society; the common beliefs and practices he has learned make him the embodiment of what Durkheim calls the collective conscience. When this regulation of the individual is upset so that his horizon is broadened beyond what he can endure, or contrariwise contracted unduly, conditions for anomic suicide tend toward a maximum.[19]

In this category would be individuals who suddenly become wealthy. This sudden change in position may then act as a stimulus for suicide. This same situation may occur after divorce.

Barclay D. Johnson of the University of California reduces Durkheim's three causes of suicide -- egostic, altruistic, and anomic -- to one cause so that the variation in suicide rates can be

explained by this one cause. He writes, "The more integrated (regulated) a society, group, or social condition is, the lower its suicide rate."[20]

While the sociological approach to suicide finds the cause of suicide in the community or society in which an individual lives, recent studies demonstrate that there are still other factors influencing suicidal action.

Other Aspects

In the book Clues to Suicide, edited by Norman L. Farberow and Edwin S. Shneidman, three determinants are suggested for the suicidal act. One is the hope for greater satisfaction. The individual contemplating suicide hopes for a life of greater satisfaction, namely that his life after death will be better than his present life. The second determinant is hostility. Here the person thinking about suicide feels hostile toward others, blaming them for his present frustrations. He then feels guilty about this, and the hostility becomes directed inward to himself. For example, a husband might feel hostile toward his wife because he believes her to be the cause of his present frustration. Then he feels guilty about blaming his wife so he becomes hostile or angry with himself.

The third determinant in the suicidal act is a feeling of hopelessness and frustration, and the individual sees no other way to end this unhappy situation than suicide. These three determinants coexist, either consciously or unconsciously, in a suicidal situation.[21]

The element of revenge is another aspect which may be found as

a cause of suicide in some cases. An illustration of this is the lover's quarrel. Following an argument between a couple, the young woman desires to "get even" with her boy friend by attempting suicide. Another factor in suicide is imitation. After a man leaps from a building in New York City, the police expect this to be followed by one or two similar incidents.[22] The imitation aspect, of course, is not the primary factor in another person jumping from a building, but it may well be the catalyst.

Some people attempt suicide to avoid social disgrace or to end a prolonged illness. Others attempt suicide in order to help their families. A husband, for example, might kill himself so that his family may receive the benefits of his life insurance, thus finally putting himself in the position of being an adequate provider.

These various aspects do not solely explain why some individuals attempt suicide while others in the same situations handle their frustrations and problems in a more acceptable and appropriate manner.

Summary

The problem of suicide effects thousands of individuals every year. There are no accurate records of the exact number of people who find the solution to their problems in self-destruction. No doubt many suicides are recorded as accidental deaths or deaths resulting from acceptable causes. Many studies have been carried out to determine the cause or causes of suicide. Age, sex, and marital status have a bearing on the suicidal rate. Significant inter-personal relationships reduce the risks of suicide. Society has had many ideas about suicide, and even today many misconceptions are perpetuated.

Menninger sought the cause for suicide in the psychological aspect of man. He concluded that three elements precipitate self-destruction: the wish to kill, the wish to be killed, and the wish to die. Durkheim sought the answer to the problem of suicide in the sociological condition of man's environment. He places the causes of suicide into three categories: egostic, altruistic, and anomic. Johnson reduced these three to one: the integration that one has in society.

Studies today find other aspects involved in self-destruction. Three determinants -- a hope for greater satisfaction, misplaced hostility, and hopelessness -- are suggested in Clues to Suicide. Other aspects include revenge, imitation, and escape from social disgrace, to name a few.

Therefore, suicide cannot be explained as the result of a single cause. Rather suicide is the result of various factors. These factors can be systematized and categorized so that those concerned with the prevention of suicide can recognize a potential suicidal situation and perhaps can prevent the self-destruction action. The prevention of suicide lies within the domain of pastoral care.

FOOTNOTES - CHAPTER II

[1]Andrew F. Henry and James F. Short, Jr., "The Sociology of Suicide," in Clues to Suicide, edited by Edwin S. Shneidman and Norman L. Farberow (New York: McGraw-Hill Book Company, Inc., c. 1957), p. 60.

[2]The World Almanac 1966 and Book of Facts. Edited by Luman H. Long (New York: New York World Telegram and The Sun, 1966), p. 299.

[3]"Autocide," Time, Volume 89, Number 10 (March 10, 1967), 23.

[4]Edwin S. Shneidman, "Suicide," Taboo Topics, edited by Norman L. Farberow (New York: Atherton Press, 1966), p. 39.

[5]Erich Lindemann and Ina May Greer, "A Study of Grief: Emotional Responses to Suicide," Pastoral Psychology, IV (December, 1963), 9.

[6]Ibid.

[7]"On Suicide," Time, Volume 88, Number 22 (November 25, 1966), 48.

[8]Samuel Southard, "The Minister's Role in Attempted Suicide," Pastoral Psychology, IV (December, 1963), 27.

[9]Lindemann, p. 9.

[10]Shneidman, Taboo Topics, p. 33.

[11]Ruth Cavan, "Suicide," Encyclopaedia Britannica, edited by Harry S. Ashmore (Chicago: Encyclopaedia Britannica, Inc., 1961), p. 533.

[12]For a complete discussion on the misconceptions of suicide, see Norman L. Farberow and Edwin S. Shneidman, The Cry for Help (New York: McGraw-Hill Book Company, Inc., 1961), pp. 13-14.

[13]Ibid.

[14]Karl A. Menninger, Man Against Himself (New York: Harcourt, Brace and Company, 1938), p. 3.

[15]Ibid., 45.

[16]Ibid., 63.

[17]Emile Durkheim, Suicide (New York: The Free Press, 1951), p. 14.

[18]Ibid., 14-15.

[19]Ibid., 15.

[20]Barclay D. Johnson, "Durkheim's One Cause of Suicide," American Sociological Review, XXXI (December, 1965), p. 886.

[21]Leonard M. Moss and Donald M. Hamilton, "Psychotherapy of the Suicidal Patient," Clues to Suicide, p. 100.

[22]John S. Bonnell, "The Ultimate in Escape," Pastoral Psychology, IX (February, 1958), 21.

CHAPTER III

PASTORAL CARE OF THE POTENTIAL SUICIDE

The Role of the Pastor

A clergyman who is in continual contact and communication with the members of his congregation is in a position to give initial help in all areas of distress, including suicide. By virtue of his position he is with his members during emotional crises. The people trust him and turn to him for help and guidance. He represents the ultimate meanings of life and death and people seek his interpretation of the events in their lives. In addition to the people coming to the pastor with their problems, he can be sensitive to the words and actions of his people which represent a cry for help. This recognition of the potential suicide is one of the contributions that the clergyman can make in the area of suicide.

Leif J. Braaten, former Cornell University psychologist, in an article about suicide among college students, says, "Evidence shows that at least one person often has been given a clue to the young suicide's intentions."[1] The pastor, by being sensitive to these clues, can recognize suicidal behavior.

A second aspect of the pastoral role is to provide emergency help for the person contemplating suicide. This help may be in the form of supportive counseling or, if the risk of suicide continues to be high, in the form of referral to a psychiatrist or other qualified personnel. Studies indicate that there is an element of risk involved

when the pastor chooses to counsel a person whose suicidal potential is high. By accepting the suicidal person, the counselor also accepts the threat that during the next crisis the individual may attempt suicide and succeed.[2] The counselor must be strong enough emotionally to endure such an error in judgment in his part, Moreover, suicidal persons demand a great deal from the counselor in terms of time, effort and responsibility. The counselor must be willing to allow the individual to intrude into his private life any time, day or night, and he must be able to endure the tension of not knowing what the potential suicide is doing while out of sight. Calling upon professional help for the treatment of a potentially suicidal person may mean the difference between life and death.[3]

A third aspect of the pastor's role, suggested by Howard Clinebell in "The Suicidal Emergency," is: "Helping the suicidal person fill the 'value vacuum' (Viktor Frankl) at the root of his problem."[4] This vacuum is filled when the individual sees meaning and purpose to life. This aspect can be fulfilled by the pastor as he works with an individual whose suicide risk is not high or imminent or by working in cooperation with the psychiatrist.

An individual considering suicide is usually not doing so in an isolated vacuum. Frequently he has a family and friends. Pastoral care of the suicide's family is the fourth aspect of the pastor's role. It is difficult for the family to accept the fact that one of its members has threatened, attempted, or even committed suicide. The goal of the pastor here should be to help the family accept the suicidal person and to give him new meaning and significance in his life.

The pastor is not only concerned about the individual of his congregation who is threatening suicide, but he is also concerned about the individual's family and the community in which he lives. In this final aspect of the clergyman's role he can encourage the development of or support the community suicide prevention service.

Among these several aspects of the minister's role, the most important for the sake of the individual considering suicide is recognition. Only after the pastor has recognized the cry for help can he be of service to the individual.

Recognition of the Suicidal Person

There are many clues indicative of potential suicide. Some are obvious; others are obscure. Not all of the signs examined in this section indicate the certainty of suicidal action. The pastor must interpret these clues with the possibility of suicide in mind. In the light of these clues he evaluates the risk of suicide.

The foremost distress signals of a suicidal person are the obvious threats and fantasies. In this category is the individual who announces matter-of-factly that he is going to take his life. All suicidal threats of this kind must be taken seriously, especially avoiding the misnomer that those who talk about it don't actually do it. If the individual threatening suicide is doing so merely to manipulate others without actually intending to carry out his threat, it still indicates that something is wrong in his life and he needs help.[5]

Also to be considered as obvious threats are fantasies of committing suicide and attitudes expressing that life has no meaning or

purpose.

Regarding the obvious suicidal threat, Elsa Whalley in an article entitled "Values and the Suicidal Threat," writes: "Whatever else it says, an expressed suicidal communication states that a decision is about to be made, but has not yet been made."[6] The person is seriously considering suicide but has not completely resolved to do it. Therefore, perhaps he still sees some value, however minute, to his life. This then can become a starting point for the counselor.

More difficult for the untrained person to interpret as being potential for suicide are the obscure cries for help. These may or may not be verbal suicide communications. An individual in this category would be one who has recently endured the loss of self-esteem, health, money, status, prestige, or the loss of a spouse by death or divorce. During the initial reaction to the loss, the person sees life as empty and he may be depressed. The longer it takes the individual to adjust to his loss, the higher the risk of suicide. For example, it is normal for one to feel depressed and to see life as empty and meaningless following the death of his spouse, but if he fails to adjust after a normal length of time he may be suicidal. On the other hand, an individual may be suicidal if he has no appropriate mourning for the loss of his spouse, i.e., a husband who does not mourn his wife's death at all.

Another clue indicating possible suicidal action, especially if it immediately follows a loss, is a drastic change in behavior. Here the individual who has been withdrawn from social situations

suddenly becomes active in church work and other previously scorned activities. Or the abrupt change may be in the other direction: the person withdraws from previously prized activities and social friendships and fails to regain his interest in them.

An added aspect should be sought in anyone who has suffered a loss and that is depression. The risk of suicide rises in direct proportion to the depth of depression. Commenting on depression, Clinebell states:

> Depression may be characterized by general retardation in moving and speaking, or by tension and agitation. Other symptoms which indicate depression include severe feelings of hopelessness, guilt and unworthiness; chronic insomnia [especially if the individual wakes up during the night and cannot get back to sleep]; loss of appetite and sexual desire; severe weight loss; chronic apathy and fatigue; social withdrawal; loss of interest in previously-prized activities; or a facade of exaggerated and brittle cheerfulness.[7]

These merely indicate the possibility of depression and should alert the pastor to other possible signs. Any functional complaint, for example, loss of appetite not backed up by an organic symptom, should cause the pastor to look for evidence of depression. Inherent in this approach is a physical examination by a physician to determine whether or not the cause of the complaint is organic.

Another factor which may lead to suicide is the pressure placed on an individual by his family, community, or job. An example of the kinds of pressure which could lead to suicidal action is found in an editorial in the United Church Herald regarding suicide among college students:

> Educators cite five areas which heighten the rate of suicides among American students: increased academic competition,

> heightened tensions of modern life, difficult personal adjustments, the unrealistic aspirations of parents and a combination of pressures beyond the adolescent's capacity to respond.[8]

Any of these may cause frustration and depression culminating in suicide. These same pressures in different forms may also be placed upon the adult.

There are clues prior to suicidal action ranging from verbal communication of intent to non-verbal cries for help. After the pastor has recognized a potentially suicidal person, he must evaluate the suicidal risk. Robert E. Litman and Norman L. Farberow suggest the following outline as a guide for determining the self-destructive potentiality:

I. Case History: factual
   - A. Age and sex
   - B. Onset of self-destructive behavior: chronic, repetitive pattern, or recent behavior change? Any prior suicide attempts or threats?
   - C. Method of possible self-injury: availability, lethality?
   - D. Recent loss of loved person: death, separation, divorce?
   - E. Medical symptoms: history of recent illness or surgery?
   - F. Resources: available relatives or friends, financial status?

II. Judgmental - evaluative
   - A. Status of communication with patient
   - B. Kinds of feelings expressed
   - C. Reactions of referring person
   - D. Personality status and diagnostic impression[9]

All of this information will help the pastor in deciding if he can work with the individual or if he should immediately refer him to a hospital. Suicide rates are higher for men than women and for older people than for younger. Also, one who has had a recent behavior change and a recent suicide attempt is likely to attempt suicide again. Regarding the history of suicide attempts, Litman and Farberow write:

> If there has been a pattern of repetitive self-destructive behavior over a long period of time, the eventual outlook may be extremely pessimistic, especially as the potential victim grows older and the condition gradually grows worse. However, in such chronic cases, although emergency intervention may be necessary for the immediate situation, it usually has no lasting effect, and a more gradual long term rehabilitation plan must be formulated in addition.[10]

The methods by which the potential suicide plans to kill himself may also reflect the degree of emergency. A person who has a gun and threatens to use it should be taken more seriously than the person threatening to take aspirin. Recent hospitalization, surgery, and especially an incurable disease, such as cancer, may tend to heighten the suicidal risk. Also the resources in terms of family or friends may mean the difference between threatening suicide and actually attempting it. If the relationship of the individual to his family has been a stable inter-personal one, he is less likely to complete the suicidal act. The person's financial status indicates the kind of treatment he can afford and it may also indicate whether a financial reverse is causing his depression.

Application of the judgmental-evaluative section of the outline requires skill in counseling and interviewing. The status of communication with the patient refers to the communication he has with others. The danger of suicide is much greater for the person who withdraws and refuses to talk than it is for the one who is willing to express his troubles. Also the kinds of feeling that are communicated must be evaluated. Feelings of helplessness and hopelessness and similar ones elevate the suicide potential. The reactions of the referring person, if it is a referral, are important. Does the referring person feel a sense

of concern and helplessness in the situation? Or is the attitude one of rejection? The referring person can be a source of strength in the situation. If the counselor detects the presence of psychotic thinking and severe depressive effects, especially if combined with alcoholism, immediate hospitalization should be considered.[11]

Recognition of the signs indicative of potential suicide and the evaluation of the situation are the most important aspects of the pastoral role in suicide. Only after he has done this can he be of help to the individual in terms of referral or counseling.

Pastoral Care

The role that the pastor assumes in relation to a suicidal person depends, to a large extent, upon his evaluation of the self-destructive potential. If he interprets the situation as an emergency, he will want to refer the individual to professional help. Here his role should be worked out in cooperation with the person to whom he has referred the potential suicide. On the other hand, if it is not an emergency situation, the pastor may choose to work with the individual and consult the advice of the helping professions.

Concerning the role of the clergyman, Earl Grollman writes:

> The minister can play a significant role in the treatment of the potential suicidal person through pastoral counseling -- in extending his loving concern, in sharing a religious orientation of life, a feeling of belonging, a power of faith, and a meaningful belief in God.[12]

Grollman is suggesting a supportive role for the clergyman. Through his words and attitudes he indicates to the suicidal person that someone <u>does</u> care about him. This is an appropriate role for the pastor

both when he is working alone with the individual or working in co-operation with a psychiatrist.

A psychiatrist can effectively evaluate the depth of depression, administer drugs to help the person over his crisis and place him in a hospital. Further, a psychiatrist or psychologist is trained to utilize what is termed depth counseling and psychoanalysis. On the other hand, the psychiatrist and psychologist can ill afford to minimize the contribution which the clergyman can make to the patient, that of supportive counseling.[13] Furthermore, the clergyman is in a better position to enlist the strength and support of family and friends, especially if they are members of his church.

Ruth Blom, a social case work supervisor, suggests seven principles in supportive counseling which the pastor may utilize in his supportive therapy. These principles are: acceptance, permissiveness, controlled emotional involvement, individualization, non-judgmental attitude, client self-determination, and confidentiality.[14]

The first of these principles is acceptance. This is the recognition of the person as one with certain basic needs and rights, regardless of his individual qualities resulting from his behavior, environment or heredity. This does not mean that the pastor accepts the individual's proposed action. This attitude of acceptance cannot merely be verbalized. Rather it is conveyed to the parishioner by the total context of the inter-personal relationship.

The second attitude on the part of the pastor is permissiveness, which is defined as the recognition by the minister of the individual's need to express his feelings freely, especially his negative feelings,

and the minister's responsibility to listen purposefully.[15] The goal of the pastor is to help the individual adjust to himself and society. Understanding the person and his problems is important for the achievement of the goal. The main source of information for this is the person himself. The pastor can learn what happened to the individual and how he feels about what happened. The attitude of permissiveness will give the minister this understanding. The mature and emotionally secure pastor accepts all of the feelings, including the negative feelings of anger, hate, and hostility, of the potential suicide. The pastor listens purposefully, that is, he knows when to ask for additional details and when not to press for details. He also "listens" to the gestures, facial expressions, and the tones of voice. All of this will help him to understand the disturbed person.

The third prerequisite of a good counseling relationship with a potentially suicidal person is controlled emotional involvement. This is being sensitive to the individual's feelings, the ability to understand their meaning, and skill in responding to these feelings in a purposeful and appropriate manner.[16] It is necessary that the minister does not become too emotionally involved with the feelings of the person seeking his help. If the pastor identifies with the problem of the individual to the extent that it becomes his problem, he can no longer be effective.

The fourth aspect of the pastor and suicide relationship is individualization. This is the recognition of the person's uniqueness. All suicidal persons have certain things in common. They are all people with certain needs and rights, drives and impulses, and they

are considering self-destruction as an escape from their present situation. Yet each one of these is distinct from the other. They have many differences: age, sex, temperament, intellectual capacity, ego strength, etc. In this perspective the pastor tailors his approach and methods to the uniqueness of the individual.

A non-judgmental attitude on the part of the pastor is the fifth aspect of the counseling relationship. This attitude is conveyed to the individual primarily through the tone and manner of the interview. Only after the suicidal person feels that he is not being condemned will he be free to express his true feelings. Neither does this aspect imply that the minister condone the person's attitudes concerning life and proposed escape. Telling the person that his proposed action is against the will of the Lord or that if he carries out his intent he will not die in the grace of God or a similar statement, will do nothing beyond erecting a barrier between the pastor and client. It tells the person that this pastor doesn't really care about the "why" of his present situation. On the other hand, if the pastor tells him that most people have thoughts of suicide at one time or another but that he is carrying these thoughts to an extreme, or "making a mountain out of a molehill," this may also be seen as a lack of concern in the eyes of the disturbed individual.

The sixth element of the relationship is self-determination on the part of the individual seeking help. This is the recognition by the pastor of the person's need and right to make his own decisions. The helpfulness of the pastor might be in helping the person work through his feelings so that he can see the problem in its full

perspective. While the pastor cannot usurp the right of decision, he should help the suicide recognize that there are certain limitations to this right. If the pastor presupposes that only God has the right to take a life, he will then help the individual to recognize this limitation of his right. Other limitations of the individual's right are those arising from law and authority and the mores of society. However, the individual must be given the freedom to make his own choices and decisions regarding the problems which culminated in his self-destructive desire.

The final aspect of the counseling relationship suggested by Blom is confidentiality, which is the recognition that the information revealed to the counselor is to remain secret.[17] The pastor only has the right to reveal this information with the permission of the person. The individual will have enough adjustments to make without the added feeling that everyone in the church knows that he has threatened or attempted suicide. The only exception to this guideline is if it means the difference between life and death for the individual.

The foregoing seven principles, according to Blom, are the presuppositions in a supportive counseling relationship. They underline any methodology used by the pastor. Concerning the methodology used by the pastor, Clinebell states:

> In supportive counseling the pastor uses those counseling methods which stabilize, undergird, nurture, motivate, or guide troubled persons, enabling them to handle their problems and relationships more constructively within whatever limits are imposed by their personality, resources and circumstances.[18]

The focus of supportive counseling is on the present problems, the

self-destructive thought, and the elements which brought about those thoughts. If the parishioner can be helped with the daily problems of living, his suicide thoughts can be resolved. The counselor makes use of guidance, information, reassurance, inspiration, planning, asking and answering questions, and encouraging or discouraging certain forms of behavior.[19]

Clinebell suggests at least seven procedures in supportive counseling which the pastor may utilize.[20] The first is that he can gratify the individual's need for dependency. The counselor becomes a parent figure. The client can lean upon him for comfort, guidance, protection, and instruction. The second feature is the pastor allowing the individual to "pour" out his burdensome feelings. Thirdly, the counselor can help the person explore the feasible alternatives of his problem. Together they can examine the implications of suicide and the other possible ways of transcending the stressing situation. The fourth procedure the clergyman can use is to aid the ego's defenses. For example, the potential suicide may be blaming others for his present frustration and hopelessness. He is repressing his own responsibility and projecting the cause of others. Should the counselor tear down these defenses before the individual's ego is strong enough to handle it, suicide would almost be certain.

A fifth method which the pastor can employ is to help change the individual's situation either by changing the individual himself or by helping him to change the external circumstances. If the pressures leading to self-destructive acts were caused by a particular job, the pastor may help him seek different employment. A sixth method which

the pastor may find helpful is action therapy. By prescribing some kind of activity ("homework") the individual will be kept functioning. Regarding the use of action therapy, Clinebell writes:

> At the Suicide Prevention Center in Los Angeles it has been discovered that taking a battery of psychological tests is, in itself, often beneficial. This activity gives temporary structure to the suicidal person's chaotic world, offers hope of diminishing his pain, and an opportunity to please the authority figure who requested the activity.[21]

While the pastor may not have psychological tests available nor be qualified to use them, he might request that the person list the ways that he sees to solve his own problems.

The seventh and last method of supportive counseling which is available to the pastor and which is also unique to him is the utilization of religious resources, such as the Lord's Supper, Scripture, and prayer. These can help the individual see that life does have meaning. The minister cannot afford to be content with using just the last method, although he may be tempted to do so. Rather, he should tailor the total methodology to the individual and his needs.

Although supportive counseling is the most appropriate form of counseling for the pastor, he should be aware of its inherent dangers. The primary danger in this type of counseling is that the individual becomes so dependent upon the counselor that there is no growth. This can happen when the pastor does things for the client which he could well do for himself. The minister can avoid this by resisting the individual's neurotic needs and by saying "no" flatly to certain demands. By avoiding this ever-present danger, the pastor who effectively employs supportive counseling can help the individual to

adjust or to change the circumstances which led to his suicidal thoughts.

Summary

The clergyman, by his unique position, can make a valuable contribution to the problem of suicide. Some individuals will seek him out and relate their thoughts about suicide. In others, the pastor, through his continuing contact with his people, can see the areas of stress which could lead to suicide. The role which the pastor then assumes will depend upon his evaluation of the suicidal risk. If it is an emergency, he will want to make an appropriate referral; if not, through supportive counseling he may be able to prevent the situation from becoming a crisis. Also, supportive counseling is appropriate for the pastor if he is unable to make a referral during a crisis and after the crisis is over and the individual is on his way to recovery. The role of the pastor in suicide, unlike that of a psychiatrist or psychologist, also extends beyond the potentially suicidal person to his family. This aspect of the pastor's role will be examined in Chapter IV.

FOOTNOTES - CHAPTER III

[1]"Danger Signals," The United Church Herald, VII (February 15, 1965), p. 24.

[2]Norman L. Farberow, "The Suicidal Crisis in Psychotherapy," Clues to Suicide, edited by Norman L. Farberow and Edwin S. Shneidman (New York: McGraw-Hill Book Company, Inc., c. 1957), p. 130.

[3]Ibid., p. 129.

[4]Howard J. Clinebell, "The Suicidal Emergency," The Expository Times, LXXVII (August, 1966), p. 328.

[5]Ibid., p. 329.

[6]Elsa A. Whalley, "Values and the Suicide Threat," Journal of Religion and Health, III (April, 1964), p. 242.

[7]Clinebell, p. 329.

[8]"Danger Signals," p. 24.

[9]Robert E. Litman and Norman L. Farberow, "Emergency Evaluation of Self-Destructive Potentiality," The Cry for Help, edited by Norman L. Farberow and Edwin S. Shneidman (New York: McGraw-Hill Book Company, Inc., c. 1961), p. 49.

[10]Ibid., p. 50.

[11]Clinebell, p. 329.

[12]Earl A. Grollman, "Pastoral Counseling of the Potential Suicidal Person," Pastoral Psychology, XVI (January, 1966), p. 46.

[13]Ibid.

[14]Ruth M. Blom, "Seven Principles of Casework," Social Work for the Pastor (St. Louis: Concordia Seminary Press, 1967), p. 96.

[15]Ibid., p. 100.

[16]Ibid., p. 105.

[17]Ibid., p. 121.

[18]Howard J. Clinebell, Basic Types of Pastoral Counseling (Nashville: Abingdon Press, c. 1966), pp. 139-140.

[19]Ibid., p. 141.

[20]Ibid., p. 141-144.

[21]Ibid., p. 143.

CHAPTER IV

PASTORAL CARE OF THE SUICIDE'S FAMILY

This chapter comprises an examination of the role that the pastor assumes toward the family of the suicidal person. Not only does the pastor want to help the family adjust to the situation, but he also recognizes the resources of the family for the restoration of the suicidal individual to society. This chapter will treat the pastoral care of the family in which a member is threatening suicide and also the family in which a member <u>has</u> committed suicide.

The Family of a Pre-Suicidal Individual

A family suffers emotional shock when it learns that one of its members is considering self-destruction. Suicide in the minds of many is associated with insanity and people are not trained to handle their feelings on this subject. The family will be anxious about the kinds of responses they can give to other people. "What will people think if they learn that our son is considering suicide?" They are afraid that their friends will blame them for the situation and, moreover, they are not entirely certain that they are blameless. Then they feel guilty, anxious, and helpless. If a member of the family has already attempted suicide, the others wonder what they should say and how they should act toward him when he returns home from the hospital. In brief then, they have never experienced a situation like this before and possibly have never known any people who have. All they really know about suicide are those negative feelings shared by so

many. The pastor's role, then, is to help stabilize their state of turmoil and to mobilize the family's therapeutic support of the suicidal person.[1]

The first task of the pastor is to bring some stability into the situation. Supportive counseling here, too, is appropriate. The pastor can help and encourage the family as a unit to express their feelings and to work through these feelings. He may choose to explore their feelings concerning the cause of the individual's self-destruction wishes. In some cases the pastor must be prepared to deal with hostility rather than concern or despair. Edwin Shneidman comments on this in Taboo Topics:

> Open hostility...is often reserved, not for the person who commits suicide, but for the person who, to use a word in an un-American way, "unsuccessfully" attempts it.[2]

This hostility, if it exists, must be dealt with before the family can be mobilized to help the suicidal person. After the pastor has helped the family express its feelings and has, hopefully, helped them to understand their feelings, he can begin to equip them for their important role which lies ahead.

The family is very important in the "healing" aspect of the suicidal person's recovery. He needs to be accepted and understood. He needs help to transcend his present situation. His family can become an extension of the pastor's supportive counseling. The pastor can educate the family in the dynamics of supportive counseling in, of course, an unsophisticated manner. He can give them ideas of what they can do and what they should not do for the potential suicide. Moreover, he can explain, especially if they are intelligent and eager

to help, the purpose of the role he wants them to assume. This act of equipping the family, therefore, serves to help the suicidal person and at the same time encourages growth on the part of the family.

The Family of a Post-Suicidal Individual

There are also certain dynamics present in the bereavement following a suicide which are not found in normal grief. An awareness of these dynamics will aid the pastor as he helps the survivors work through their grief following a suicide.

Wayne E. Oates, in an article entitled "The Funeral of a Suicide," states:

> Since time immemorial persons who believe in heaven and hell as eternal realities have also tended to believe that the person who commits suicide is eternally condemned.[3]

Therefore, the pastor must deal not only with death but also with the idea of an eternal death. Shneidman says, "No other kind of death -- whether by accident, cancer or heart disease -- creates such a backwash of guilt, remorse, and shame."[4] These are some of the dynamics apt to be present in those who remain.

The pastor cannot make the burden easier for the family by telling these grieving persons that their loved one was insane or mentally ill. Rather, if the pastor presents the suicide as a fatal illness the act will be better understood and the mourning can pass more easily. Also the pastor can encourage the family to discuss the question of suicide and their feelings about it.

Summary

The role of the pastor in suicide goes beyond the potentially suicidal person to his family. Here the pastor endeavors to help the family work through their negative feelings which they perpetuate toward the situation, and he equips the family to help the individual through acceptance, love, and support. The pastoral role changes when he is called upon to minister to a family mourning one who has already committed suicide. The pastor must help them work through their feelings about suicide. Then he can deal with their bereavement.

The concern of the pastor for the problem of suicide goes beyond the care and counseling of the potential suicidal person and his family, however, to the aspect of prevention on a community level. This point will be discussed in the following chapter.

FOOTNOTES - CHAPTER IV

[1]Howard J. Clinebell, "The Suicidal Emergency," The Expository Times, LXXVII (August, 1966), p. 328.

[2]Edwin S. Shneidman, "Suicide," Taboo Topics, edited by Norman L. Farberow (New York: Atherton Press, 1966), p. 40.

[3]Wayne E. Oates, "The Funeral of a Suicide," Pastoral Psychology, IV (December, 1953), p. 16.

[4]Shneidman, p. 40.

CHAPTER V

THE PASTOR AND SUICIDE PREVENTION

Inherent in the title of this study, "The Suicidal Person and Pastoral Care," is the idea of suicide prevention. The pastor, because he is concerned about people, counsels those individuals who are considering self-destruction. Moreover, he perhaps unknowingly strives to prevent suicide by helping the people within his congregation to see that life does have meaning and value. John Bonnell writes in "The Ultimate in Escape": "The most powerful preventive of suicide is a firmly grounded religious faith."[1] But the pastor is also concerned about the problem of suicide on a community level. This chapter comprises an examination of the role of the pastor in community suicide prevention. Many cities, especially the larger ones, already have Suicide Prevention Centers. These are organized somewhat on the order of an answering service and the helping individual on the line does his or her best to convince the suicidal person that self-destruction is not the answer to his problem. The pastor can work in close cooperation with such a center and encourage its support. If his community does not have such a center, he might encourage the development of one. Addresses of several such Suicide Prevention Centers are found in the Appendix of this paper.

The Suicide Prevention Center

Milo F. Benningfield, in "A Review of Suicide Prevention Centers in the United States," defines the center as "a place where a person

thinking of or intending suicide may seek help with his particular problem any time of day or night."[2] The prevention of suicidal action is the most important function of a Suicide Prevention Center, albeit not the only one.

The Suicide Prevention Center in Los Angeles has these goals: the clinical aspect, the community aspect, and the research aspect.[3] The presupposition of the clinical aspect is that the individual who is considering self-destruction reveals his intent and that at any given time a number of people are potentially suicidal. Through various methods the center collects the needed data on presuicidal persons. The data will better equip the center in its prevention of suicide and in the restoration of the individual to society.

The community aspect is the second function of the center. Part of this aspect lies in integrating the center with the other health and welfare agencies. With this integration the entire resources of the community could be directed to the suicidal person and his family. Also within the scope of the community aspect is the education of the people in the community so that the many misconceptions concerning this topic are dispelled.

In the research aspect of the Suicide Prevention Center the staff investigates why people take their lives so that suicide can be prevented in the future by increased knowledge. Also involved in the research aspect is the presenting and publishing of professional papers.

Therefore, the Suicide Prevention Center is a community agency which attempts to prevent suicidal action, to educate the community, and to carry on research for a better understanding of the causes of

suicide. The pastor can play a significant role in at least the prevention aspect and the educational aspect.

The Role of the Pastor

If the community in which the pastor lives does not have an organized Suicide Prevention Center, he can investigate with other professionals the possibility of developing such a center.

However, if his community has such a center, the pastor can help the organization in several ways. Firstly, he can volunteer to be on the call list -- a list of the phone numbers which potentially suicidal persons can call for help. Secondly, he can also encourage his members to seek the necessary training so that they can also help in this manner. In addition, the pastor can educate the people in his congregation on the problems of suicide. Moreover, the pastor can encourage the financial support of a center. The Suicide Prevention Center in Los Angeles, for example, is incorporated as a non-profit organization.[4]

In brief, then, through a community Suicide Prevention Center, the concern of the pastor for the prevention of suicide may be extended.

FOOTNOTES - CHAPTER V

[1]John S. Bonnell, "The Ultimate in Escape," Pastoral Psychology, IX (February, 1958), p. 24.

[2]Milo F. Benningfield, "A Review of Suicide Prevention Centers in the United States," Pastoral Psychology, XVI (January, 1966), p. 42.

[3]Edwin S. Shneidman, Norman L. Farberow, and Robert E. Litman, "The Suicide Prevention Center," The Cry For Help, edited by Norman L. Farberow and Edwin S. Shneidman (New York: McGraw-Hill Book Company, Inc., c. 1961), pp. 7-8.

[4]Ibid., p. 16.

CHAPTER VI

CONCLUSION

Suicide is a growing problem in society today, affecting the lives of thousands of people each year. Suicide encompasses people of every age, social stratum, and of both sexes. The exact number of suicides cannot be ascertained. Statistics do not include deaths resulting from the complications following an attempted suicide. Moreover, there is no possible way of determining whether the death of an individual in an automobile accident, for example, is actually accidental or an act of self-destruction. Therefore, the available statistics indicate only the minimum number of suicides for a given period of time.

Part of the inadequacy of statistics, in that many death certificates do not cite suicide as the cause of death, lies in the stigma that society surrounds suicide. Throughout history society has had strongly negative feelings regarding acts of self-destruction which have been met with hostility, censure, and condemnation, especially in Occidental cultures. Even today's society, because of fear and ignorance, perpetuates many misconceptions about suicide. A few individuals, however, have sought answers to the problem of suicide.

Karl Menninger is a representative of the psychological approach to suicide. He concludes that the completion of the suicidal acts rests upon three aspects: the wish to kill, the wish to be killed, and the wish to die. While any one of these may be found in people, the successful suicide requires the presence of all three.

On the other hand, Emile Durkheim employed a sociological approach to suicide. He developed three categories of suicide: egostic, altruistic, and anomic. Egostic suicide results from lack of integration of the individual into society. Altruistic suicide results when an individual's life is rigorously controlled by custom and habit. The individual commits suicide in obedience to a higher commandment, either religious or political. In his third category, anomic, suicide results from a lack of regulation of the individual by society. A drastic change in a person's life, such as divorce, for example, could act as a stimulus for suicide. Barclay Johnson reduced these three categories to one, that of integration; the more integration, the less the rate of suicide.

Studies today have found three determinants in self-destruction: a hope of greater satisfaction, misplaced hostility, and hopelessness. Therefore, suicide is the result of several causes which can be classified so that presuicidal behavior can be recognized and suicide prevented. The role of the pastor is to recognize the clues to suicide so that he can perhaps prevent the action.

For many people in distress the first person to whom they turn is a minister. The pastor should be able to recognize both the obvious and obscure suicidal communications. He should be sensitive to those stress situations which may lead to suicidal behavior. These stress situations include: loss of health, money, spouse, status; depression; or pressure placed upon an individual by his occupation or family.

Following the recognition of a potentially suicidal person, the

pastor must evaluate the suicidal risk. His evaluation determines the course of action. If the risk is high, the pastor should refer the person to professional help. If the risk is not an emergency, he may choose to counsel the individual himself. The most appropriate pastoral approach is supportive counseling. Supportive counseling presupposes seven attitudes: acceptance, permissiveness, controlled emotional involvement, individualization, non-judgmental attitude, client self-determination, and confidentiality.

The focus of supportive counseling is on the present situation, the here and now. The counselor guides, informs, reassures, inspires, helps to plan, asks and answers questions, and encourages or discourages certain forms of behavior. The pastor will also utilize the Lord's Supper, Scripture and prayer so that the suicidal person may see that life does hold meaning. The pastor should be aware of the dangers of utter dependency upon him which may result from supportive counseling. He can avoid this by refusing to do for the individual what he himself could do.

But the concern of the pastor for the problem of suicide extends beyond the individual to his family. He helps the family to adjust to the situation by encouraging them to express their feelings. He recognizes the tremendous supportive role that the family can play to help the potentially suicidal person. When working with a family who is mourning the death of one resulting from suicide, the pastor must help them to work through their feelings about the suicidal act itself before he can help them in their grief.

Besides the potentially suicidal person and his family, the pastor is interested in suicide prevention on a community level. He encourages the development and the support of the Suicide Prevention Centers. He can help the Center prevent suicide and help to remove the misconceptions which society has about suicide.

Suicide is a growing problem in society. It scars communities and families and destroys individuals. Suicide does not generally occur without some communication of the intention. Alertness and sensitivity on the part of the pastor can help to combat this growing problem in today's society.

APPENDIX

Suicide Prevention Agencies in the United States as of 1961:

The Suicide Prevention Center
P. O. Box 31398
Los Angeles 31, California

National Save-a-Life League, Inc.
505 Fifth Avenue
New York 17, New York

Rescue Incorporated
Boston City Hospital
Room 25 BD South Department
745 Massachusetts Avenue
Boston, Massachusetts

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