

Warning Signs for Suicide

- Frequent, intense suicidal thoughts
- Talking or writing about suicide
- Making preparations for suicide
- Suicide attempt or rehearsal
- Hopelessness
- Agitation
- Anxiety
- Increased anger
- Recklessness or impulsivity
- Dramatic mood changes
- Feeling trapped
- Sense of having no purpose or reasons for living
- Increased use of alcohol or other drugs
- Sleep disturbance
- Withdrawal from others
- Feeling like a burden to others
- A sense of disconnection from others
- An Increase in high-risk activities and exposure to violence

(Stacey Freedenthal, *Helping The Suicidal Person*, 69-70)

Risk Factors for Suicide² Certain events and circumstances may increase risk.

- Losses and other events (for example, the breakup of a relationship or a death, academic failures, legal difficulties, financial difficulties, bullying)
- Previous suicide attempts
- History of trauma or abuse
- Keeping firearms in the home
- Chronic physical illness, including chronic pain
- Exposure to the suicidal behavior of others
- A history of suicide in the family

²Adapted from: *Suicide Risk Factors*, Substance Abuse and Mental Health Services Administration, and *Warning Signs and Risk Factors*, American Association of Suicidology

Possible Questions for Exploration

- How religious of a person are you?
- How do your religious beliefs help you to cope with stress, if at all?
- Are there ways that your religious beliefs or community add to your stress?
- What does your religion say about suicide? Do you agree?

(Stacey Freedenthal, *Helping The Suicidal Person*, 90)

How to Make a Referral for Mental Health Treatment

Communicate clearly about the need for referral. Make the referral a collaborative process between the person and/or family and the faith leader. "Let us think together about the helping resources that will be of most value to you." Be clear about the difference between spiritual support and professional clinical care.

- **Reassure the individual and family that you will journey with them** and will help navigate any obstacles. Seek to understand possible barriers or preconceived ideas that may hinder the process (fears, stigmas, religious misunderstandings, economical challenges, and so on). Ask about medical insurance.
- **If possible, have a list of professionals at hand for immediate reference.** In some instances, it may be helpful to provide help with finding a professional and making an appointment.

Follow-up. Remain connected with the family to see how the situation evolves. Provide the spiritual encouragement necessary to stay the course. Offer community resources (see resources at end). Support the person's re-integration into the faith community.

Keep in mind: Not all individuals/families will immediately accept the need for referral. If this is the case, continue to journey with the family providing guidance (see next section, "Dealing With Resistance").

For emergencies, call 911 or go to the nearest hospital; ask if a person with Crisis Intervention Team (CIT) training is available. If there is a life-threatening situation, the referral process should not precede calling 911 or going to the nearest emergency room.

Dealing With Resistance to Accepting Mental Health Treatment

Remember, the person *has* an illness; the person *is not* the illness. Mental health and illness involve multiple factors, including biology and neurochemistry, and are not the fault of the person, the family, or anyone else. Faith leaders are in unique positions to educate their congregations about mental health in order to overcome the stigma and shame often associated with mental illness with understanding and acceptance.

Acknowledging a problem. Resistance to treatment may come from the fact that the person does not think he/she has a mental health problem. Helping individuals

understand that effective treatment is available for the issues that trouble them is an important first step.

Stigma. Realize that for many people the stigma about mental health conditions, involving stereotypes, prejudice, and discrimination, is a significant part of dealing with the illness itself. This encompasses both public stigma (general population reaction to people with mental illness) and self-stigma (prejudice that people with mental illness turn against themselves). Faith leaders should know enough about mental health conditions to understand the challenges an individual may be facing and be able to comfortably and confidently deal with stigma-related resistance.

Past experience with medication. People may have received mental health treatment in the past, but then decided on their own to stop taking medication. Stopping medication may have been prompted by bothersome side effects or because they felt it was no longer needed. Focusing the conversation on how they were functioning while taking medication as compared with their level of functioning without medication may be helpful in motivating individuals to consider resuming treatment.

Support team. A personal "support team" for someone who is resisting treatment is often a valuable resource. Such a team would be composed of several trusted people who could provide feedback whenever they observed the individual's thinking or behavior interfering with his/her ability to function. A support team could help the individual over time to see the need to resume treatment.

Religious concepts. At times, religious concepts and understandings may be a source of resistance to treatment. People may "depend on God" for healing or regard receiving psychiatric services as a "lack of faith." They may interpret their symptoms as a "curse" or a "punishment from God." When engaging in conversation and counsel, a faith leader may usefully affirm that "God has given us the ability to develop medicines that are helpful in keeping us well."

Hopelessness. People sometimes avoid or discontinue treatment because they can see no hope in their situation. In fact, hopelessness can be a significant symptom of the mental disorder itself. In some cases faith stories from one's religious tradition that illustrate how people have found "a way forward when there seems to be no way" can facilitate hope. Personal stories of those who have come through times of crisis and resistance can also be effective in conveying an assurance that people can recover if they reach out for help that is available.

Perhaps the most helpful is the faith leader's expression of his/her own confident trust that the troubled individual can find the strength to take the next step toward his or her own healing.

If the resistance becomes extreme and if you think the person who is resisting treatment may hurt himself or herself or someone else, seek immediate assistance; call 911/Emergency Medical Services; ask if a person with Crisis Intervention Team (CIT) training is available.

As a faith leader, you can convey that each person is sacred, is a person of extreme value, and is a person who is loved ultimately.

Distinguishing Religious or Spiritual Problems From Mental Illness

Clinical needs and spiritual concerns are often inextricably intertwined among people of faith. People of faith who have a mental health condition may experience distressing spiritual concerns (for example, Has God forsaken me? Why doesn't God heal me? Is taking medication evidence of a lack of faith?). They may also express distress in a spiritual term consistent with a DSM-5 Religious or Spiritual Problem that is not a mental health condition (for example, prayers not answered, possession by an evil spirit, anxiety over an unforgivable sin, and so on).

In dealing with individuals with both spiritual and mental concerns:

Meet with the individual and/or family to assess the needs and problems they are experiencing. Faith leaders should be clear about the difference between religious/spiritual support and professional clinical treatment.

- Consult the policies and guidelines for pastoral care and counseling adopted by your denomination or faith group. These will usually delineate boundaries for both clergy and congregants regarding how pastoral care is to be practiced.
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- Take particular note of issues or concerns that require urgent clinical care. For example, suicidal intent or behavior, despondency, impulses to self-harm or harm others. Immediate referral to a clinical care professional is critical when these concerns or issues arise. The person should be assured that you will be there with spiritual care and support.
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- Attend carefully to the language a person uses with you as a faith leader to describe her/his distress. Be aware that mental health conditions are sometimes expressed as religious or spiritual concerns such as committing an "unpardonable" sin, vocational indecision, family problems, and distress that one's prayers are not answered. Recognize that cultural differences exist in understanding mental health versus religious or spiritual issues.
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- Resist prematurely understanding a complex situation as entirely related to religion or spirituality. When mental health issues are not readily apparent, a faith leader may appropriately decide to offer religious counsel and spiritual guidance. If after 4 to 6 sessions, the issues still persist and the congregant exhibits a sense of hopelessness and undiminished distress or additional areas of life

dysfunction, referral to a clinical professional should be made for further diagnosis, assessment, and treatment with ongoing support from you.

NATIONAL SUICIDE PREVENTION HOTLINE:

800-273-TALK

800-273-8255

Available 24/7 (Trained Counselors Can Refer To Local Resources)

http://www.mentalhealthministries.net/resources/resource_guides/APA/3-31-16_Mental_Health_Guide_Tool_Kit_RGB.pdf

The National Action Alliance for Suicide Prevention announces the 2nd Annual **National Weekend of Prayer for Faith. Hope. Life.** the weekend of September 7-9. It is part of the Alliance's ongoing **campaign for mental health and suicide prevention.**

Started in 2010, the Action Alliance is a private -public partnership (including Departments of Defense, Veterans, and Health/Human Services), various clinical organizations like American Psychological Association, businesses and faith communities and pastoral care/counseling organizations. For the Faith Communities Task Force, our goal is both to break the silence in faith communities about mental health and suicide and also help clergy and congregations build on what they're already doing to foster good mental health and care for persons dealing with mental illness.

This national campaign is intentionally interfaith--bringing together both Progressive and Evangelical Christians, Jews, Muslims, and other faith communities. With all that is happening both nationally and globally right now-- all of our congregations and denominations already have a lot to deal with, but we hope you and others see this also as a social justice ministry, as well as a deeply pastoral one, for many congregations, and help spread the word to encourage other churches and members to join in this " Weekend of Prayer ."

*God of all mercy,
From whose love nothing can separate us, we pray this day for all persons dealing
with mental illness and those who love and care for them.
Especially this day, we pray for all whose lives have been touched by suicide, for
those who have died by suicide and those who have attempted it.
We pray for those who, because of mental health challenges such as depression,
PTSD, bipolar disorder, or live with thoughts of suicide.
We pray for those who live in despair and without hope because of poverty or
discrimination.
We pray for families and friends, colleagues and co-workers, who have been
touched by the suicide of a loved one,
We pray for counselors and therapists, psychologists and psychiatrists, for pastors,
rabbis, priests, and imams, and for all who seek to help.
We pray, too, that you might give us the courage and wisdom
to be there for others in distress,
to offer your love and our care,
to help break the silence and change the conversation about
suicide,
to be your listening ear, your hands, and your heart for others.
Amen.*

Written by Rev. Talitha Arnold
United Church of Santa Fe, Senior Pastor

The American Psychiatric Association Foundation has produced two new resources to help faith leaders better understand mental illness and treatment, and better help individuals and families in their congregations facing mental health challenges. The resources, *Mental Health: A Guide for Faith Leaders* and a companion two-page *Quick Reference on Mental Health for Faith Leaders*, are the culmination of work from the *Mental Health and Faith Community Partnership*, a collaboration of psychiatrists and faith leaders representing diverse faith traditions.

Many people facing a mental health challenge personally, or with a family member, turn first to a faith leader. And for many receiving psychiatric care, religion and spirituality are an important part of healing. In their role as "first responders," faith leaders can help dispel misunderstandings, reduce stigma associated with mental illness and treatment, and facilitate access to treatment for those in need. The *Guide* and *Quick Reference* provide faith leaders with the knowledge, tools and resources to support that role. For more information see www.psychiatry.org/faith.

Get and Share Support:

The National Suicide Prevention Lifeline 1-800-273-TALK (8255)

A free, 24/7 confidential service that can provide people in suicidal crisis or emotional distress, or those around them, with support, information, and local resources.

[**Learn More**](#)

**The Veterans Crisis Line
and Military Crisis Line
1-800-273-8255 Press 1**

The Veterans Crisis Line and Military Crisis Line connect veterans and service members in crisis and their families and friends with qualified, caring U.S. Department of Veterans Affairs responders through a confidential toll-free hotline, online chat, or text.

[**Learn More**](#)

**Crisis Text Line
741-741**

This free text-message service provides 24/7 support to those in crisis. Text 741-741 to connect with a trained crisis counselor right away.