WHO CARES?
SUICIDE AND CHRISTIAN PASTORAL INTERVENTION

by

Debra Kay Averitt

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

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ABSTRACT

The fallen world we live in presents challenges that often seem too much to bear. How we view those challenges depends not only on our worldview but also on our interpretation of it. These same beliefs help determine if, when, and to whom we go for help. Beliefs and worldviews also drive those who provide help, making the decision of who to see that much more important. This study addresses the dispute between pastoral and secular counseling—Who is better prepared to treat individuals presenting with severe distress? In essence, this quantitative survey is a letter to the churches asking pastors to reflect on their own experiences, articulate their beliefs, and report on their strategies for helping individuals who are fighting depression and contemplating suicide. Further, it is a clarion call for pastors of the Christian faith to stand on the Word of God in a tangible and bold way. Suicide grieves the heart of God. There was a reason Jesus called on His disciples to go into the world and preach the gospel—it equips us to fight evil with Truth, providing hope while saving lives and souls in the process.

Keywords: suicide, hopelessness, depression, voice commands, spiritual battle, pastoral counseling, hope

Dedication

To those who feel forgotten, rejected and abandoned;
taunted by the unseen enemy with accusations, lies,
and distorted pictures of reality…
and to those who intervene on their behalf,
know there is a God who sees and hears you in your darkest moments.
Hold on…

"Be of good courage, and He shall strengthen your heart,
all you who hope in the Lord"
(*New King James Bible*, 1982/2013, Psalm 31:24)

Acknowledgments

A heartfelt thank you to my Lord and Savior, Jesus Christ,
for walking me through the fire.

"Now to Him who is able to do exceedingly abundantly
above all that we ask or think,
according to the power that works in us,
to Him be glory in the church by Christ Jesus
to all generations, forever and ever. Amen"
(*New King James Bible*, 1982/2013, Ephesians 3:20)

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List of Abbreviations

American Counseling Association (ACA)

American Psychological Association (APA)

Centers for Disease Control and Prevention (CDC)

Christian Association for Psychological Studies (CAPS)

Cultural Assessment of Risk for Suicide (CARS)

Diagnostic and Statistical Manual of Mental Disorders (DSM)

Federal Drug Administration (FDA)

Integrated Motivational-Volitional Model of Suicidal Behavior (IMV)

Institutional Review Board (IRB)

Interpersonal Theory of Suicide (IPTS)

Minnesota Multiphasic Personality Inventory-2 (MMPI-2)

Motivational Moderators (MM)

Painful and Provocative Events (PPEs)

Perceived Burdensomeness (PB)

Severe Mental Disorders (SMD)

Suicide Acceptance (SA)

Thwarted Belongingness (TB)

Visionary Spiritual Experience (VSE)

World Health Organization (WHO)

CHAPTER ONE: INTRODUCTION

"In the beginning God created the heavens and the earth"

(*New King James Bible*, 1982/2013, Genesis 1:1).

Overview

For born again Christians, these first words of Genesis through the last words of Revelation are true. In the gospels, Jesus assured His disciples that they would endure trials throughout their lives (*New King James Bible,* 1982/2013, John 16:33). Based on His warning, it is easy to understand that Christians continue to face tremendous hardships, but what robs someone of the will to live to the extent that they take steps to end their own life? After all, Jesus proclaimed that He had overcome the world (John 16:33) and that, with His help, those who followed Him would do the same (John 17:16).

In the past, suicide has been considered a mental illness (Kiamanesh et al., 2014; Pridmore & Pridmore, 2016). Yet, there is no unique single problem that signals suicide's imminence (Nugent et al., 2019; Pridmore & Pridmore, 2016). Often, it is an accumulation of experiences that leads to a hopelessness of any future positive events (Horwitz et al., 2017) or a series of defeats and humiliations that lead to entrapment (O'Connor & Kirtley, 2018) where suicide is perceived as the only way out of one's circumstances. Depression has been targeted as a precipitator of suicide (Edwards & Jovanovski, 2016; Horwitz et al., 2017) but due to impulsivity, the standard for clinical depression is not always met before suicide completion takes place (Rimkeviciene et al., 2015). This may, in part, explain why mild depression and bereavement lasting over two weeks has been moved in the *Diagnostic and Statistical Manual of Mental Disorders – 5* (DSM-5) to the classification of major depressive disorder, resulting in overdiagnosis and increased antidepressant prescriptions (Dorwick & Francis, 2013; American

Psychological Association [APA], 2013).

Seventy-five percent of suicide victims reach out to someone before following through with their plan (Grant et al., 2015). Others do not disclose feelings and become isolated due to stigmatization associated with such experiences as hearing voices (Vilhauer, 2017) commanding them to injure themselves, which may result in death (Goldblatt et al., 2016). When they do reach out first, who do they contact? Is it a stranger, family member, friend, pastor, or doctor? Does the strength of that relationship determine the outcome? How does their worldview—or lack of one—impact their decision making? Does the Christian community offer an atmosphere of hope beyond that found in the secular or nonbelieving world? Where are we currently on the spectrum of integration of Biblical truth and mental health treatment?

If we propose to expand current suicide models to add a spiritual component that addresses the needs of the Christian, we must do so in a way that is faithful to God and His Word. “You shall not go after other gods, the gods of the peoples who are all around you (*New King James Bible*, 1983/2013, Deuteronomy 6:14). And we must believe Jesus when He said, “I am the way, the truth, and the life. No one comes to the Father except through Me” (John 14:6). And do so, unashamedly: “For whoever is ashamed of Me and My words in this adulterous and sinful generation, of him the Son of Man also will be ashamed when He comes in the glory of His Father with the holy angels” (Mark 8:38). One objection to pastoral counseling is that pastors are not educated to treat or even recognize individuals with severe mental illness. According to the Bible, that is simply not true: “All Scripture is given by inspiration of God, and is profitable for doctrine, for reproof, for correction, for instruction in righteousness, that the man of God may be complete, thoroughly equipped for every good work” (2 Timothy 3:16-17). This verse supports the work of pastoral counseling in helping those with mental distress. Further,

Christians are warned that letting in a fraction of outside influence will permeate the whole with false teachings (Galatians 5:9). Might this give a pastor pause before referring out to a mental health professional?

Today, suicide models distinguish between ideation and action, pinpointing personality traits, attachment styles, and meaning making as targets for intervention (Benson et al., 2016; O'Connor & Kirtley, 2018). These models offer exciting opportunities for pastors to identify a relational or developmental problem and provide Christian understanding to address it. The gospel of Jesus Christ demonstrates God's desire to be reconciled with the world (*New King James Bible*, 1982/2013, 2 Corinthians 5:19) and Christian pastors have the responsibility to act as ambassadors on His behalf (2 Corinthians 5:20). Yet, many refer their hurting congregants to mental health professionals, believing them to be better qualified to treat mental health issues (Bledsoe et al., 2013; Stanford & Philpott, 2011). Mental health professionals question the ethics of pastoral counseling for distressed individuals (Swenson et al., 2009), often relegating their Christian faith to the background (Tomkins et al., 2015). Both actions raise the question, Who cares? To find that answer, we must start from the beginning.

Background

Biblical Truth and Psychological Integration

Adam and Eve, living in relationship with God, had everything they could ever need in the Garden of Eden. That perfect existence, void of pain and suffering, was short-lived when they disobeyed God's command and ate the forbidden fruit. Satan claimed that eating the fruit would allow them to distinguish between good and evil and become like God (*New King James Bible*, 1983/2013, Genesis 3:4-5). McCall (2019) describes it as "the first instance of when things went so horribly wrong" (Chapter 3, para. 2). Because God had warned Adam and Eve

that they would die if they ate the forbidden fruit, the temptation could be considered a subtle voice command by Satan to commit slow suicide—both for themselves and every human that followed. The subsequent expulsion of Adam and Eve from the Garden of Eden put the tree of life out of reach and death took its place.

Knabb and Emerson (2013), applying Bowlby's theory of attachment to Scripture, describe the fall as a decision by Adam and Eve to separate from their attachment to God and become their own secure base and safe haven. Without this attachment to God, humans have developed varying styles of attachment to their human parents and, later, to significant others which continues throughout the lifespan (Knabb & Emerson, 2013). This need for connection is particularly evident in times of stress (Knabb & Emerson, 2013). Tillman (2018) believes each suicidal individual has a unique story, and viewed together with other similar stories, they collectively highlight a suicidal mindset that points to interrupted tasks of human development.

Narratives provide the framework to deal with unresolved life events (Fitzpatrick, 2016). The famous British author Virginia Woolf (1882-1941) died by suicide, drowning herself just one day after seeing the family doctor who had sent her home to rest (Androutsopoulou et al., 2020). Psychobiographers, using narrative inquiry, researched Woolf's last diary entries and letters and found that she was again hearing opposing voices as she had in the past (Androutsopoulou et al., 2020). For most of us, an internal dialogue is an important construction of self, but for suicidal individuals it may oscillate between happiness and despair (Androutsopoulou et al., 2020). These inner voices may also be critical, accusing one of worthlessness (Androutsopoulou et al., 2020). Closely related to feelings of worthlessness is perfectionism, a personality construct believed to increase suicide risk (Shahnaz et al., 2018). Self, familial, and social pressure to be perfect are associated with increased suicidal ideation

(Smith et al., 2017).

According to Bhargav et al. (2015), hearing voices is either a psychotic experience that originates from personality derangement or a spiritual experience ridding itself of the selfish ego. Bhargav et al., discussing Jesus' ability to see, hear, and speak to God, admit that psychiatrists today might detect auditory and visual hallucinations, confusing spiritual beliefs and experiences with delusion. This reaction to such claims is not new. In His day, the religious leaders of the time sought to kill Jesus because He claimed to be the Son of God (*New King James Version*, 1983/2013, John 5:18).

The Christian worldview supports the belief in Satan and his demons as detailed in Scripture and recognizes the ongoing battle between good and evil where the enemy continually seeks to destroy God's children (*New King James Bible*, 1982/2013, 1 Peter 5:8). According to the Bible, God spoke the world into existence and created light with a simple command (Genesis 1:3). It is generally accepted by Christians that God, who is unseen, speaks to His children (Jeremiah 33:3). Further, His son, Jesus Christ, is the shepherd of His sheep and His sheep hear His voice and will follow Him (John 10:4). By contrast, the voice of a stranger will cause them to flee (John 10:5). It could be argued that this Scripture refers to actual sound rather than an internal voice and therefore any description of hearing voices will be—and has been (Kalhovde et al., 2014)—determined to be caused by mental illness. Deeper exploration of the Bible suggests otherwise. There is a recounting of a father who believes his son is mentally ill and having been disappointed by the disciples failed attempts to cure him, asks Jesus to heal him. The father has analyzed the child's condition based on his continual falling into fire and water (Matthew 17:15-16). Did the boy suffer from voice commands followed by self-harm behaviors? Jesus's response was to rebuke the devil, who departed the child. This healing highlighted the

disciples' shortcomings when encountering extreme demonic entrenchment. Does it highlight pastoral shortcomings as well? Is it time to return to the original assessment? Matthew 4:6 and Luke 4:9 describe how Jesus was tempted by Satan to throw Himself off a high point overlooking the temple (Matthew 4:6, Luke 4:9). For anyone else, this act would have been fatal, but for Jesus, it would have exposed Him as the Messiah before the appointed time and represented disobedience to God. Jesus responded correctly by rejecting Satan's suggestion and standing firm on the Word of God. Might others follow His example?

Medical anthropology has shown that mental illnesses are the result of how personal experiences are viewed by society and how they are treated within the healthcare system (Ouwehand et al., 2019/2020). Studies have shown that more than 50% of the population has experienced voice hallucinations, frequently after the loss of a loved one or in life-threatening, stressful circumstances (Lukoff, 2007). Visionary spiritual experiences (VSE) can lead an individual to seek help from a mental health professional, but these experiences have often been ridiculed or ignored by mainstream psychology despite the inclusion of a brief description vaguely explained as "distressing experiences" under the category of Religious or Spiritual Problem in the DSM-IV and, more recently, the DSM-5 (Lukoff, 2007; APA, 2000, p. 741; APA, 2013, p. 725). Viewing the decision tree in Appendix A of the DSM-IV for Differential Diagnosis of Psychotic Disorders where the entry box includes delusions and hallucinations and subsequent "no" choices for symptoms attached to various psychotic disorders on the chart lead only to Psychotic Disorder Not Otherwise Specified, one might wonder where the consideration of Religious or Spiritual Problem went (APA, 2000).

The question of whether an experience is psychotic or spiritual may well depend on the counselor making the diagnosis and largely explain the dispute that has emerged between

pastoral and secular counseling—who is better prepared to treat individuals presenting with severe distress? While Jackson (2015) asserts that some licensed professional counselors claim that pastors lack education and may overlook serious mental health issues, he notes research shows they are among the least religious of all scientists (Delaney et al., 2007). An even greater spiritual disparity exists between counselors and those they are counseling (Delaney et al., 2007). For their part, Christian counselors believe clinicians have a lack of knowledge of religious traditions which interferes with their ability to collaborate with faith-based organizations (Kinghorn, 2015). Payne (2014) examined the influence of specific theological and secular education of pastors on depressive intervention decisions and recognized that pastors are often the first to receive requests from community members for mental health concerns.

The effects of the fall are far reaching, and man continues to set himself up as the judge and jury over God and others, believing we discern wisely the knowledge of good and evil, the difference between the spiritual and the psychotic, and understand unfailingly the meaning and purpose of life. Without God's help provided through the Holy Spirit, which we receive through our acceptance of Christ's sacrifice on the cross and His resurrection from the dead, such discernment and understanding are impossible: "for without Me you can do nothing" (*New King James Bible*, 1982/2013, John 15:5).

Historical and Societal Background

Arguments over mental health issues and their causes, along with the appropriate response to them, is nothing new. The infamous Salem Witch Trials began when two young women experienced seizures and blamed them on supernatural activity (Street, 2019). Two polar opposite views of these events emerged soon afterward. One claimed, "Satan was working through a variety of personal, social, economic, and judicial systems to murder Christians" and

the other “argued that the witch-hunt had done exactly what they had intended, to destroy witches” (Street, 2019, p. 33). It is worth noting that these opposing conclusions were both reached from the perspective of a Calvinist worldview within the context of a theological battle (Street, 2019), making it imperative to understand the potential for disparity even among those who claim identical worldviews.

Perhaps less dramatic than witch trials, institutionalization posed its own horrors until the 1950s when insane asylums and psychiatric hospitals were closed down and patients with severe mental disorders (SMD) were delivered back to relatives or in some cases, quite literally, to the streets (Ventriglio et al., 2015). Gostin (2007/2008) argues that the deinstitutionalization movement, far from being compassionate, merely relocated patients to their new confinement located in “jails, prisons, and homeless shelters” (p. 906). Homelessness, which may cause or be the result of mental illness, is associated with higher rates of attempted suicide (Perry & Craig, 2015). Given the presence of spiritual themes in the homeless community and Christian outreach to those communities (Snodgrass, 2013), pastoral counseling offers an important opportunity for the ministry of suicide prevention to the homeless population.

Theoretical Background

Moving from a mental illness view of suicide, more recent theoretical models of suicide trace ideation to action, pointing to disruptions in human development as indicators of potential risk. Inability to trust, insecure attachment, perfectionism, and loneliness are the new suspects in suicidal ideation. O’Conner and Kirtley (2018) investigate the development of suicidal thinking by focusing on comprehensive theoretical frameworks such as the integrated motivational-volitional model of suicidal behavior (IMV) that tags individual vulnerabilities including perfectionism and disrupted attachment relationships as conferring higher risks. Benson et al.

(2016) present an explanatory model of suicide that pinpoints lack of trust and an absence of inherent self-worth that may be linked to Eric Erickson's theory of psychosocial stages of human development that posits social interactions with early caregivers as shaping trust versus mistrust from birth to 12 months and autonomy (closely related to self-confidence and self-worth) versus shame and doubt from 12 months to 3 years (Craig & Dunn, 2010). Benson et al. (2016) further connect the interpersonal-psychological theory of suicide to loneliness and the absence of reciprocal care found in Mary Ainsworth's research of early child development in relation to secure and insecure attachment to caregivers (Craig & Dunn, 2010). In addition, Benson et al. (2016) name thwarted belongingness and perceived burden to others as factors found to influence suicide. Relatedly, in his Hierarchy of Needs pyramid, Abraham Maslow's view of self-development identified the need of belongingness as the first after physiological and safety needs (Craig & Dunn, 2010).

Background Summary

Research shows that the history of suicide points to mental illness (Pridmore & Pridmore, 2016). The term mental illness fails to encapsulate the multitude of conditions and symptoms that result from traumatic experiences, individual or collective, that affect everyone at some point in their lives, accompanied by inner dialogue essential in creating meaning and understanding (Androutsopoulou et al., 2020). Life does not always live up to one's high expectations (Kiamanesh et al., 2014). Sense of self is constantly pulled at and rearranged to accommodate social affiliation and its breakdown may lead to suicide (Benson et al., 2016). The world presents challenges. How those challenges are viewed depends not only on one's worldview but also on the interpretation of it (Clouser, 2005). Those same beliefs help determine if, when, and from whom help is sought. Beliefs and worldviews also drive those who provide

that help, making the decision of who to see that much more important.

Pastors and pastoral counselors have a unique opportunity to help restore broken individuals through reconciliation with God who offers love, comfort, worth, and purpose (Knabb & Emerson, 2013). Will they take it? Mental health professionals claim ethics prevent them from doing so (Eliason et al., 2013; Rosenthal, 2008). Who *really* cares? "Therefore humble yourselves under the mighty hand of God, that He may exalt you in due time, casting all your care upon Him, for *He* cares for you" (*New King James Bible*, 1983/2013; 1 Peter 5:6-7).

Problem Statement

Sanders et al. (2011) questioned the ethics of non-sexual multiple relationships of Christian psychotherapists. Previously, they had scrutinized general Christian integration with counseling services where they surveyed 1,279 members of the Christian Association for Psychological Studies (CAPS) about their beliefs on same sex attraction, obtaining informed consent prior to using Scripture or praying, and the treatment of immoral behavior (Swenson et al., 2009). Further, Liegeois et al. (2018) questioned religious rejection of suicide, asking whether one has an obligation to live and if suicide prevention is still valid or interferes with an individual's freedom to die as recent euthanasia laws suggest. Swenson et al. (2009) recommend studies to discover how Christian therapists make decisions ethically and call for additional ethics training in graduate school or continuing education. Given arguments for euthanasia, who makes that decision? Jeremiah states that hearts are deceitful, wicked, and unknowable (*New King James Bible*, 1982/2013, Jeremiah 17:9). Without God, any imagined role is incomplete and temporary, built on sand that is destined to collapse (Matthew 7:26-27), and not only by its own design. The story of the tower of Babel in the Bible is an illustration of mankind trying to redefine life, build Heaven on Earth, and replace God. God's response was to confuse their

communication and scatter them across the globe (Genesis 11:8-9). Still, Payne (2014) found that *both* the clergy and mental health professionals are concerned with pastors' lack of formal training regarding counseling those with serious mental health issues, including depression and suicidal ideation. Payne proposed researching several assumptions that had not been tested: (a) Pastors are antiquated or uneducated, (b) Pastors have theological education, (c) Theological education does not equip pastors to make mental health decisions such as when to refer, they are unqualified to treat depression, and are against medical models for treatment, and (d) Pastors with mental health degrees are more likely to refer. Interestingly, Payne found no correlation between pastor education and the decision to refer to outside mental health professionals and called for more research to test these assumptions.

The problem is that current assessments such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) to determine the suitability of candidates for pastoral ministry (Adams et al., 2014) and the National Counselor Examination for accreditation/licensure for Christian counselors (Rosenthal, 2008) prohibit or impede Christian intervention due to concern for ethical suitability of the integration of the Christian worldview and their educational preparedness even when completing secular degrees in the counseling field.

Purpose Statement

The purpose of this study is to survey American pastors regarding their education, belief system, and views on spiritual experiences as they relate to the Christian worldview and how it predicts their interventions for suicide. As was shown earlier in the Salem Witch Trials, not all those claiming a Christian worldview come to the same conclusions when making an important, lifesaving decision. One aspect of differentiation may be the education that they have received. A pastor who was educated in the seminary may hold largely differing viewpoints on counseling

someone with suicidal ideation than a pastor who has also received a clinical mental health counseling degree (Payne, 2014). This study would expand on Payne's work regarding a pastor's education and its influence on depression intervention decisions and subsequent mental health referrals.

Closely related to their education, a pastor's beliefs regarding help-seeking, especially regarding visions and voices, should predict their response to individuals who seek their help. Perhaps this should not be surprising as faith in Jesus Christ is a sure way to attract the attention of the devil who is intent on destroying anyone he can (*New King James Bible*, 1982/2013, 1 Peter 5:8). Less surprising is that there might be casualties. Salwen et al. (2017) acknowledge that spiritual battles are not necessarily an indication of a mental disorder but caution that avoiding seeking help from Christian counselors may put them at risk. In their study, Salwen et al. utilized a sample of evangelical seminary students but found a gap in the research and recommended future studies of established pastors and their help-seeking behaviors. This study would help fill that gap as it is centered around the subject of suicide, including the susceptibility of pastors and where they go for help when they need it.

Significance of the Study

Tomkins et al. (2015), citing the Pew Research Center and the Berkley Center for Religion, Peace and World Affairs, reported that over 80% of the people across the globe claim adherence to a religious faith. Yet, current suicide models have focused predominantly on the biopsychosocial context of suicidal ideation and its transition into suicide attempts or death, leaving out any spiritual component.

Christians are not exempt from suicidal ideation or completion any more than nonbelievers but may be more reluctant to seek help due to associated stigma (Waitz-Kudla et

al., 2019). Christian interventions are viewed skeptically by mental health professionals and pastoral counselors are encouraged to refer troubled individuals out to them (Payne, 2014). This study would expand on the Payne study by increasing data on pastoral views of treating depression and suicide. Stanford and Philpott (2011) found that Baptist pastors have mainstream views about mental illness but prefer to refer members to a therapeutic environment supportive of faith. This study would expand and update Stanford and Philpott's efforts by including other Christian denominations' experience, knowledge and beliefs on mental illness and the interventions for suicide prevention.

Knabb and Emerson (2013) call for further work connecting attachment theory with Christian theology. More recent theoretical models of suicide lend themselves to the narrative of Scripture and, together, help to explain why this connection is possible. Santrac (2016) calls for new ways to integrate scientific accomplishments of psychology with the Christian worldview through debate of theories of personality. Bazley et al. (2019) report the protective effect of faith on suicide and call on previously overlooked religious organizations to help in suicide prevention efforts. This study will help pastors synthesize their beliefs regarding mental illness and suicidal ideation within the framework of their education and Christian worldview and articulate how it informs their Christian intervention for suicide prevention.

Research Questions

RQ1: Do pastors feel equipped to recognize suicidal symptoms and provide counseling?

RQ2: How do pastors distinguish between spiritual experiences and psychotic symptoms?

Definitions

"The entrance of Your words gives light; it gives understanding to the simple"

(*New King James Bible*, 1982/2013, Psalm 119:130).

1. ***Biblical/Christian Worldview*** - The belief that the Bible is God's revelation to the world. God created the heavens and earth. He created Adam and Eve who, tempted by Satan, disobeyed God and ate the forbidden fruit which resulted in man's separation from God. God sent His Son Jesus to die on the cross for our sins so that through His death and resurrection we might be reconciled to God by accepting Christ as Lord and Savior.
2. ***Culture*** - Values and beliefs that are passed down from generation to generation, often adapted based on personal experiences that are no longer explained or accepted by earlier traditions which results in subcultures within families and the community as a whole (Alesina & Giuliano, 2015).
3. ***Hope*** - Hope is the expectation of good things to come.
4. ***Hopelessness*** - Sachs et al. (2013) view hopelessness as a persistent darkness that interferes with the ability to function. Sullivan (2003) defines hopelessness as the loss of attachment to a hope that was previously present.
5. ***Impulsivity*** - Impulsivity refers to suicide or an attempt at suicide that lacks planning, involves a short duration of the suicide process, or is reported as impulsive by the attempter (DeBastiani & De Santis, 2018).
6. ***Pastor*** - A practicing minster of a church that lives by the tenets of the Biblical/Christian worldview.
7. ***Suicide*** - The Centers for Disease Control and Prevention (CDC, 2020) defines suicide as intentional death by self-directed violence. Suicide is a process that begins with suicidal thoughts or ideation and progresses to suicidal behaviors that end in death (Rimkeviciene et al., 2014; Thompson et al., 2012).

8. ***Visions*** **-** Visions are images of people and objects that others cannot see (Billock, 2016).
9. ***Voice Hearing*** - Voice hearing occurs when one hears voices that no one else can hear (Lewis et al., 2020). They are more than thoughts because they are identified by the hearer as from another. They may be either benevolent or malevolent (Lewis et al., 2020). Voice hearing occurs both in the healthy and unhealthy, though perceptions of those who hear voices is usually negative and results in stigmatization (Vilhauer, 2017).

Summary

The fall of Adam and Eve brought about separation from God. The ability to withstand the resulting hardships and spiritual attacks waged by Satan is determined by one's current relationship with Jesus Christ. Historically, suicide has been linked to mental illness. More recently, suicide models point to the disrupted tasks in human development such as trust, attachment, identity, self-worth, and purpose that lead to such illnesses and end in despair. Narrative therapy uses stories to help individuals make sense of life events. There is no greater narrative than the Bible, God's revelation to His people. Scripture describes the spiritual aspects of life not always seen and provides explanation for the troubles endured. It also provides meaning and hope for the future. Throughout history, culture and society have had their say on mental illness. A Jewish upstart claimed to be the Son of God, performed many miracles, and gathered followers by the multitudes. Fearing loss of power, the religious establishment of the time called Him a demon and hung Jesus on the cross.

Today, talk of Jesus and His resurrection as if it is Truth may be considered an infringement on someone else's rights, especially in any institution outside of the church. The mention of hearing from God or seeing a vision borders on the psychotic—often even inside the church! So, where does one turn when their suffering becomes overwhelming? *Who cares?* The

educational system and government agencies determine who is capable of ethically serving the public through accreditation and licensure, often prohibiting, or impeding Christian intervention. The purpose of this study is to survey American pastors regarding their education, beliefs, and experiences as they relate to the Christian worldview and how it predicts their interventions for suicide.

Biblical or pastoral counseling should be inherently different from any other intervention. The restoration of relationship to God through Jesus Christ and the power of the Holy Spirit to restore joy and hope through faith seems infallible. Yet, pastors and their congregants still suffer from depression even to the point of suicide. Has the evangelical church fallen from its solid foundation? Are pastors unprepared for the battle the enemy wages? Have they forgotten the power of God? Do they believe it? Or have they slipped back into the trap of works, seeking unattainable perfection that was achieved only by Christ Himself? Answering these questions will shed light on the current state of the church and its ability to care for its wounded flock. Specifically, what Christian interventions are currently being utilized and what impact are they having on suicide prevention? This study seeks to answer these questions.

CHAPTER TWO: LITERATURE REVIEW

"Where there is no counsel, the people fall; But in a multitude of counselors, there is safety" (*New King James Bible*, 1982/2013, Proverbs 11:140).

Overview

The purpose of this literature review is to take a critical look at the increasingly common and horrific problem of suicide within the United States and around the world. Suicide rates in the United States have increased over 33% since 1999 (Sher, 2020). According to the Centers for Disease Control and Prevention (CDC, 2018a, 2018b), suicide levels in the United States reached a high of 14 per 100,000 or roughly 49,000 deaths by suicide in 2017—that is about 134 per day. Each year in America alone, 1.3 million people survive suicide attempts (Sheehan, et al., 2017).

Historically, suicide has been linked to mental illness, but Pridmore and Pridmore (2016) push back on that assessment, arguing that including naturally sad circumstances such as grief into the classification of depressive disorder is misguided and call for churches and non-profit organizations to improve on the current insufficient suicide prevention strategies. Nugent et al. (2019) identify this current insufficiency on the inability to conduct studies on individuals with suicidal ideation due to the limitations imposed by investigators and bioethicists citing practical and ethical concerns.

The majority of research studies on the subject of suicide default to explanations of mental illnesses such as major depressive disorder, bipolar personality disorder or schizophrenia (Nugent et al., 2019). This continued focus on illness allows for easier treatment such as for those with schizophrenia, where the antipsychotic drug clozapine has Federal Drug Administration (FDA) approval to treat those at risk of suicide (Nugent et al., 2019). Cognitive behavioral therapy has been shown effective for the prevention of suicide attempts or

completions after hospitalization, but the cost is prohibitive for many (Nugent et al., 2019). While means restriction—removal of objects that can cause harm or death—and hospitalization may prevent suicide initially, they are not viable long-term solutions. Indeed, the highest risk for suicide comes during the weeks after release from a psychiatric hospital (Nugent et al., 2019).

Fifty years of research has failed to predict or decrease suicide (Nugent et al., 2019; O'Connor & Kirtley, 2018). Underpinning the question of *how* to prevent suicide is the debate surrounding *who* should do it. In addition to presenting research findings on suicide and its causes, this literature review offers an examination of the arguments for treatment of suicidal individuals by licensed mental health professionals, pastors or pastoral counselors, and proposed integration of the two. It includes theoretical models of suicide from the scientific community and support for Christian intervention. Specifically, this study is an examination of the disconnect between the discourse of Christian leaders in the church and its application to their suffering members. Suicide is not a discriminatory event. However, Christians placing their trust in the Lord Jesus Christ should represent a model for the rest of the world. This message of hope becomes garbled when a pastor suffers immense spiritual warfare to the breaking point (Austin, 2019) and takes his own life (Mariotinni, 2019) or when a church member is afraid to come forward because of the stigma associated with hearing voices (Vilhauer, 2017) or seeing visions (Lukoff, 2007)—though the Bible presents this phenomenon as a common occurrence for believers.

Lewis et al. (2020) notes that both psychosis and spirituality are social constructs and maintains that understanding how spirituality provides a framework for making sense of hearing voices would provide improved interventions for treatment. Pastors have the opportunity to provide context for that understanding (Knabb & Emerson, 2013), but may be afraid of the

responsibility of treating an afflicted congregant without additional training (Mason et al., 2017), convinced the science of the secular world better prepares them for such situations than the Bible does (Payne, 2014).

Spiritual well-being plays an important role in suicide prevention (Kopacz et al., 2014). Though faith may guard against suicide, believers are not exempt from the effects of suicide and suicidal ideation or attempts to take one's life. Sansone & Wiederman (2015) found that while religion as a means of explaining difficult life situations did little to reduce the chances of suicide attempts or self-harm, religious/spiritual well-being may protect against both. One's perception of oneself as religious only protected against suicide, not self-harm behaviors, and spirituality did not appear to lower either risk. This may be because church attendance provides individuals with a strong support system that a less defined individual spirituality does not, and churches most likely present a clear statement against suicide, but non-suicidal self-harm behaviors may be more ambiguous (Sansone & Wiederman, 2015).

Suicide has historically been linked to mental illness, largely excluding social, political, and financial explanations that may contribute to suicidal ideation and preventing collaborative discourse on combative strategies (Pridmore & Pridmore, 2016). Not all forms of suicide provide logical forms of argument for their prevention by removal of available means. For instance, asphyxiation, completed using various methods including hanging or chemicals, is the second most common form of suicide in the United States and would be best prevented through mental health services as the means for asphyxiation are readily available (Yau & Paschall, 2017).

Assisted suicide, in particular for those with mental illness, has been added to the dialogue and is becoming a conversation within the church (Mason et al., 2017), leading to further confusion regarding the preservation of life against the backdrop of human suffering

(Liegeois, et al., 2018). Though legalization of physician assisted suicide passed in some states through compelling arguments that it would reduce or delay suicide**,** has instead produced evidence of increased influence on suicide completions (Cook, 2015).

Diagnosis of mental health illness has again become the scapegoat for lack of spiritual knowledge and antipsychotic drugs the treatment of choice. Consider the homeless population. A high percentage suffer from mental illness and drug dependence, placing them at high risk for death by suicide (Perry & Craig, 2015). Pastoral counselors who ignore spiritual experiences of the homeless negate positive contributions to the individual's spiritual life, risking their alienation from religious services and the benefits derived from church community (Snodgrass, 2013).

Similar to society's increased acceptance of physician assisted suicide are homosexuality (Nystedt et al., 2019) and transgenderism (Dickey & Budge, 2020). Both have contributed to the increase of suicide and easily confirm Santrac's (2016) reminder that Scripture highlights humans' faulty sense of right and wrong. As a result, Potgieter (2015) calls for a dedicated effort to invest in pastoral education in answer to God's call to serve His people.

Theoretical Framework

In an effort to understand its process, most recent theories regarding suicide separate suicidal ideation from actual suicide attempts and completions. In 2005, Thomas Joiner introduced the Interpersonal Theory of Suicide (IPTS) which identified thwarted belongingness (TB) and perceived burdensomeness (PB) as the two conditions that combine to create passive suicidal thoughts that lay mostly dormant until exposure to painful and provocative events (PPEs) lead to the acquired capability for suicidal acts in the form of attempts and completions (Klonsky et al., 2018). When conducting research to support IPTS, studies for loneliness, social

support, and quality of relationships were used as proxies for thwarted belongingness and perceived burdensomeness (Klonsky et al., 2018).

The IMV model of suicide describes the biopsychosocial context in which suicidal ideation transitions into suicidal behaviors and death (O'Connor & Kirtley, 2018). The IMV model maintains that certain individuals have an elevated risk of suicide based on background factors of personal characteristics, environment, and life events that comprise the pre-motivational phase of suicidal behavior (O'Connor & Kirtley, 2018). The motivational phase of the IMV emphasizes the psychological process that leads to suicidal ideation due to the perception of entrapment, a sense that there is no escape from current circumstances or threats whether they originate internally or externally, resulting from social rejection and loss (O'Connor & Kirtley, 2018). It is within the motivational phase of the IMV that the presence of different positive or negative motivational moderators (MM) determines whether or not entrapment results in suicidal ideation (O'Connor & Kirtley, 2018). Particular to this study are the MM of unrealistic expectations of perfection that others demand or internal expectations one has of oneself and attachments to others that are currently unhealthy or that were disrupted during early development (O'Connor & Kirtley, 2018). The final phase of IMV is the volitional phase where suicidal ideation leads to suicide attempts or completions (O'Connor & Kirtley, 2018). During this phase, access to means, mental imagery of death, and past attempts are important risk factors (O'Connor & Kirtley, 2018).

Benson et al. (2016) offer an explanatory model of the process of suicide that focuses on three contributing elements of suicide and suicide attempts: lack of trust, lack of inherent self-worth, which creates the context for suicidal exhaustion. Benson et al. call for future research in suicide prevention that includes applications of their model in real life situations.

While these theoretical suicide models may be useful or informative, they neglect the most important element in the Christian's life—the reality of the spiritual foundation. This study, beginning with American pastors, reviews the Christian worldview approach and its attempt to fill that gap.

Related Literature

Tomkins et al. (2015) reminds us that secular ethics are based on humanist values, while faith-based ethics are based on sacred texts and suggests diligence in analyzing interactions between politics, cultures, and faiths in order that pastoral counselors may prevent being manipulated by opposing viewpoints. Tomkins et al. (2015) identifies an effort by secular mental health care providers to keep out spiritual/religious influences. Santrac (2016) echoes this idea that distrust impedes integration between psychology and faith. However, Monroe & Schwab (2009) concede that the psychological community has come to consider the effects of religion and spirituality on the mental health of individuals, but arguably this trend has leaned heavily on inclusivity that blends faiths and dilutes truth. The recent trend of introducing mindfulness from the Buddhist faith into Christian counseling is one such example that has resulted in questioning the morality of its use in practice (Krägeloh, 2016).

Suicide and Suicide Models

A review of the literature shows that suicide has historically been considered a mental illness. Cavanagh et al. (2003) concluded, as recently as the early 2000s, that mental disorders contributed to suicide more than any other factor and recommended prevention strategies focusing on psychosocial factors and specific disorders. Dreyer (2018) recognizes that the impact of fear and anxiety on an individual can affect an entire society. Suicide victims are usually suffering from depression (Kheriarty, 2017). Other contributing factors include social

fragmentation and loneliness; but hopelessness is the most dangerous symptom of someone with suicidal ideation and cannot be cured with a medical psychosocial prescription (Kheriarty, 2017).

In more current intent to action suicide models, O'Connor and Kirtley (2018) differentiate hopelessness, which they define as a sense of continued pessimism regarding the future, from entrapment which involves a more defeated inability to escape circumstances. O'Connor and Kirtley (2018) indicate a lack of significant progress on treatments to reduce entrapment but suggest targeting the motivational moderators of new reasons to live or meaning making, belongingness or connectedness, and future thinking or goal pursuit to prevent ideation from progressing to action. Cheavens et al. (2016) believes that forgiveness of self may be one such motivational moderator that attenuates the movement from suicide ideation to action. Closely related, is accepting forgiveness from Christ.

By causing separation from God, Satan shattered the secure attachment to God that Adam and Eve had previously enjoyed. Knabb and Emerson (2013) explore the role of Attachment Theory as it relates to God and offer suggestions for counselors working with Christians who are struggling in their relationships due to distorted patterns of attachment. Meaning making is an important strategy in coping with life's difficult situations and attachment to God has been found to have a strong relationship with meaning making (Bock et al., 2018). Research has found that attachment relationships influence an individual's relationship with God and those with secure attachment see Him as a secure base and safe haven (Bock et al., 2018). The opposite has also been found to be true. People with anxiety attachment or avoidant attachment styles do not find God and others reliable, and have lower levels of self-worth (Bock et al., 2018). Further, attachment styles determine whether or not the individual finds value in suffering (Bock et al., 2018).

After reporting that over 75% of American adults believe Satan exists and almost 70% believe that demons exist, Jung (2020) proposes that it is this belief that results in psychiatric disorders. Jung (2020) bases this idea on Evolutionary Threat Assessment Systems Theory which posits that holding the view of the world as unsafe results in increased vigilance and causes psychiatric symptoms. As a counter measure to belief in supernatural evil, Jung hypothesized that secure attachment to God helps to mediate anxiety and mental health problems. In addition, Jung reports that secure attachment to God has been connected with benefits such as lower psychological distress, reduced loneliness, higher life satisfaction, greater self-esteem, and a more optimistic view of the future. These benefits all represent evidence-based indicators of a lower risk for suicidal ideation and completion.

Mental Illness or Spiritual Experience

Lukoff (2007, 2019) found that both the healthcare system and religious institutions give little support to people experiencing visionary spiritual experiences. Likewise, Goldblatt et al. (2016) believe that many patients suffering from auditory hallucinations or voice commands keep their experiences to themselves for fear of a malevolent therapist, representing a lack of engagement and trust. Strauss et al. (2018) argues that whether mental distress is described as pathological by either the medical or religious authority does not affect its transformative potential. By contrast, Lukoff (2007, 2019) suggested it was the clinician's original diagnosis that can guide an individual's experience into personal growth, or dejection and isolation. The former promotes healing, while the latter two are indicators of suicidal risk.

Mental Illness

Impulsivity is a serious trait factor in individuals with suicidal ideation (May & Klonsky, 2015). It often lands them in the emergency room of their local hospital, where emergency

department psychiatrists determine the necessity of inpatient hospitalization (Shah, 2018). Contributing factors to impulsivity and suicidal ideation exist. Depression and hallucinations treated and/or caused by drug use, have been shown to increase risk of suicidal symptomatology (Kjelby et al., 2015; Lukoff, 2019). Chouinard et al. (2019) classifies visual hallucinations as a common psychotic symptom that is understudied but highly relevant in suicide assessment. Goldblatt et al. (2016) found that the patients with psychotic symptoms who keep much to themselves due to mistrust are hard to understand but do not seem particularly depressed. This results in a high percentage of suicide unanticipated by hospital staff (Goldblatt et al., 2016).

Though scientists have attempted to associate hallucinations with a purely neurological breakdown, this one-size-fits-all connection remains elusive (Price, 2016). Price suggests that delusions may occur as a coping response to hallucinations where narrative construction becomes necessary to make sense of their experiences, but dismisses these narratives as false realities. Price classifies the common occurrence of visual and auditory hallucinations experienced by those who are dying as a culturally accepted, even expected, event. Scientists question whether these hallucinations are auto-suggested, physical due to the dying process, or a result of pain medications (Price, 2016). This contrasts sharply with Burke and Neimeyer (2014) who believe that the loss of someone close often results in a crisis of faith and methods are needed to alleviate psycho-spiritual anguish.

Spiritual Experience

Suicide was once considered surrendering to demonic temptation, but Deschrijver (2011) traced a decrease in the attribution of the devil's role and a corresponding increase of madness as explanation for suicide to the second half of the seventeenth century.

The history of the church supports the doctrine of original sin (McCall, 2019). This

temptation to disobey God, which Christians today know as part of an ongoing spiritual struggle where Satan is determined to destroy them, might be classified by skeptical therapists as the very first example of paranoia, complete with delusions and hallucinations (Bhargav et al., 2015). Distinctions between spiritual experience and psychosis remain hard to define (Bhargav et al., 2015).

The recent interest in addressing spirituality in counseling covers a wide range of beliefs. Bhargav et al. (2015), when attempting to distinguish between schizophrenia or spiritually advanced, cited Tapasyananda (2005) and Yogananda (2009) who made a spectacular claim that those who are spiritually advanced would never burden anyone. The word burden here is important because perceived burdensomeness is one of the indicators of moving from suicidal ideation to action (Nagra et al., 2016). Culture may also have an effect on how a religious experience is viewed (MacDonald et al., 2015).

Culture and Suicide

As noted in Chapter One, culture not only includes values and beliefs passed down in families for generations but is also constructed by the communities in which those families live. Recent criminal cases have centered around victims being encouraged by peers to commit suicide (Sweeney, 2017). Winterrowd et al. (2017) report that suicide of older adults in the United States is highest among European Americans. Illness plays a role in many of these end-of-life decisions where suicide becomes an acceptable response (Winterrowd et al., 2017). In fact, suicide by older individuals may be viewed as brave, strong, or wise by college-aged students and viewed as rational or normal by physicians who, as a result, are less likely to counter with therapeutic counseling for suicidal adults over 70 than those under 50 (Winterrowd et al., 2017).

Historically, Japanese culture has encouraged suicide as a sign of loyalty or means for taking responsibility or clearing one's guilt (Russell et al., 2017). Though times have changed and this motivation for suicide is rare today, Japanese students continue to view suicide as more acceptable than students in America do (Russell et al., 2017). Walker et al. (2018) attribute the overall suicide resilience of African Americans in response to negative life events to religious coping but recognize that the cultural worldview is critical in its development, resulting in vulnerable African American subgroups.

Suicide may be influenced by occupation. Henderson et al. (2016) concluded that firefighters are at increased risk of suicide due to posttraumatic stress disorder and substance use disorders. Lack of occupation or homelessness are also high-risk categories for suicide (Perry & Craig, 2015).

The Cultural Model of Suicide acknowledges the influence of culture on suicide and the Cultural Assessment of Risk for Suicide (CARS) assesses certain cultural risks for suicide including sexual minority groups such as the LGBTQ community and individual, family, or community beliefs regarding suicide (Chu et al., 2013).

Clearly, culture influences suicide. Indeed, an effort to prevent suicide in one group may create a responding increase in another—think awareness campaigns and copycat suicides—making effective treatments and interventions all the more critical in suicide prevention.

Treatments and Interventions

Roughly half of those who commit suicide do so on their first attempt (Chu et al., 2015). This burdens family and friends with detection of the possibility without equipping them to do so (Grant et al., 2015). Often the clues are buried in humor or kept silent (Kalhovde, 2014). Even if the signs are apparent, the stigmatization related to suicide and associations with failure may be

too strong for some to overcome (Cruwys et al., 2018; Sheehan et al., 2017).

Decreasing stigma of mental illness by increasing help-seeking and referrals for at-risk individuals was the 10th prioritized goal of the National Action Alliance for Suicide Prevention Research in 2014 (Niederkrotenthaler et al., 2014). Mass media campaigns to reduce stigma regarding suicide with the caveat that it should not be described as frequent or normal and therefore seen as acceptable was one suggested area of future research (Niederkrotenthaler et al., 2014). Hom et al. (2015) highlight the importance of connecting at-risk individuals to the appropriate caregivers in the mental health field, noting those with the greatest risk are often the least likely to seek care citing inability to problem solve due to diminished mental capacity, denial of seriousness of condition, desire to handle issue on their own, financial concerns, transportation issues, doubt of treatment effectiveness, fear of hospitalization, stigmatization, homosexuality, gender, and cultural differences.

It is estimated that the cause of death for up to 20% of cases received by coroners is unclear and a psychological autopsy which interviews close family members, friends, co-workers and neighbors combined with review of all critical medical documents and personal communications of the deceased can determine whether they died of natural causes, died by suicide, or died by other means (Sampoorman, 2020). Similar scrutiny of journals and personal communications in counseling prior to an act of suicide may shed significant light on an individual's state of mind, providing valuable time for prevention. Barash (2009) lists gaining time as the fourth aspect of treatment for suicidal individuals after establishing trust, identifying cues of desire for rescue, and validating pain to avoid the inclination to prove it through suicidal behavior. Chu et al. (2015) offer additional potential symptoms of suicide that clinicians may observe and investigate, including agitation, social withdrawal, irritability, sleep disturbances,

extreme weight loss, and severe affect.

Sheehan et al. (2017) recommend programs that recognize and address the stigma of suicide and depression. Encouraging help-seeking for suicidal individuals by reducing stigmatization of mental health and suicidal ideation requires careful implementation of awareness campaigns that prevent the normalization of suicide—termed suicide acceptance—and may be accomplished through the collaboration of mass media and public health professionals (Niederkrotenthaler et al., 2014). Education should better integrate Christian beliefs with assessment scales to bring to light bias in personality measures that would otherwise result in pathology determinations (Adams et al., 2014).

But suicide literacy on its own is not enough to increase help-seeking (Cruwys et al., 2018). Once both high suicide literacy and low suicide stigma are accomplished, more positive help-seeking attitudes and greater intentions to seek it occur (Calear et al., 2014). Tomkins et al. (2015) believe faith messages may be used to communicate ways to adopt healthy behaviors and encourage appropriate health care services. Wagshul (201/2019) recommends interventions designed to raise hope levels. Granello (2010) found the information available on interacting with suicidal clients decreases in accordance with an increase in risk and stresses the importance of support groups. The Christian community is uniquely designed for providing just such support (Spencer-Thomas, 2018).

The Christian community is also uniquely designed to provide truth. Suicide occurs within an ideation-to-action framework where there is a failure to oppose disillusionment with sustained reasons for living (Tillman, 2018). The reality of pain and hopelessness meets a fictional idealization of some event that may occur after death such as the reunion with deceased loved ones, regret by enemies over their treatment of victim, and/or ability to hear positive

reflection about themselves from the grieving loved ones left behind. These illusions are intermingled with elements of delusion (Tillman, 2018). Truth presented in a loving environment provides greater meaning and reason for living, while shattering these illusions. Anderson-Mooney et al. (2015) highlight the supportive network of religious communities providing reconstructive meaning making and improved feelings of self-worth. Spencer-Thomas (2018) outlines a faith community's ability to provide social connectedness, meaning making, and connection to the larger community. Simpson et al. (2009) recognizes that connection is hardwired into our existence, a longing for a relationship with God and others.

Beyond overcoming difficulties and restoring comfort to our lives or restoring lost relationships, what is the purpose of the days spent here on earth? What happens after death? These existential questions help to examine the counselor's role in the therapeutic relationship. Hall et al. (2010) point out the legitimate role of suffering in peoples' lives and ask whether the alleviation of it in treatment is always the desired goal. From a Christian standpoint it is not. Sin has a way of producing consequences that are far from comfortable and needs to be dealt with in a responsible way, raising questions about the possibility of the integration of faith and psychology and highlighting the reason friction is often found between the two.

In the United States, modern psychologists have identified the need for integration of the spiritual and psychological (Santrac, 2016). Krok (2015) found that people are more able to cope with difficult challenges when they have identified meaning in their life, a form of religious coping which promotes psychological well-being. In the midst of otherwise debilitating circumstances, hope offers an inexplicable detour from despair and is intrinsically available within the Christian faith (Edwards & Jovanovski, 2016). Yet, the World Health Organization's (WHO) inclusion of spiritual well-being as a component of one's overall health (Bhargav et al.,

2015) has done little to settle the debate on who should counsel those experiencing severe mental distress. de Oliveira and Braun (2009) find spirituality to be an unappreciated dimension of the medical model. Elkonin et al. (2014) believe that though faith has been found to be a positive coping resource, it has been neglected in psychological training. Perhaps research attention has been diverted elsewhere. Overholser (2014) warns against jumping on the bandwagon of mental illness fads which he describes more like an advertising campaign than a breakthrough in scientific discovery. Overholser explains that sometimes researchers set diagnostic criteria lower to include more participants in a study, resulting in an overdiagnosis of that particular disorder. Some fads are completely financially motivated as Overholser reports that contemporary psychiatry has relied on prescribing medication that overshadows any other therapeutic intervention. Often these drugs cause side effects that are prohibitive of their use, are highly addictive, or numb the senses to reality (Overholser, 2014). Eschewing the pursuit of money, outdated explanations, and current popular opinion, Overholser encourages compassion for those most vulnerable as motivation for research of mental illness, noting that simply reducing the symptoms with medication is not a cure.

The Argument: Who Cares?

Family and Friends

The decision to seek help for suicidal thoughts resides first with the individual experiencing a critical time of their life. Their first option may be to turn to a friend or family member. Though they provide the closest relationships, friends and family may be less likely to refer others to mental health professionals due to stigmatization, and while suicidal literacy made them more sensitive to the struggle of suicidal ideation, it did not increase referrals to professionals (Cruwys et al., 2018). Despite their proximity to the crisis, family members find

little support from the mental health community (Grant et al., 2015), possibly in part because family members may help or hurt progress with suicidal clients (Granello, 2010) and it is often difficult to distinguish between the two, especially during a crisis. This lack of intervention creates an opportunity for suicidal individuals to cope the best way they know how by acting as usual and keeping busy, avoiding relevant topics of conversation, taking medication, or resorting to self-harm (Kalhovde, 2014). The suicidal individual may feel they are too close and do not want to disappoint or burden family or friends with their problems (Kalhovde, 2014). These relatives or friends may be, in the worst case, the cause of the crisis (Granello, 2010). Grant et al. (2015) found little research on the inclusion of family members in suicide prevention, revealing that families have been described as both a source of protection and of risk. The only instance of the delivery of reciprocal information between the family caregiver and the mental health provider is the common desire to prevent a suicide crisis, overcoming such obstacles as stigma of mental illness, legal and privacy issues, physical and mental stress, and fear (Grant et al., 2015).

Pastor

A second option for those of faith experiencing a crisis is to seek out counsel from their pastor. For many veterans, chaplains provide this role (Kopacz et al., 2017). Hirono (2013, 2019) identifies pastors as the missing link in suicide prevention for the Christian community and advises mental health professionals to take note for integration, stating that inclusion of the spiritual or religious has been merely an afterthought. By contrast, this study is focused primarily on the pastoral counseling area of the equation. Building on a trusted relationship, individuals may be more likely to admit their struggles to someone who has perhaps known them for a good portion of their lives and who should resist judging them for going through difficult times. Payne (2014) recognizes that pastors deal with mental health issues of their parishioners on a regular

basis, pointing out that some have treated generations of a family over the years creating a strong community and trust which reduces the stigma associated with seeking help and reducing the financial burden as these services are often provided for free. But this pastoral source may also present its own unique problems such as an added layer of guilt for seeking help in addition to prayer to God and may erroneously be seen as some sort of spiritual failure by the individual (Salwen et al., 2017). Bledsoe et al. (2013) broke down negative results of seeking pastoral care into feeling that they were abandoned by their church, believing demonic activity led to mental illness, and guilt of personal sin or a lack of faith. Sansone and Wiederman (2015) found those who perceive themselves as spiritual are less likely to attempt suicide but may exhibit other self-harm behaviors.

In times of need, church attendees first seek help from their pastors over mental health professionals. This puts clergy on the front lines during high stress situations, leading to emotional vulnerability (Bledsoe et al., 2013). Mason et al. (2011) found the clergy in their qualitative study, despite their general label as “gatekeepers” for mental health issues, did not see themselves in, nor aspire to take on, that role. This attitude might explain why Mason et al. (2011) found the clergy in the study reported low confidence in assessing suicidal risk and the 10% referral rates documented in other studies did not apply and calling on larger quantitative replication to further test referral rate generalizability. Payne (2017) found lower income neighborhoods did not have the luxury of mental health professionals to refer individuals to and pastors, despite seminary and Christian university educations, felt unprepared for the types of mental health issues they encountered and overwhelmed by the time requirement involved to fulfill this calling. Alternately, other environments such as the one researched in another qualitative study, Mason et al. (2020) reported infrequent suicide funerals and only an annual

average contact of two suicidal persons. In addition to feeling inadequately trained to address suicide in their congregations, such low engagement to do so precludes developing suicide prevention competencies (Mason et al., 2020). Mason et al. also call for a larger sample size for result comparison.

Bledsoe et al. (2013) found clergy participants displayed 68.9% positive attitudes toward referring congregants to mental health professionals without reservations or stipulations regarding the counselors' spiritual beliefs. Could there be a correlation between pastor vulnerability and referrals? Perhaps in an attempt to address this vulnerability and reduce referrals, Capps (2014) identified a need for greater service to mentally ill congregants who are not being treated and may present a danger to the community, recommending more education regarding mental illness for seminary students. Unless this additional education examines the contributing factors to suicidal ideation through the lens of the Bible rather than merely adopting the secular mental health professionals' ethical guidelines, this effort will only result in a watered-down version—or complete removal—of the gospel and offer only the temporary hope to be found in a fallen world without Christ or as Santrac (2016) clarified regarding the integration of psychology and Christian faith:

> The purpose of this integration is to demonstrate the superiority of a holistic Christian theory of personality to compartmentalized and disintegrated psychological theories of personality. For Christians, the reference point of this Christian theory of personality is Christ, as He unifies the faculties of the soul into a holistic perception of human nature created in God's image. (p. 7)

The pastoral counselor believes in God's unique power to heal (Monroe & Schwab, 2009) but understands that suffering plays an important role in our growth, and capacity building

for disappointment is a developmental necessity (Tillman, 2018). Pain can be a reminder that we are not living according to God's will and unconfessed sin, such as perpetrating child abuse, is dangerous and does not warrant comforting (Hall et al., 2010). It requires correcting. Christians are called to reconcile people to God, aiding in their healing and restoration (Monroe & Schwab, 2009). God's grace offers forgiveness to those who repent, providing a formidable deterrent to suicide and suicidal ideation. Greggo (2016) identifies a need for metaphors that illustrate, as Jesus did with His parables, the tension of discipleship as it is lived out in the Christian community and the professional counseling culture. This is a daring and difficult prospect that may be more prone to result in dissociative identity tendencies from juggling the dichotomies of living in both worlds—unless one is truly committed to the sacrificing of all to follow Jesus. In which case, the acquisition of the label "crazy" or diagnosis "psychotic," with all the accompanying stigmatization, may be applied by the mental health professionals once considered colleagues. But as Evans (2012) reminds us, the goal of the counselor—as a Christian—is to remain faithful to God.

Mental Health Professionals

It is into this breach that a great deal of literature flows to encourage referral to outside mental health providers or increased mental health education for pastors who, ideally, will then see the necessity of referring to outside counsel (Payne, 2014). Stanford and Philpott (2011) found a greater need for mental health care education for Baptist clergy, while noting mental health professionals lack an interest in the faith issues that may affect their clients. Likewise, integration of spirituality or Christian faith into secular counseling programs as a nod to diversity and social justice is encouraged only to the extent that it does not interfere with the guidelines set forth by the governing boards, warning students to avoid ethical violations (Elkonin et al., 2014).

Greggo (2016) encourages the nurture of spiritual formation of students at faith-based learning institutions, applauds Smith and Smith's (2011) teachings that students of professional counseling should aspire beyond the accepted vague term of spirituality into the more controversial unequivocal dedication to the Lord Jesus Christ, yet affirms core values of the American Counseling Association's (ACA) Code of Ethics which include people's unique qualities that are derived from their cultural and social contexts that in some instances most certainly will conflict, for example, with Jesus' admonition to a man who had been made well to avoid further sin so that worse conditions might not follow. Tomkins et al. (2015) discuss controversies such as female mutilation, end-of-life, and family planning, acknowledging that culture, economics, politics, education, and law very often manage to undermine the authority of individual religious beliefs and the authority of sacred texts. Suicide Acceptance (SA) has been studied against the fabric of cultural context and shown to highlight self-expressionism, including those value orientations that tolerate deviant behavior from conventional norms except where religiosity provides a protective factor (Stack & Kposowa, 2016).

Payne (2014) conducted a study on the level of education of pastors and its influence on referring people to mental health professionals for treatment of depression. Payne notes that pastors have been on the frontlines of care for their parishioners for a very long time but suggests that not only do they lack training to treat these cases, but they feel overwhelmed from having to do so. Payne outlines several assumptions including pastors' lack of education or its primarily theological focus, old-fashioned ideas/antiquated thinking, inability to handle depressed cases and need to know when to refer to mental health providers, and prejudice against medical treatment. Payne calls for the need of additional studies to determine the validity of these assumptions. Potgieter (2015) supports church-based counseling teams to expand on the ability

to provide care to the local community, while Payne (2014) warns against the short-term training of pastors for treating depressed individuals as it may embolden them to believe that they are qualified to treat these individuals themselves. Who determines such qualifications? Who cares? Still, Payne's (2014) study did not conclude that the level of secular or theological education had any effect on views regarding referral.

An Integrated Approach

In response to the claim that secular psychology adds no contribution to Christian counseling, de Oliveira and Braun (2009) contend the Apostle Paul never claimed Scripture to be all-sufficient and never prohibited the use of other resources to support its teaching, noting that the Bible, as comprehensive and complete as it is, does not represent an all-encompassing manual with answers for every potential problem one will face. de Oliveira and Braun further explain these other resources may exhibit God's common grace with the purpose of declaring His glory. Swenson et al. (2009) question whether or not some Christian integration in counseling such as prayer, confrontation of immoral behavior, and self-disclosure by the counselor are ethical. Haynes (2016) believes wisdom may be best discovered by the integration of psychology and spirituality, suggesting the study of individuals such as Victor Frankl would widen the worldviews of clergy trained in counseling and that emotional or spiritual growth beyond the adolescent years might be possible if the necessities of life did not interfere with the pursuit of self-improvement. Such sentiments align heavily with Maslow's hierarchy of needs where the pursuit of self-actualization is the greatest goal of attainment in life (Craig & Dunn, 2010).

Hodgson and Carey (2017) maintains the spiritual and religious components within the definition of the concept of moral injury have been buried in favor of secular explanations.

Deschrijver (2011) believes suicide to be understudied due to linguistics and its hybridized meaning before the eighteenth century, largely attributed to the legal system rather than society's held beliefs, when criminalization of suicide was experienced by family through the confiscation of the deceased's possessions as penalty for the offense, the dragging and hanging of the body in public as a deterrent for others, and eventual burying in unhallowed ground as continued stigmatization. The discontinuation of these practices was gradually accomplished with a corresponding shift in the language regarding suicide: devilish temptations implied a yielding of the will to sin resulting in a verdict of guilt, while insanity depicted a more defenseless innocence that avoided censure (Deschrijver, 2011). Notice the act of suicide does not change, only the perception of the cause and reaction to it. Both extremes are equally dangerous; one condemns, while the other excuses. Pastors, in preventing suicide, have the delicate duty of avoiding both approaches.

McMartin (2015) argues the Holy Spirit works in therapy by promoting therapeutic growth whether specifically invited to participate or not but allows that leaving out salvation actually leads one further from God rather than closer to Him. Still, in his argument, McMartin maintains that while we are still alive, we are connected to God, but being separate from that relationship leads to death. McMartin believes therapy, though not eternally oriented, is empowered by the Holy Spirit and works to affect natural psychological growth. Porter et al. (2017) state that God does not force His transformational presence on anyone and that the Holy Spirit may be resisted. The continual interaction with Christians constantly in crisis, experiencing failure or exhibiting Christian immaturity results in spiritual struggles for counselors involved in helping them (Porter et al., 2017). Porter et al. (2017) agree with McMartin (2015) that much growth may occur outside of relationship to Christ due to common grace.

Krok (2015) stresses the need for long-term goals that incorporate a search for meaning which contributes to psychological well-being, but his argument relies on the findings that religion is linked to well-being through the use of positive religious coping skills that help people persevere through difficult times—skills unavailable, unexplored, or even forbidden in secular circles. Kheriarty (2017) agrees religion gives meaning and purpose that helps to overcome difficulties. It is important to have a sense of how one fits within the world (Krok, 2014). As belief in God has decreased in America an increase of those claiming no religious affiliation has occurred (Kheriarty, 2017).

Amato et al. (2017) agree suicidal individuals may seek help from clergy who are well situated to encourage them to seek treatment but advise that such treatment must be in alignment with the individual's beliefs. Amato et al. define spirituality and religion with broad terms and attribute their protective factors from suicide to theories of social integration, networks, and the psychoanalytic perspective of belongingness. The latter may require removal from one religious community into another LGBT-affirmative group, religious or otherwise, to maintain such individual beliefs (Amato et al., 2017).

It should not be surprising then that suicide rates have continued to climb—and continue to climb—over this same time period. Part of today's problems stem from the meritocratic age that requires a sense of usefulness by others in order to be valued (Kheriarty, 2017). Additionally, steps toward Suicide Acceptance (SA) have increased thanks to new American laws that allow for assisted suicide. As a result, the value of life has decreased. Copycat suicides are aptly called outbreaks of deaths of despair (Kheriarty, 2017). Elliot (2018) considers euthanasia for the disabled an undermining of all humanity which risks self-hatred, noting a model of Christian theology would counter this anthropology of despair.

In some areas, specifically excessive alcohol consumption, pastoral care is incorporated into hospital care in order to lighten the demands made on clinical personnel without overburdening the patient as visits are limited to only three to four minutes unless otherwise extended by the patient (Overton et al., 2014). This type of corroboration between the mental health system and religious advisors represents an example of an established alliance where training of religious advisors on mental health disorders and interventions by primary care authorities modeled by the WHO could begin (Kovess-Masfety et al., 2017). According to Kovess-Masfety et al., this connection is necessary to utilize a current entry relationship between free religious providers, whose training is extremely poor, and those suffering from a mental health disorder who seek their help due to the unavailability of funds to access more adequate care. They further acknowledge the participation of about 90% of the population in religious or spiritual practice means that religious advisors, however ill-equipped, are unlikely to decrease any time soon.

Recognizing the failed attempts at integration of the Christian worldview and contemporary psychotherapy through philosophical assumptions, Santrac (2016) calls for a new type of integration that answers the plea for wholeness through human intellect, emotions, and free-will connected directly to the transcendental experience of Christ's Lordship which provides ultimate meaning for every individual made in His image. Such a passionate call for Christian integration with psychotherapy would appear a nonstarter in the licensed counseling field, as would the questioning of the primary goal of treatment as the alleviation of suffering (Hall et al., 2010). Another obstacle to Christian faith integration is psychological assessment which currently resides squarely in the domain of psychologists and requires conformity to standardized procedures (Adams et al., 2014).

Pieper and van Uden (2005) reported 25% of outpatients felt mental health professionals were better qualified to help with religious experiences or worldview than a minister, and in their own study, Ouwehand et al. (2019/2020) found only 12% had spoken with clergymen, supporting a perceived move of less reliance on faith institutions and greater acceptance of worldy influence. Bledsoe et al. (2013) found over 40% of Americans who suffered emotional distress sought help from clergy. According to a 2011 Gallop poll among non-religious people, 16% sought help for personal problems from clergy (Potgieter, 2015). Whether non-religious people seek pastoral help due to finances (Nugent et al., 2019) or some perceived connectedness between their current problems and spiritual matters is unclear.

One must question the logic of pastors who believe secular counseling degrees equip one to better treat mental health issues and have obtained such a degree for themselves, yet still feel the need to refer individuals out to those who may or may not have the Biblical context to determine between mental illness and spiritual battles. In direct contrast, Salwen et al. (2017) ask the rhetorical question, “Why would the pastor, who has been convinced in his or her education and experience that he or she already occupies the most spiritually informed vocational role, bring his or her spiritual struggles to someone in a different role?” while encouraging pastors to do just that (p. 517). To pose a counter question, from a Christian standpoint, should not everything be viewed from a Biblical worldview in which the spiritual battle will continue until Christ’s return? Salwen et al. (2017) argue unrealistic expectations placed on pastoral leadership of being able to handle these difficult situations alone puts undue pressure on the pastor and results in personal psychological distress leading to loneliness and burnout because they either ignore or resist treatment from a growing number of more competent mental health professionals. It is important to note these more competent mental health professions are

committed to secular counseling guidelines that change over time based on cultural and societal influences, whereas God's Word remains.

One new area of attempted integration being explored is that of psychological assessments. Adams et al. (2014) encourage humility in the development of psychological assessments aimed at integrating faith, warning of the human tendency to inflate their abilities. However, any attempt at humility or objectivity should be viewed through the lens of truth. Similarly, Clouser (2005) maintained that regardless of one's beliefs, they will always guide and regulate the theories of philosophy and science that we construct to explain all that we experience. Adams et al. (2014) describe the use of the MMPI-2 personality assessment as a tool for determining the suitability of a candidate for pastoral ministry. One red flag in determining suitability was the student's theological conviction that they knew the truth that others who did not believe in Christ could not, which was labeled as entitled, pathological, and narcissistic (Adams et al., 2014, p. 140).

Summary

The focus on suicide rates from just a few short years ago has been overshadowed by recent news of the pandemic, riots, natural disasters, and financial strain from resulting unemployment due to all of the above circumstances. While the focus has shifted, the increasing rise of suicide—in part because of these occurrences—has not, even within the church.

This may be where the problem lies. Who wants to suffer? Whatever the hardships, the goal is to remove them rather than persevere and grow. Hall et al. (2010) insist suffering has a role in development. The feel-good sermon receives accolades while the mention of tribulation or judgment sends congregations running for the hills. Has this compliance to stick to easy, uncontroversial topics packed churches with Christians—even pastors—who are unprepared to

deal with the inevitable pain that comes from loss and suffering? Is this precisely where the mental health professionals step in to take up the challenge? Meditation and mindfulness are increasingly popular in clinical interventions and have surfaced in Christian counseling, but these are practices from Buddhist teachings. Countless scholarly articles may be found to explain why this mindfulness intervention is acceptable to the church. Compelling arguments may exist for both its acceptance and its rejection, particularly in treating someone with suicidal ideation. Again, this highlights potential difficulties for pastors dealing with such issues.

A recent declaration on the news by various politicians and newscasters is that not only are we all made in the image of God, but that we are all children of God. Bhargav et al. (2015) once again point to Tapasyananda (2005) to conclude that spiritually advanced personalities discern in all hearts a common divinity.

To determine a successful suicide prevention intervention for Christians, the Christian worldview based on Biblical Truth is the foundation on which it must be built. The problem is that the beliefs of those who are questioned for studies matter and trying to label the Christian worldview as simply "spiritual," blends it together with opposing religions and threatens its validity.

Research for this study is intended to reconnect pastors to their responsibilities in caring for their congregations beyond the hour-long sermons presented once a week. It proposes to do this by asking questions that alert them to the dangers of blindly referring troubled church members to outside mental health professionals who have declared their support of counseling people of all faiths without preference for one religion over another and without imposing their views on their clients. While this sounds like a compassionate and trustworthy approach, it denies the most powerful tool available to the Christian pastor—faith in Jesus Christ and His

healing power. At the same time, it is important to remember the ongoing spiritual battle. The church's downplaying or outright denial of supernatural activity promotes silence of experiences for fear of stigmatization and represents culpability in the labeling of mental illness and exposure to secular treatment that has no room for God or His Holy Word. While the world may label Christians as "crazy," the role of pastors is quite different. Preventing their subjection to critical assessment and subsequent medicated, and/or actual hospital imprisonment falls within their purview. Even pastors may find themselves embroiled in a spiritual battle that they have relegated to the Old Testament or underestimated in its intensity, receiving a fatal blow that affects the whole community, which is what made them a prime target from the outset.

If the development of new biblical assessments and the ministering of Christian interventions are combined with open communication on formerly sensitive topics, God will not fail to answer the prayers of His faithful followers to set the captives free. He has already proclaimed to do so.

CHAPTER THREE: METHODS

"Who is this who darkens counsel by words without knowledge?

Now prepare yourself like a man; I will question you and you shall answer Me"

(*New King James Bible*, 1982/2013, Job 38:2-3).

Overview

Despite available resources and hotlines to help those suffering from depression, anxiety, grief, loneliness, financial difficulties, and major illnesses, suicide continues to increase in the United States and around the world. Are suicidal individuals failing to reach out for help? Are would-be caregivers missing their signals? Or both? Or, perhaps what the Bible says is true. There is an enemy prowling around and searching for the next victim, a victim who is ill-equipped to defend against the relentless onslaught of lies, taunts, and prods that lead to unimaginably heartbreaking death. How is the church responding to this crisis and how could they do more? This research study is designed to take the pulse of the Christian faith community—through its leadership—in regard to their response to mental health and related issues that lead to hopelessness and the compulsion to take one's life. This survey highlights specific areas to structure information around seven important components: History, Education, Coping, Assessment, Religiosity, Experiences, and Strategy or HE CARES.

Design

Overholser (2013) believes the Socratic Method is a useful guide in counseling as it helps promote problem solving and self-discovery. Jesus often asked questions of others when He was healing or teaching them. In John 5:6, Jesus asks the lame man if he wants to get better (*New King James*, 1982/2013). It was a probing question that required honest introspection. In John 21:15-17, Jesus asks Peter three times if he loves Him. Peter, having denied Christ three times

(John 18:17, 25-27), is able to make the connection between the questions and his earlier behavior.

Survey research may be traced back to ancient Egypt and remains an important design for research today (Heppner et al., 2016). In particular, survey research may be used to identify patterns within a particular group by collecting quantitative data in epidemiological studies to aid in the development of preventative interventions (Heppner et al., 2016). Christian interventions for suicide prevention, including referrals to outside sources, are the focus of this study.

The first step in counseling is building rapport. Without trust, there is no confidence that the results will be accurate. However, when conducting research, anonymity is preferred. Using surveys presents questions in a nonthreatening form, providing protection of identity and room for self-discovery. When surveys are provided through one's organization, there is a level of trust already built in as approval has been given for its use from a known entity. Researchers want participants to feel safe and free to answer questions truthfully—it is the best way to fruitful and meaningful work. This study utilizes a survey of 35 questions to gather data for statistical analysis.

Research Questions

RQ1: Do pastors feel equipped to recognize suicidal symptoms and provide counseling?

RQ2: How do pastors distinguish between spiritual experiences and psychotic symptoms?

Hypotheses

H1: Pastors' perceived importance of mental health education will have a positive effect on the number of referrals to mental health professionals.

H2: Pastors who believe visions and spiritual communication occur today will be more

engaged in counseling those with such experiences themselves.

Participants and Setting

The population of this study includes Christian pastors in the United States. The sample was drawn from members of national organizations, including Christian universities. Permission was sought from these organizations and requests were made that they email their pastor members, or pastor students, and asked them to complete a survey by a given deadline. In addition, pastors from individual churches were directly contacted through their emails listed on their respective websites. All participants were asked to forward the email to other qualifying participants, potentially creating a snowball effect. This instrument allowed participants to answer questions in private at their own pace within the allotted timeframe. The anticipated sample size was 200. Out of over 2,000 email requests, only 89 pastors completed the survey.

Calear et al. (2014) believe that volunteers who answer surveys are those who have a greater interest in the questions being asked; therefore, the questions need to be carefully crafted to elicit a response. Though this was not a completely random sample, Heppner et al. (2016) refer to the "good enough" principle in which the characteristics of the sample are conducive to generalization of the results to the population.

Instrumentation

The experiences we have and the beliefs we hold affect how we will respond in any given situation. The integration of Christian faith into psychological assessment is a relatively new concept and Adams et al. (2014) lament the fact that most are focused on deficits and weaknesses, while imagining a MMPI with a positive spin. Payne (2014) found no significant influence of secular and theological education on pastors' decision-making regarding depression intervention, but instead suggested better training outlets that gave pastors knowledge directly

corresponding to the problems they face on a daily basis. Questions to determine what those problems are may help tailor such programs, but obstacles remain. This may be due to lingering distrust between the mental health professionals and the clergy, though cooperation between the two has become increasingly appealing (Stanford & Philpott, 2011). Where does this collaboration, from the pastors' viewpoint, stand today? Through a survey intended to discover pastor beliefs, such as the one below, this study sought to gain those answers.

The instrument developed for this study is a survey including 35 questions that can be directly answered, are rated on a Likert Scale, or are multiple choice. As stated earlier, the questions and their responses are divided into groups corresponding to the acronym HE CARES or History, Education, Coping, Assessment, Religiosity, Experiences, and Strategy.

HE CARES Survey

History:

1. Did you grow up in the church? Yes _____ No _____
2. If so, what denomination of church did you attend? _____
3. What church denomination do you currently pastor? _____
4. My testimony or conversion to Christianity involved a road to Damascus moment or supernatural experience: Yes _____ No, I just believed _____

Education:

1. What is your education level? _____
2. Are you currently working toward a degree? Yes _____ No _____
3. If so, are you pursuing study in the counseling field? Yes _____ No _____
4. Do you feel your education equips you to recognize suicidal symptoms? Yes _____ No _____

5. Do you feel your education equips you to provide counseling to suicidal individuals?

   Yes _____ No _____

Coping: Select all that apply.

1. When experiencing difficulties, I seek help from:

   a) peers within the church,

   b) professional counselors,

   c) God through prayer and Scripture,

   d) all of the above

   e) other, please specify _____

Assessments: Select all that apply.

1. How do you determine the mental health needs of your congregants? _____

   a) through questionnaires or assessments,

   b) through self-reports or help-seeking requests,

   c) through observation of changes in behavior,

   d) through prayer requests,

   e) through referrals from others,

   f) all of the above

   g) other, please specify _____

2. Do you distinguish between a spiritual experience and a psychotic episode?

   Yes _____ No _____

   Explain your answer:

   _____

   _____

_____

_____

3. Approximately what percentage of individuals seeking your help for mental health issues do you refer to outside professional counselors?

   0%-25%_____26%-50%_____51%-75% _____76%-100%_____

4. Approximately what percentage of individuals seeking your help in regard to spiritual experiences such as visions or prophetic dreams do you counsel yourself?

   0%-25%_____26%-50%_____51%-75% _____76%-100%_____

Religiosity: Rate your current faith level:

1	2	3	4	5
Extremely Low	Low	Medium	High	Extremely High

1. Love for God is… _____
2. Readiness for persecution is… _____
3. Resistance to compromising influences is… _____
4. Sensitivity to sin is... _____
5. Repentance is… _____
6. Level of faith in God is… _____
7. Passion for Christ is… _____

Experiences: Label frequency of occurrence as follows:

Never	Rarely	Sometimes	Often	Constantly
1	2	3	4	5

1. I have counseled someone with life struggles such as marital problems, financial issues, or child concerns. _____

2. I have counseled someone who has experienced a mental health disorder. * _____
3. I have counseled someone who has experienced psychotic symptoms such as auditory or visual hallucinations. _____
4. I have counseled someone who has experienced a prophetic dream or vision. _____
5. I have counseled someone who has experienced spiritual warfare or temptations to do something that they know is wrong. _____
6. I have experienced the Holy Spirit helping me through difficult times. _____
7. My experiences equip me to counsel others with spiritual experiences. _____

*Mental health disorder is defined as a significant disturbance to one's cognition, emotions, and/or behavior which interferes with daily functioning in social, occupational, and relational activities due to impaired mental functioning (APA, 2013).

Strategies: Label level of agreement as follows:

SA- Strongly Agree MA- Moderately Agree A- Agree

SD- Strongly Disagree MD- Moderately Disagree D- Disagree

1. The Bible illustrates how to heal people with mental illness. _____
2. Education in mental health counseling is necessary to counsel mental health concerns. _____
3. If a church member told me that they were suicidal, I would counsel them myself. _____
4. If a church member told me that they were suicidal, I would refer them for counseling elsewhere. _____
5. If a church member told me that they were suicidal, I would rely on prayer and guidance from the Holy Spirit on whether to treat them or refer them elsewhere. _____
6. Licensed mental health professionals are better equipped to treat individuals who see

visions or hear voices. _____

7. Licensed mental health professionals may not understand the spiritual implications of seeing visions or hearing voices, resulting in the diagnosis of a psychotic illness. ____

Optional: Use this space to add any additional comments on the survey questions or the survey content:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Procedures

Procedures used include securing Institutional Review Board (IRB) approval, contacting pastor associations within the United States to secure their permission and help to e-mail their members the HE CARES instrument and relate to them that it is time sensitive. As previously shown, the questions and statements shed light on pastors' educational background, beliefs about mental health, beliefs on biblical response, religiosity, attitudes toward mental health professionals, care for suicidal individuals, and reception to/need for new mental health approaches within the church. Pretending suicide and its contributing factors are not affecting the

church is no longer an option. Pastors need help in being available before the call for funeral arrangements are made. In some cases, the pastors themselves are the ones in need of encouragement and support. It is time to speak out and fight against suicide.

Data Analysis

Data is expected from over 200 pastors from different denominations throughout the United States. Denominations may affect answers to specific questions or statements and provide comparison for across groups interpretations. Education level was expected to influence attitude regarding pastor referral to mental health professionals.

Summary

Research is an important step in solving problems. Some problems are more urgent than others. Suicide is an incredibly complex and compelling one. It deserves actions to prevent as well as consideration of its causes. During the literature review process, it was discovered there is an indication that education on suicide within the church would be a welcome addition. Implementation of such information is to be delivered cautiously in respect for the serious subject matter. The most important aspect of addressing an issue such as suicide is ensuring that the individual understands that they are not alone. There is comfort in knowing you are not the only one struggling. Interventions should be designed to increase help-seeking (Hom et al., 2015). At the same time, pains should be taken to reduce stigmatization and avoid normalization of suicide or self-harm (Niederkrotenthaler et al., 2014).

CHAPTER FOUR: FINDINGS

"As for God, His way is perfect; The word of the Lord is proven;

He is a shield to all who trust in Him" (*New King James Bible*, 1982/2013, Psalm 18:30).

Overview

Who Cares: Suicide and Christian Pastoral Intervention sought to discover if pastors in the United States feel able to recognize suicidal symptoms and believe themselves competent to counsel individuals who present with these symptoms. The findings from the data collected are presented in this chapter using descriptive statistics that explore each section of the HE CARES study and inferential statistics which test the null hypotheses and report the alternative hypotheses significance found through Chi-square tests performed by the Qualtrics analysis tool provided by Liberty University.

Descriptive Statistics

This research study, utilizing a convenience sample, reached out to over 2,000 pastors who currently pastor a church and who are 18 years of age or older. At least seven denominations in all 50 states in America were invited to participate in the HE CARES survey. From this sample, only 89 completed the survey. The emails directly sent to churches were intended to target and question seven specific church denominations which, though individual in some regard, should all share the basic biblical worldview: Baptist, Methodist, Presbyterian, Pentecostal, Catholic, Lutheran, and Episcopalian. The survey offered a space for denomination, but the write-ins were so varied and specific as to make scoring them burdensome and fragmented. Cultural backgrounds and changing beliefs which have resulted in denomination splitting may account for these differences.

The following descriptive statistics highlight the areas of the HE CARES survey,

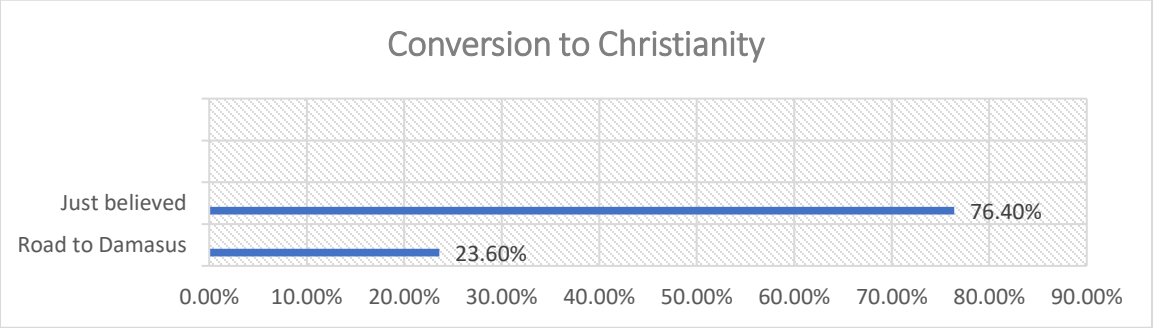
including History, Education, Coping, Assessment, Religiosity, Experiences and Strategies.

History

The HE CARES survey questioned respondents on their conversion to Christianity. Figure 1 shows that 23.6% agreed their conversion included a supernatural or Damascus road experience, while 76.4% said they simply believed, making the mode of central tendency, or most frequent answer, the latter group who simply believed.

Figure 1

Bar Chart for Pastor Conversion

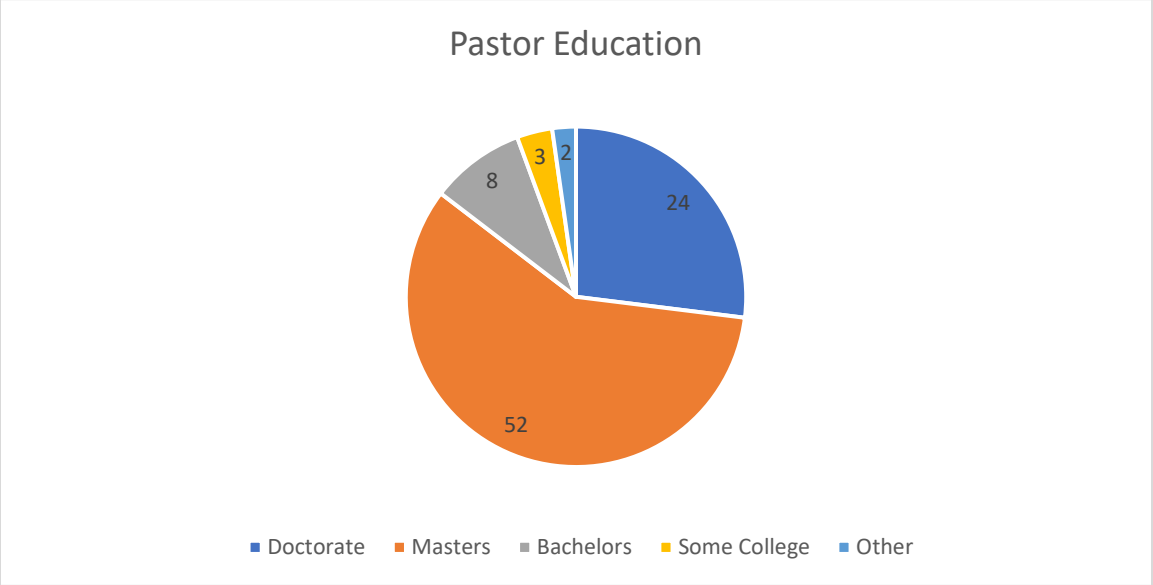


Education

The HE CARES survey asked pastors about their level of education. As expected, the majority of learning was acquired through seminaries and universities in theological studies. Pastor education data represents nominal data requiring a mode measure of central tendency. As Figure 2 shows, the category of master's degree represents the mode because it occurs the most frequently (52 times) over the remaining categories that make up the 89 participants. In addition, 24 pastors reported having a doctorate, eight a bachelor's degree, two an unspecified degree, and three had some college. Only one reported currently pursuing study in the counseling field.

Figure 2

Pie Graph for Pastor Education



Coping

The coping question from the HE CARES survey asked pastors who they turn to when they are experiencing difficulties. In addition to expanding existing data from earlier studies, this question also serves as an indicator for intervention suggestions from pastors to their congregants. An overwhelming percentage of pastors (79.8%) chose all of the above, pointing to a willingness to use multiple approaches in helping their congregant members.

As Figure 3 shows, the help-seeking results included seeking help from a source not listed, or other, as 10.10%, seeking help from church peers as 16.9%, seeking help from professional counselors as 24.7%, seeking help from God, prayer, and Scripture as 25.5% and seeking help from all of the above as 79.8%. The Qualtrics data and analysis tool used for this study calculated confidence intervals for each of the five responses as shown in Table 1. Because the data is calculated from a small sample of nominal data where the answers are not mutually exclusive, the confidence interval displays a larger range of percentages for the potential true

values.

Figure 3

Line Graph of Pastor Personal Help Seeking

Table 1

Confidence Intervals for Pastor Personal Help Seeking

Sources of Help	Confidence Intervals
Other	5.4% to 18.1%
Church Peers	10.5% to 26.0%
Professional Counselors	16.9% to 34.6%
God, Prayer, and Scripture	17.9% to 35.8%
All of the above	70.3% to 86.8%

Assessments

The HE CARES survey questioned pastors on the determination of mental health needs

of their congregants. Figure 4 displays a line graph of the pastor respondents' determination methods for assessing the mental health needs of their congregants.

As with the previous coping question, Qualtrics calculated the percentages of respondents and confidence intervals for each answer. They are presented in Table 2. Unlike the coping question, the determination of mental health needs for congregants showed a low percentage (only 11.2%) who chose all of the above. Larger percentages were found for self-reports or help-seeking requests (79.8%), observation of changes in behavior (79.8%), referrals from others (69.7%), and prayer requests (66.3%). Only two pastors (2.2%) chose questionnaires and assessments and one pastor (1.1%) selected other with a write in of "through personal interactions." These percentages, which plummet for questionnaires/assessments, represent an expected pastoral approach to determining congregants' mental health needs.

Figure 4

Line Graph of Congregant Mental Health Needs Determination

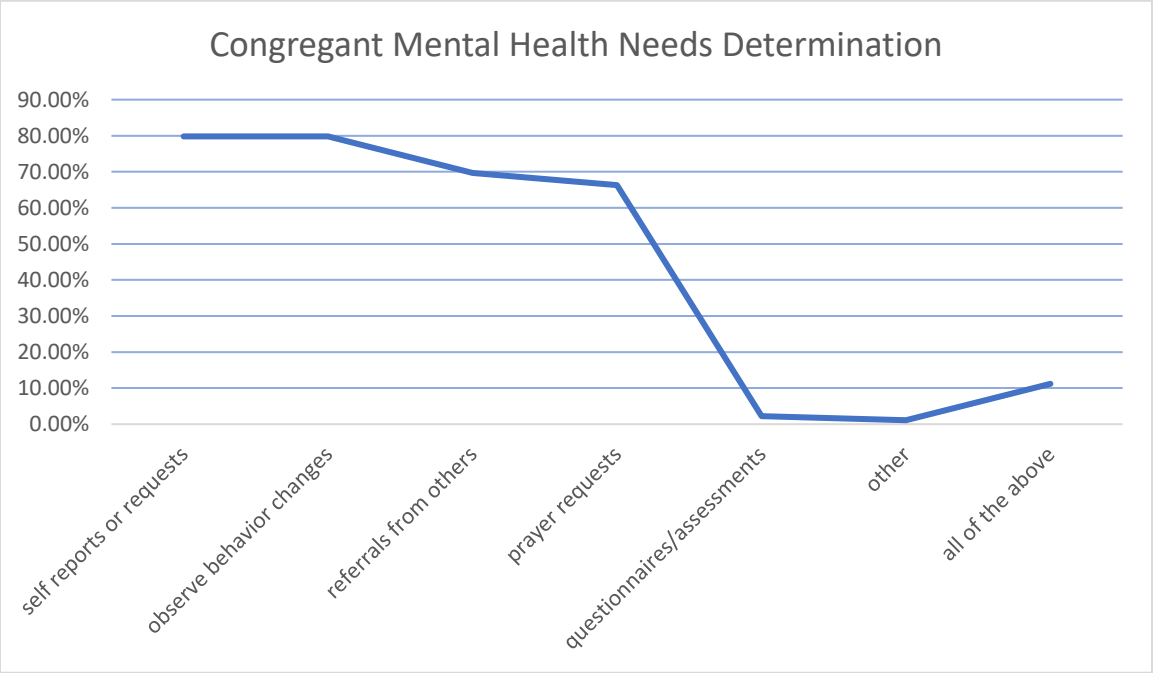


Table 2

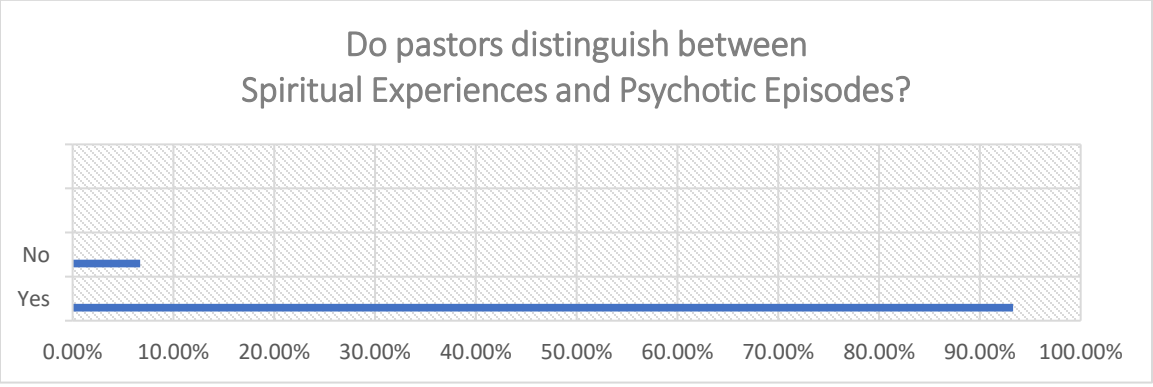
Confidence Intervals for Congregant Mental Health Needs Determination

Needs Determination	Percentage	Confidence Intervals
Self-reports or requests	78.8%	70.3% to 86.8%
Observe behavior changes	79.8%	70.3% to 86.8%
Referrals from others	69.7%	59.5% to 78.2%
Prayer requests	66.3%	56.0% to 75.3%
Questionnaires/Assessments	2.2%	0.6% to 7.8%
Other	1.1%	0.2% to 6.1%
All of the above	11.2%	6.2% to 19.5%

Another area of assessment in the HE CARES survey questioned pastors on whether or not they distinguish between a spiritual experience and a psychotic episode. The bar graph in Figure 5 shows 93.3% of pastor respondents (83) said yes, while 6.7% (6) said no. These results indicate the majority of pastors feel confident in their ability to distinguish between spiritual experiences and psychotic episodes which would inform their treatment intervention decisions.

Figure 5

Bar Graph for Distinguishing Spiritual Experiences from Psychotic Episodes



Religiosity

The HE CARES survey measures the current temperature of pastor respondent faith levels through self-reporting, asking them to rate their responses to the following prompts as extremely low, low, medium, high, and extremely high.

1. Love for God is… _____
2. Readiness for persecution is… _____
3. Resistance to compromising influences is… _____
4. Sensitivity to sin is... _____
5. Repentance is… _____
6. Level of faith in God is… _____
7. Passion for Christ is… _____

The results, shown in column percentages, are presented in Figure 6. The corresponding percentages are provided in Table 3. The higher percentages appearing on the bottom two rows of Table 3 indicate a tendency toward higher levels of religiosity, to be expected from a sample group of pastors.

Figure 6

Religiosity Histogram

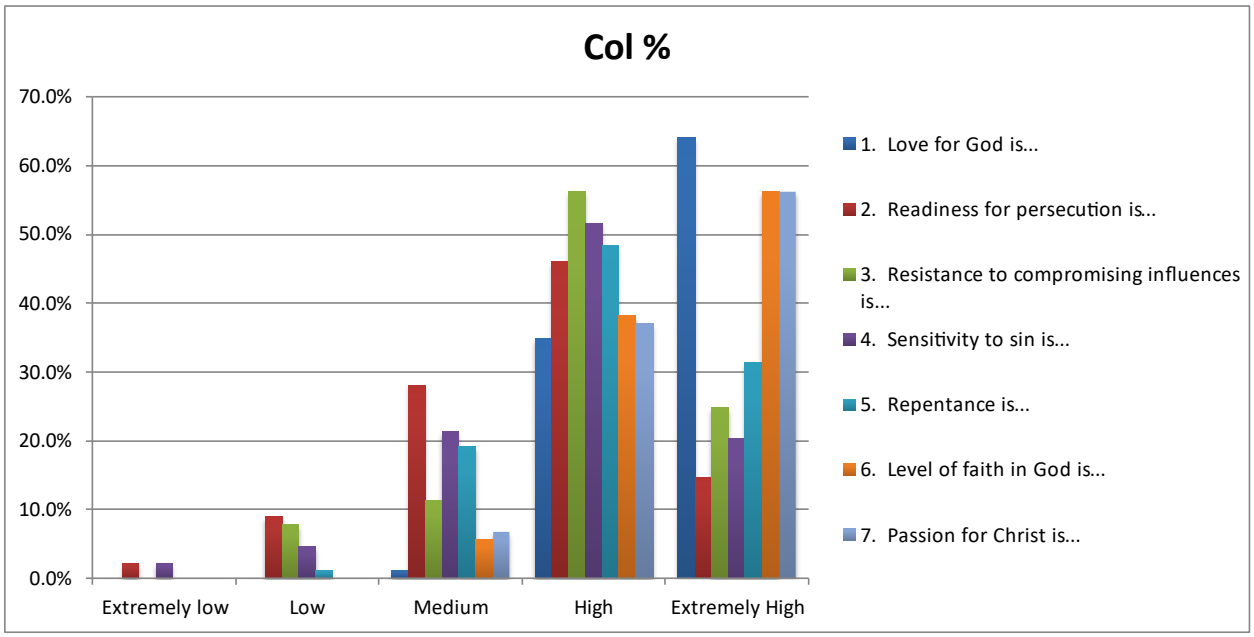


Table 3

Religiosity Percentages

	Q1	Q2	Q3	Q4	Q5	Q6	Q7
Extra low	0.0%	2.2%	0.0%	2.2%	0.0%	0.0%	0.0%
Low	0.0%	9.0%	7.9%	4.5%	1.1%	0.0%	0.0%
Medium	1.1%	28.1%	11.2%	21.3%	19.1%	5.6%	6.7%
High	34.8%	46.1%	56.2%	51.7%	48.3%	38.2%	37.1%
Extra High	64.0%	14.6%	24.7%	20.2%	31.5%	56.2%	56.2%

Experiences

To gain an understanding of the types of concerns that pastors experience in helping their congregants, the HE CARES survey asked the following questions:

1. I have counseled someone with life struggles such as marital problems, financial issues,

or child concerns. _____

2. I have counseled someone who has experienced a mental health disorder. * _____
3. I have counseled someone who has experienced psychotic symptoms such as auditory or visual hallucinations. _____
4. I have counseled someone who has experienced a prophetic dream or vision. _____
5. I have counseled someone who has experienced spiritual warfare or temptations to do something that they know is wrong. _____
6. I have experienced the Holy Spirit helping me through difficult times. _____
7. My experiences equip me to counsel others with spiritual experiences. _____

*Mental health disorder is defined as a significant disturbance to one's cognition, emotions, and/or behavior which interferes with daily functioning in social, occupational, and relational activities due to impaired mental functioning (APA, 2013).

Figure 7

Histogram of Pastor Counseling Experiences

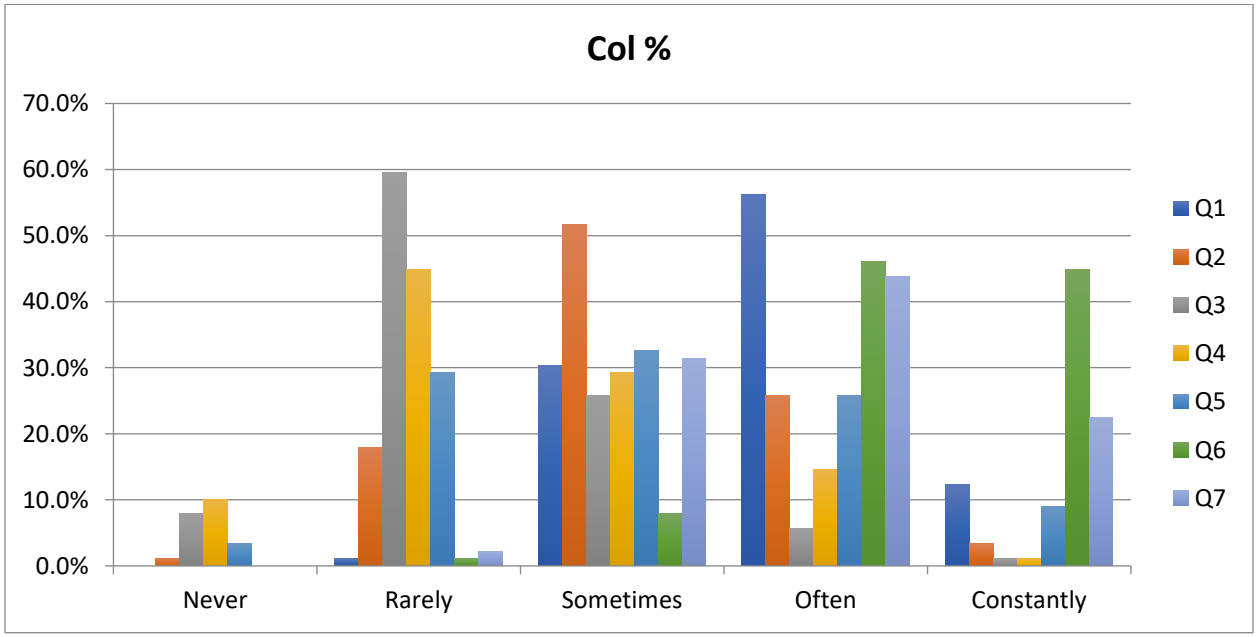


Figure 7 shows a histogram of the pastor responses. The corresponding percentages are provided in Table 4. The percentages in Table 4 provide insight into pastor experiences pertaining to counseling their congregation members. While 56.2% of pastor respondents reported counseling common life struggles such as marital problems, financial strains, or child concerns frequently, they have much fewer interactions with those experiencing psychotic symptoms (59.6% responded rarely) or prophetic dreams or visions (44.9% responded rarely). Whether the rare occasions for counseling those with psychotic symptoms or having prophetic dreams or visions is due to fewer occurrences or intentional referrals elsewhere is unclear. Roughly half, 51.7%, have some exposure to counseling someone experiencing a mental health disorder. Counseling someone experiencing spiritual warfare or temptations was effectively split three ways among never or rarely (4.2% and 29.2% respectively), sometimes (32.6%) and often or constantly (25.8% and 9% respectively). Combining the percentages of often and constantly for Question 6, which asked if pastors experienced the Holy Spirit helping them through difficult times, results in a significant 91% of those responding. An even greater percentage, 97.8%, believe their experiences help them counsel others with spiritual experiences at least sometimes, often, or even constantly which may influence their treatment intervention decisions.

Table 4

Pastor Counseling Experiences

	Q1	Q2	Q3	Q4	Q5	Q6	Q7
Never	0.0%	1.1%	7.9%	10.1%	3.4%	0.0%	0.0%
Rarely	1.1%	18.0%	59.6%	44.9%	29.2%	1.1%	2.2%
Sometimes	30.3%	51.7%	25.8%	29.2%	32.6%	7.9%	31.5%
Often	56.2%	25.8%	5.6%	14.6%	25.8%	46.1%	43.8%
Constantly	12.4%	3.4%	1.1%	1.1%	9.0%	44.9%	22.5%

Strategies

To gain insight into pastor strategies for counseling suicidal individuals and their beliefs about dealing with mental illness, including hearing voices and seeing visions, the HE CARES survey asked the following questions:

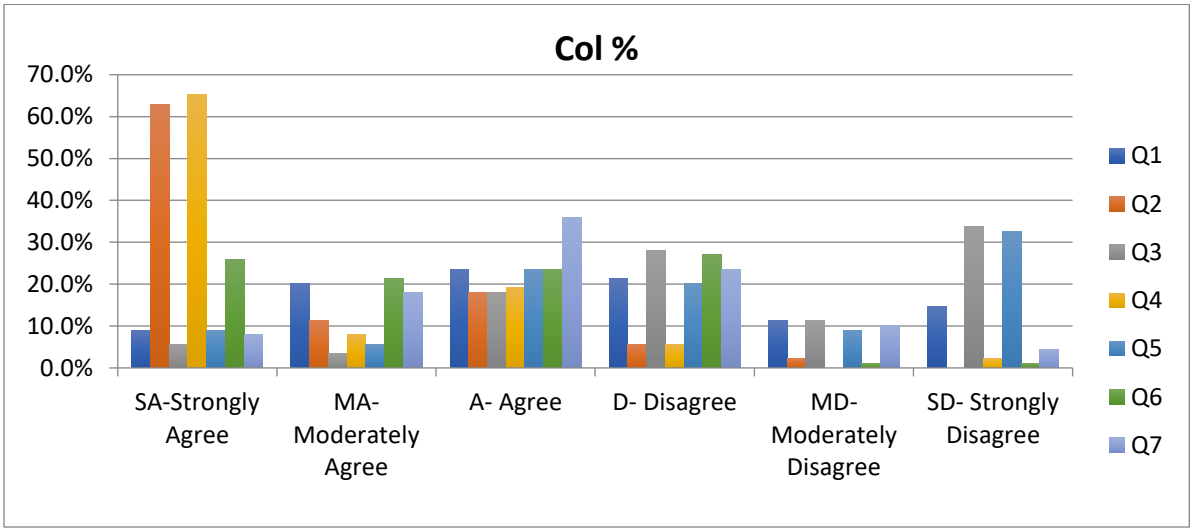
1. The Bible illustrates how to heal people with mental illness. _____
2. Education in mental health counseling is necessary to counsel mental health concerns. _____
3. If a church member told me that they were suicidal, I would counsel them myself. _____
4. If a church member told me that they were suicidal, I would refer them for counseling elsewhere. _____
5. If a church member told me that they were suicidal, I would rely on prayer and guidance from the Holy Spirit on whether to treat them or refer them elsewhere. _____
6. Licensed mental health professionals are better equipped to treat individuals who see visions or hear voices. _____
7. Licensed mental health professionals may not understand the spiritual implications of

seeing visions or hearing voices, resulting in the diagnosis of a psychotic illness. ____

Figure 8 shows pastor responses to these questions. Table 5 shows the corresponding percentages. Slightly more pastor respondents (53%) agree the Bible illustrates how to heal people with mental illness than those who do not (47%). Conversely, 92% believe mental health education is necessary to counsel individuals, indicating that even those who believe the Bible illustrates how to heal mental illnesses also believe that mental health education is additionally necessary.

Figure 8

Histogram of Pastor Strategies for Counseling Individuals



In counseling suicidal individuals, 27% of pastor respondents agreed they would counsel them and 73% disagreed, while 92.2% agreed they would refer them to outside counselors and 7.8% disagreed. Relatedly, 38.2% agreed they would rely on prayer and guidance from the Holy Spirit on how to respond, while 61.8% disagreed. These percentages represent an overlap of responses as they are not mutually exclusive, yet there is a strong indication the majority of pastor respondents would refer a suicidal individual to outside counseling, agreeing that licensed mental health professionals are better equipped for treating those seeing visions or hearing voices

(71%) and disagreeing they would diagnose a spiritual experience as a psychotic illness (62%). Still, 38% of pastor respondents agree such diagnosis of spiritual experiences as psychotic illness may occur and 30% disagree that licensed mental health professionals are better able to help those who see visions or hear voices.

Table 5

Pastor Strategies

	Q1	Q2	Q3	Q4	Q5	Q6	Q7
Strongly Agree	9.0%	62.9%	5.6%	65.2%	9.0%	25.8%	7.9%
Moderately Agree	20.2%	11.2%	3.4%	7.9%	5.6%	21.3%	18.0%
Agree	23.6%	18.0%	18.0%	19.1%	23.6%	23.6%	36.0%
Disagree	21.3%	5.6%	28.1%	5.6%	20.2%	27.0%	23.6%
Moderately Disagree	11.2%	2.2%	11.2%	0.0%	9.0%	1.1%	10.1%
Strongly Disagree	14.6%	0.0%	33.7%	2.2%	32.6%	1.1%	4.5%

Results

Hypotheses

This study, *Who Cares: Suicide and Christian Pastoral Interventions*, has two hypotheses:

H1: Pastors' perceived importance of mental health education will have a positive effect on the number of referrals to mental health professionals, and

H2: Pastors who believe visions and spiritual communication occur today will be more engaged in counseling those with such experiences themselves.

Because we cannot prove any hypothesis absolutely, we must test the null hypotheses where there is no expected effect of the independent variable (IV) on the dependent variable

(DV). For the first hypothesis, the following null hypothesis is applied: H_0: Pastors' perceived importance of mental health education will have no effect on the number of referrals to mental health professionals.

To test this null hypothesis, the HE CARES survey question from the strategies section about the necessity of education in mental health counseling was related to the percentage of mental health referrals to outside counselors reported in Assessments. Figure 9 shows the results. To test this null hypothesis, a Chi-squared test was run with the results shown in Table 6. Assuming alpha $\alpha = .05$, the null hypothesis is rejected, and the alternate hypothesis is accepted.

Figure 9

Histogram of Importance of Mental Health Education & Percentage of Referrals

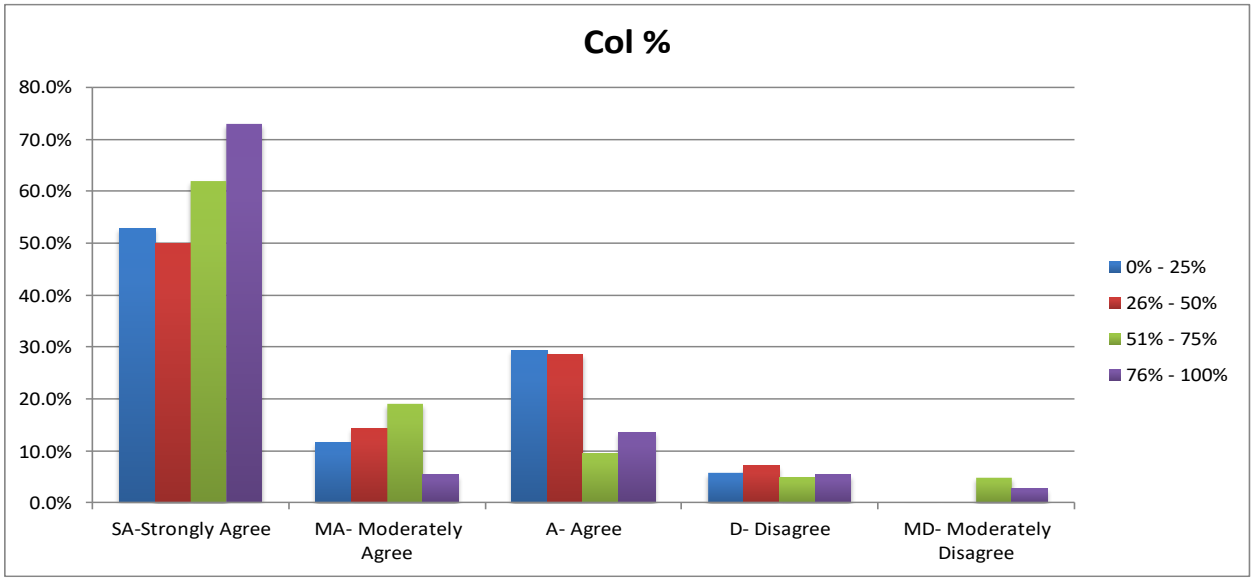


Table 6

Chi-squared Test for Null Hypothesis One

Chi-squared Test	Basic	Advanced
Statistical significance (P-Value)	Not significant	0.75431
Effect Size (Cramer's V)	Medium	0.177221
Sample Size	89	89

Alternate Hypothesis One

The first research question in the survey is, "Do pastors feel equipped to recognize suicidal symptoms and provide counseling?" This question was divided into two parts: (1) Do you feel your education equips you to recognize suicidal symptoms? and (2) Do you feel your education equips you to provide counseling to suicidal individuals? Responses for this first part, 75.28% (67) yes and 24.72% (22) no, are presented in Figure 10. Responses for this second part, 41.57% (37) yes and 58.4% (52) no, are presented in Figure 11. Combining these two parts of the first research question results in the percentages listed in Table 7.

Figure 10

Bar Graph for Suicidal Symptom Recognition

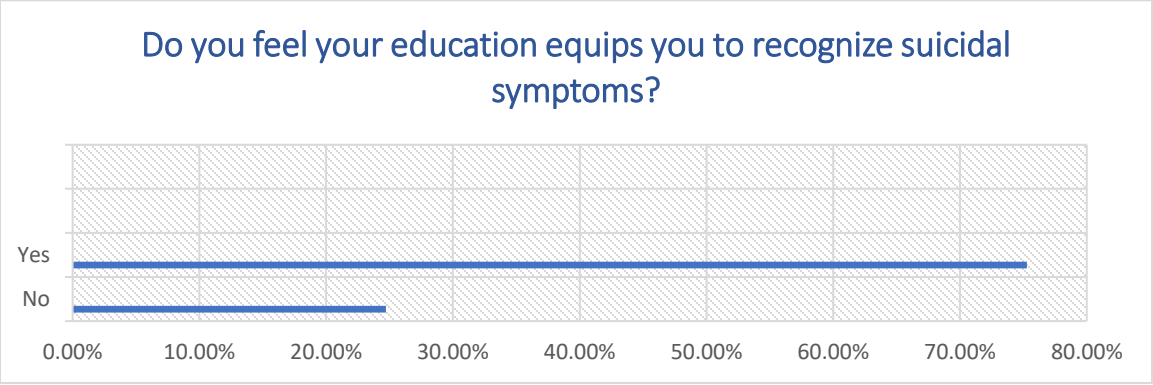


Figure 11

Bar Graph for Counseling Suicidal Individuals

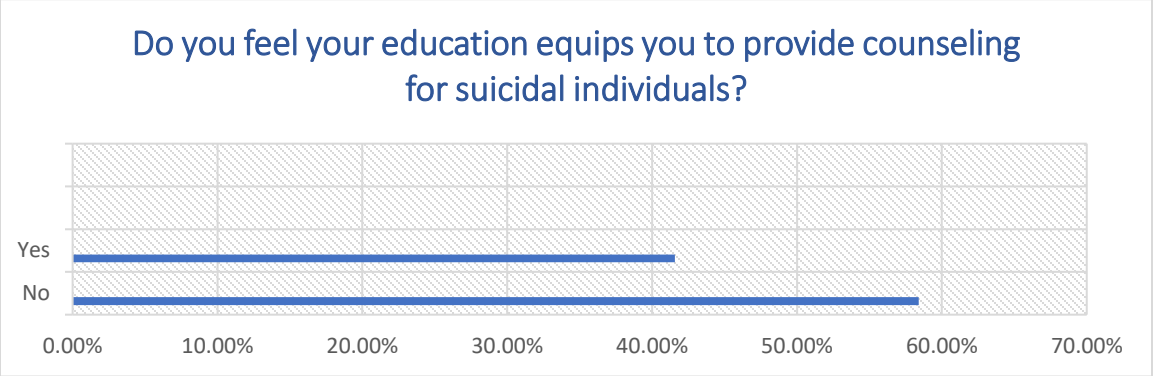


Table 7

Recognizing Suicidal Symptoms and Counseling Suicidal Individuals

		Do you feel your education equips you to provide counseling to suicidal individuals?	
		Yes	No
Do you feel your education equips you to recognize suicidal symptoms?	Yes	92.1%	63.5%
	No	7.9%	36.5%

Qualtrics, utilizing both the Fisher's Exact Test and the Chi-squared test results shown in indicate a statistically significant relationship between these two questions. The Fisher's Exact test provided the effect size of 0.329 for the study's sample size of 89 and a p-value of 0.00240. In addition, Qualtrics computed the degrees of freedom (*df*) for Research Question One, *df* = (2-1) (2-1) = 1, resulting in a Chi-square value of 9.75 and a p-value of 0.00179.

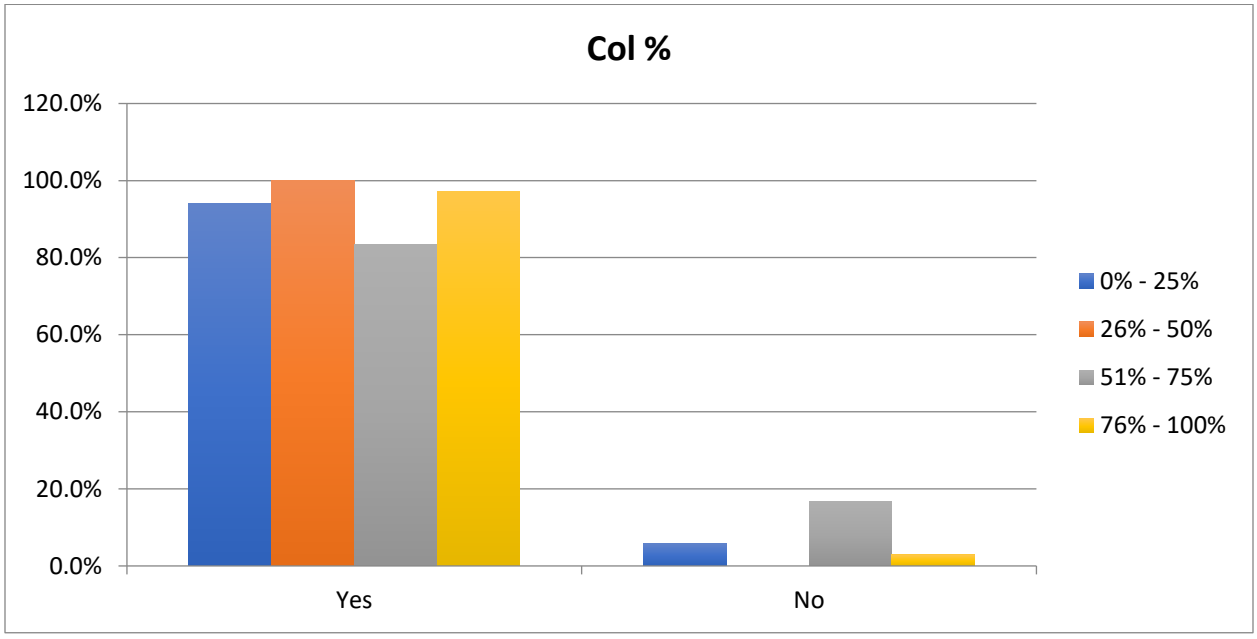
For the second hypothesis, the following null hypothesis is applied: **H_0:** Pastor beliefs about visions and spiritual communications will have no effect on their decision to counsel those with such experiences themselves.

To test this second null hypothesis, we use the HE CARES survey questions, "2) Do you

distinguish between a spiritual experience and a psychotic episode" and "4) Approximately what percentage of individuals seeking your help in regard to spiritual experiences such as visions or prophetic dreams do you counsel?" from the Assessments section. Figure 12 shows the large percentage who said yes does not correspond to a marked effect on the percentage of pastors counseling those with spiritual experiences such as visions or dreams themselves; therefore, we are confident in our rejection of the null hypothesis.

Figure 12

Histogram Comparing Distinction of Spiritual Experiences with Percentages of Pastors Counseling those with Spiritual Experiences Themselves



To test this null hypothesis, a Chi-squared test was run with the results shown in Table 8. Assuming alpha $\alpha = .05$, the null hypothesis should be rejected, and the alternative hypothesis accepted. However, the same survey questions would be used to test the alternative hypothesis, resulting in identical results as the null hypothesis and found not significant. Therefore, the alternative hypothesis two is not supported though it is useful to explore the data percentages and

write in comments from the HE CARES Survey.

Table 8

Chi-squared test for Null Hypothesis Two

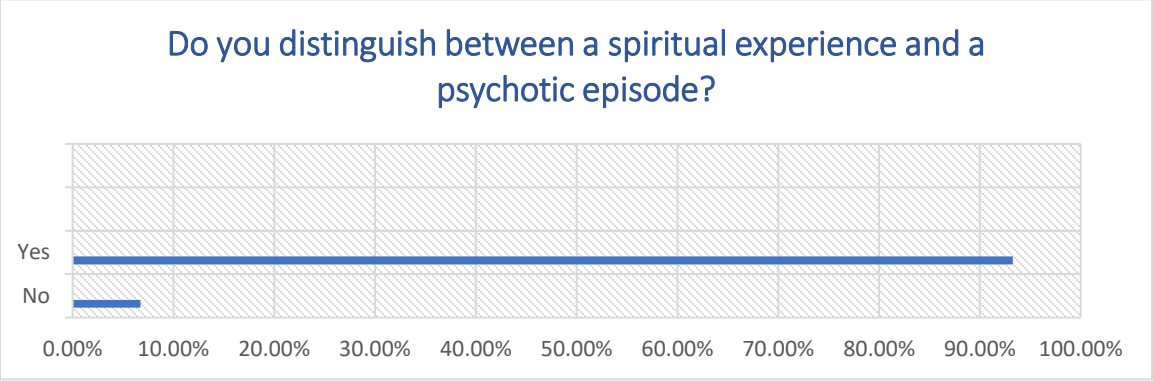
Chi-squared test	Basic	Advanced
Statistical significance (P-Value)	Not significant	0.135089
Effect Size (Cramer's V)	Small	0.249946
Sample Size	89	89

Alternative Hypothesis Two

The alternative hypothesis two addressed in the HE CARES survey includes the following question: Do you distinguish between a spiritual experience and a psychotic episode? Responses of 93.26% (83) yes and 6.74% (6) no are presented in Figure 13.

Figure 13

Bar Graph of Distinguishing between Spiritual Experience & Psychotic Episode

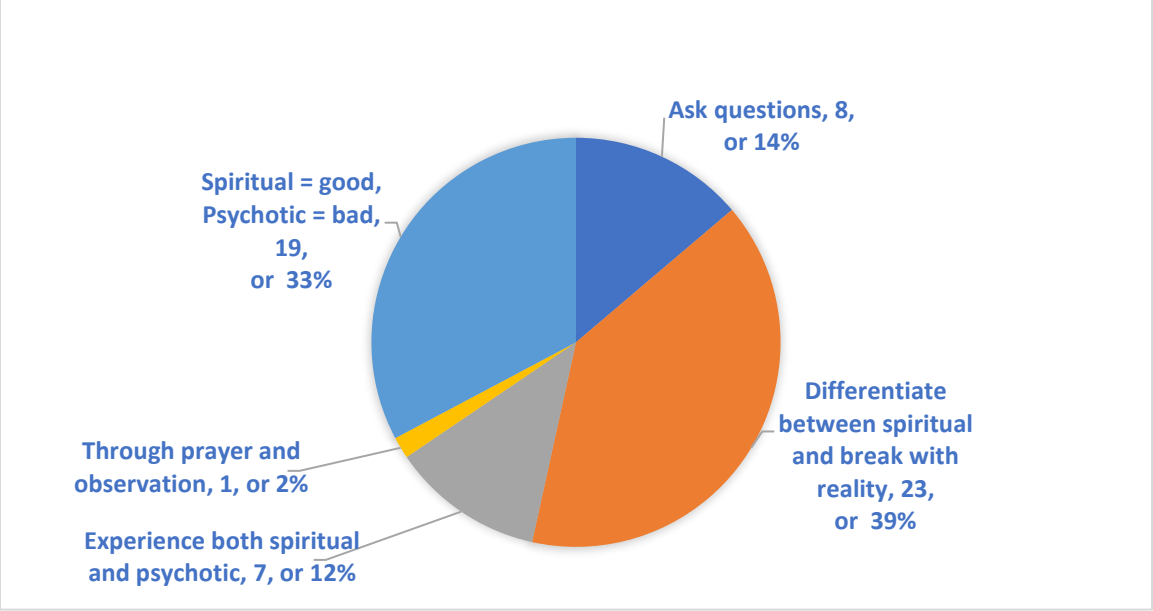


The second research question was, "*How* do pastors distinguish between spiritual experiences and psychotic symptoms?" Of the 83 respondents who answered yes, they could distinguish between spiritual experiences and psychotic symptoms; 63 of them wrote explanations to explain their answers to this question in the provided space. As would be expected, the responses were varied. However, they can be divided into several different

categories: (a) By asking questions, (b) by differentiating between spiritual experiences and breaks with reality or abnormal/irrational behavior, (c) from experience dealing with both the spiritual and mental health issues, (d) through prayer and observation, and (e) expressing the idea that spiritual experiences are "good" and psychotic episodes are "bad." Five respondents answered yes but did not explain how they knew, simply stating they would refer them to outside professional counselors. Figure 14 illustrates these response percentages. Five respondents answered yes but did not explain how they knew, simply stating they would refer them to outside professional counselors.

Figure 14

Pie Chart of Spiritual vs. Psychotic Distinction



Summary

By testing the null hypotheses and rejecting them, the alternative hypotheses were then analyzed through Qualtrics and found to be significant. Additional information was obtained from the data gathered for this study, and it will be further explored in Chapter Five in the implications, limitations, and future recommendations sections, along with comparisons to

studies from existing literature.

CHAPTER FIVE: CONCLUSIONS

"Put on the whole armor of God, that you may be able to stand against the wiles of the devil" (*New King James Bible*, 1982/2013, Ephesians 6:11).

Overview

In this chapter, the two research questions of this study are stated and their results discussed. Comparisons are made to related studies and how current literature agrees or disagrees with those results. Discussion includes how the Integrated Motivational-Volitional (IMV) model of suicide informs counseling and why the results are so important. The implications of this study are discussed, emphasizing the importance of the lives and souls at stake. There were, however, limitations in the study and these are reviewed. No study stands on its own and future recommendations are made. The Christian worldview appears throughout this chapter.

Discussion

The purpose of this study is to survey American pastors regarding their education, belief system, and views on spiritual experiences as they relate to the Christian worldview and how it predicts their interventions for suicide. *Who Cares: Suicide and Christian Pastoral Intervention* introduced two research questions. This section will discuss what the HE CARES survey revealed and how those results relate to current literature, previous studies, and relevant theories.

The first research question, "Do pastors feel equipped to recognize suicidal symptoms and provide counseling for suicidal individuals?" was designed to survey pastors regarding their confidence in recognizing and counseling individuals who present to them with suicidal ideation. This research question was presented in the HE CARES survey in two parts: 1) Do you feel your education equips you to recognize suicidal symptoms? and 2) do you feel your education equips you to provide counseling to suicidal individuals? The results show the majority (92.1%) of

pastor respondents who said they felt equipped to recognize suicidal symptoms also felt confident in their ability to counsel them. It is this confidence which prompted Payne (2014), who believes theological education would not provide adequate training for counseling depressed individuals, to research the type of education—theological or secular—that pastors had completed. Beyond the level of education, the HE CARES education survey question did not distinguish between theological or secular degrees, but the majority of respondents listed theological degrees. Payne's (2014) fear that pastors' feelings of qualification to treat depressed individuals would result in pastors treating those individuals themselves rather than referring them to outside mental health professionals appears unfounded. Payne (2014) found pastor education had no effect on referrals. Likewise, Bledsoe et al. (2013) found 68.9% of clergy have positive positions on referring congregants to outside mental health professionals. Similarly, the HE CARES strategy survey question that asked if a church member told the pastor they were suicidal, 73% responded they would most likely refer them for counseling elsewhere, supporting both Payne's (2014) and Bledsoe et al.'s (2013) research findings.

Who Cares: Suicide and Christian Pastoral Intervention is a look into how pastors provide treatment to individuals who are experiencing distress and contemplating suicide. One of those treatments is referral to outside mental health counselors. Payne (2014), in concession to the need for improved pastoral mental health training, encouraged accommodation to a variety of religious and cultural viewpoints, arguably influenced by secular education. Haynes (2016) calls for an integrated approach to counseling even though he believes many psychologists relegate spirituality to the mind alone and the religious question psychological thinking. Still, Haynes believes the psychotherapist, in order to help others, must first have experienced their own spiritual awakening and discovery of their "true" self. In contrast, the HE CARES survey

required pastors agree they hold to the Christian worldview before they could continue, endeavoring to lay the foundation of Christ before all else in order to present a common relationship that instills the trust and confidence necessary to provide hope and healing. For without Him, who determines what truth is?

How does this relate to current models of suicide? The IMV model stresses the importance of the motivational phase on the perception of entrapment or the feeling there is no way out of a situation (O'Connor & Kirtley, 2018). O'Connor and Kirtley pinpoint the motivational phase as critical in determining whether or not ideation leads to suicide attempts or completions based on the presence of positive or negative moderators. Literature reveals that both groups, pastors and mental health professionals, present complications for those in need of their care at the most critical phase of the IMV model.

Relevant literature presents pastoral counseling in both a positive and negative light, as does literature regarding mental health professionals' attempts to incorporate spirituality into their counseling toolboxes. Payne (2014) admits pastors often find themselves performing crisis interventions, reporting that two out of three pastors have had contact with suicidal individuals, but believes they are not qualified to do so. In such a crisis, Payne recommends referral to outside mental health professionals over additional training for pastors which may simply encourage a pastor to intervene themselves but acknowledges that such additional training is still necessary given the pastor's role in the community.

In other literature, Bledsoe et al. (2013) listed the potential negative results of pastoral care as abandonment, classifying spiritual experiences as "demonic" and subsequent mental illness as a result, and explaining sin's occurrence as a lack of faith. Khosa-Nkatini and Buqa (2021), based on a literature review, conducted a dialogue between psychology and Christianity

that is more a dichotomy of beliefs regarding suicide. In their discussion, the Christian view of suicide as a sin—though this may provide a protective factor—is problematic and the conflict created socially over issues such as homosexuality are detrimental to individual acceptance which may lead to depression, and subsequently, suicide, whereas the psychotherapists analysis of suicide or suicide attempts as a mental illness are more compassionate (Khosa-Nkatini & Buqa, 2021).

Sami et al. (2021), in an effort to explore the positive influence of religion and spiritual integration with psychotherapy, highlight the mental health practitioners' frustration at the reality of being unable to meet every diverse spiritual need due to lack of education and secular reductionism to outcomes prevents its implementation.

Kocet and Herlihy (2014) review the conflicting interpretations of whether referring for a conflict in values—suicide in the Catholic faith for example—represents a competence-based referral or discrimination. The literature, though often contradictory regarding referrals, suggested strong values of a counselor required a change of profession (Kocet & Herlihy, 2014). The alternative, being counseled by a pastor, was thought to be a positive choice that would introduce the needed biblical context to understand one's situation and provide a more successful outcome. The results of the HE CARES survey, however, on the whole, do not suggest this to be the case. The majority of Christian worldview respondents, though believing themselves capable of identifying suicidal symptoms and distinguishing between psychotic and spiritual experiences, were more likely to refer the individuals presenting with them to outside mental health professionals.

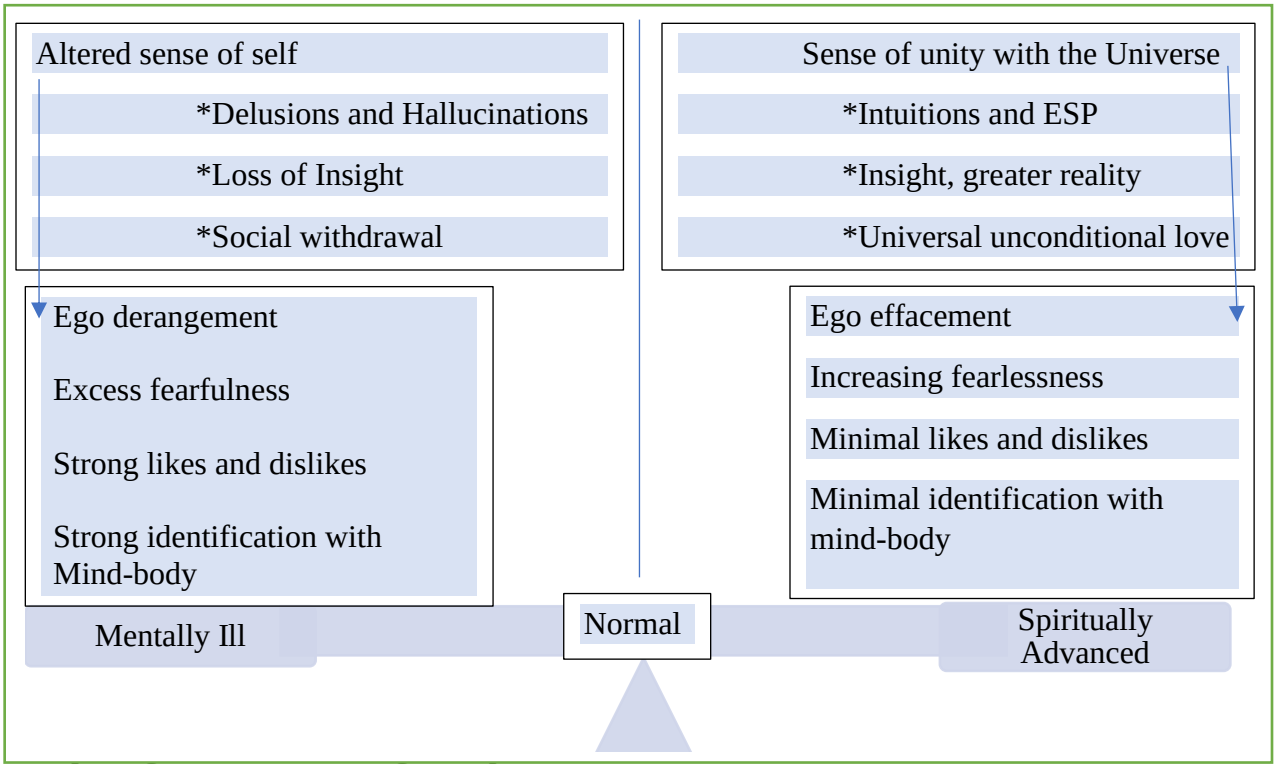
Bolger and Prickett (2021) explore the limitations of overwhelmed pastors to meet the mental health needs of their parishioners in Black and Latino communities, describing it as

outside of their scope. Yet, their parishioners seek them out for mental health issues to avoid being labeled “crazy” by mental health professionals (Bolger & Prickett, 2021). According to Bolger and Prickett, Black parishioners avoid connecting mental health with spiritual explanations, while Latinos see mental health stigmas as directly related to the spiritual and believe they must project a front of strong faith to avoid being characterized as spiritually weak or demon controlled through attacks of the mind.

It is at this point in the discussion of who is better able to care for Christians facing suicidal ideation that observations and beliefs regarding spiritual battles comes to the forefront. The second research question in this study is: Do pastors distinguish between spiritual experiences and psychotic episodes? Respondents to the HE CARES survey overwhelmingly answered that they could (93.2%). While most of the respondents agreed they could distinguish between the two, not all explained what that distinction involved. Particularly noticeable was that 19 of the 83 respondents who said yes thought the spiritual experiences must be pleasant and hopeful whereas the psychotic ones must be unpleasant and threatening. A similar theory was presented by Bhargav et al. (2015) in a continuum chart of the modes of reflective consciousness simplified in Figure 15. Satan was allowed to harm Job just short of death (*New King James Bible*, 1982/2013, Job 1:8-12) and the temptation of Jesus in the wilderness (Matthew 4:2-3) that resulted in angels coming to care for Him (Matthew 4:11) are but two examples from Scripture that contrast these conclusions.

Figure 15

Diagram of Mentally Ill vs. Spiritually Advanced



Lukoff (2007, 2019) and Goldblatt et al. (2016) discovered both religious institutions and mental health organizations, perhaps unwittingly, encourage silence from those suffering from seeing visions or hearing voices. Strauss et al. (2018) argue such mental distress may be transformative whether or not medical or religious authorities consider them pathological, suggesting that just such labeling occurs. Lukoff (2007, 2019), however, points out the importance of whether that first diagnosis is positive, resulting in personal growth, or negative, resulting in isolation and dejection. These are just the sort of motivational moderators in the IMV model that can potentially determine the outcome of survival or suicidal action in the volitional stage.

Current literature shows that Jung's (2020) conviction that belief in Satan results in

psychiatric disorders and requires a corresponding strong attachment to God to overcome also implies the opposite—that there is no need for God if Satan does not exist in one's belief system. In this way, spirituality is defined by each individual and does not include any absolute truth.

Ouwehand et al. (2019) studied spiritual experiences in patients with bipolar disorder, remarking that these experiences may be viewed as pathological in the medical field. Interestingly, Ouwehand et al. found the self-reports of patients with bipolar disorder who experienced spiritual or religious occurrences were comparable to the frequencies occurring in the general population.

The HE CARES survey questioned pastors about the frequency of counseling individuals under different circumstances. The most relevant to this second research question and the responses were as follows: (a) Counseling someone with a mental health disorder- Rarely 18%, Sometimes 51.7%, and Often 25.8%; (b) Counseling someone who has experienced psychotic symptoms such as auditory or visual hallucinations- Rarely 59.6%, Sometimes 25.5%, and Often 5.6%; (c) Counseling someone who has experienced a prophetic dream or vision- Rarely 44.9%, Sometimes 29.2%, and Often 14.6%; and (d) Counseling someone who has experienced spiritual warfare or temptation- Rarely 29.2%, Sometimes 29.2%, and Often 25.5%.

Implications

Picking up a newspaper, turning on the television, or scrolling through social media make it impossible to ignore the importance of this study's discussion—more than one respondent thanked me in the comments section of the HE CARES survey, stating the necessity of this conversation. Whether it is suicide by Christians battling depression or rock stars finding emptiness in their fame, the struggle to hold on is real.

Sadly, Naomi Judd passed away on April 30, 2022, one day before she and her daughter

Wynonna were to be inducted into the Country Music Hall of Fame. Her family officially announced her death was the result of her mental illness. Subsequent speculation is that she died by suicide. Regardless of the forthcoming details, Naomi herself, was an advocate for those suffering from depression and in 2018, along with physician Dr. Daniel R. Weinberger, wrote a letter calling for more resources to study and prevent suicide (Rosenblatt, 2018). During her speech to accept their nomination into the Country Music Hall of Fame, Wynonna Judd, along with her sister Ashley, recited Psalm 23, sharing this was also done in their last moments with their mother Naomi (Blisten, 2022). Days later, Ashley Judd, knowing an autopsy was forthcoming, revealed in a television interview, that her mother Naomi had shot herself with a firearm while Ashley momentarily left her alone to welcome a visiting friend (Romano, 2022).

Greg Laurie, an American pastor, recently authored a book on Rock and Roll Legends that explores the faith of many famous singers and the high percentage of overdose deaths and suicides among them (Giatti, 2022). He explores their faith and concludes that fame and fortune do not lessen their burdens, but just may compound them. The solution to combat these fatal outcomes, Laurie explains, is a relationship with Jesus Christ (Movieguide, 2022). So why are pastors reluctant to engage?

One respondent to the HE CARES survey stated it would be illegal for them to treat an individual with suicidal ideation. Mental health professionals are required to carry insurance coverage against lawsuits. Such insurance coverage may be cost prohibitive for some pastors, making referrals to outside mental health professionals more a reflection of avoiding potential consequences of treatment than a lack of trusting in God’s power to heal.

Who Cares: Suicide and Christian Pastoral Intervention has confirmed there are no easy answers for those attempting to counsel individuals in need, particularly those contemplating

suicide. Both pastors and mental health professionals show signs of human fallibility. However, for Christians, the common denominator should be a foundation grounded in love for Christ and a love for others. Christian pastors and licensed Christian counselors are members of the same family. Families squabble and fight for position. The family counselor is sometimes required to intervene through confrontation. In the case of Christians, the family counselor is Jesus (*New King James Bible*, 1982/2013, Isaiah 9:6). The technique of confrontation can be very effective. This researcher's Clinical Mental Health Counseling master's program included a mock therapy session where confrontation of one family member was initiated just until the second one appeared to become convinced they were in the right. Then, the tables were turned, and they were confronted. The order of confrontation did not matter because both members required it. This research has produced a similar phenomenon of thought reminiscent of Jesus asserting He did not come to bring peace, but a sword and that one's enemies would include family members (Matthew 10:34-36). Hebrews 4:12 reminds Christians the Word of God is sharp and double-sided, capable of proper discernment. If most licensed Christian counselors are willing to put ACA guidelines above the Word of God, and most pastors are content to let them do it, then who cares for Christians seeking help for suicidal ideation?

There is much talk regarding the times that we live in today. Many Christians agree we have reached 2 Timothy 3:1-5 that lists the many attributes of man that will signal the last days; one of those characteristics is denying the power of God (*New King James Bible*, 1982/2013). But God's compassion is great, and He does not wish for any to perish, but rather that we come to Christ in repentance (2 Peter 3:9). Yet, Paul asks one important question that all Christians, including counselors, should consider: How will they know of Christ's salvation if you do not tell them (Romans 10:14)?

Concerning counseling Christians, other important questions must be asked: How will they know how to fight spiritual battles if they are told or believe they do not exist? A spiritual battle requires spiritual weapons. Jesus said, "The thief does not come except to steal, and to kill, and to destroy" (*New King James Bible*, 1982/2013, John 10:10). Those weapons must be used daily. Paul detailed those weapons in Ephesians 10-13, emphasizing their necessity to fight against wicked powers in the spiritual realm. The fight requires more than a recitation of scripture and referral to mental health counselors with the ability to prescribe medication. It requires help from others, interceding on their behalf, unashamed to call on the Lord for help and guidance in every situation. Much speculation has been given to the thorn in Paul's flesh which he called, "a messenger of Satan to buffet me" (2 Corinthians 12:7). Whatever the thorn, it is apparent Christians do not escape hardship. In fact, they are Satan's targets. His tactics might change, but the goal is still the same—division and destruction. Christian counselors, pastoral or otherwise, need to pay attention. This study highlights the importance of discerning spiritual experiences, good or bad, from psychotic episodes. It has given a voice to pastors, inviting them to join the conversation with their insights and faith.

Limitations

The majority of pastors contacted for this study were identified through their own church websites. During the process of collecting qualifying emails for pastors of the identified denominations, it became apparent that the beliefs shared by what were considered groups of one faith were not as well defined as previously thought. The importance of defining terms at the outset became apparent but doing so did not ensure like-minded interpretation of those definitions, nor did a Christian worldview. In particular, some researchers have abandoned the term Christian worldview in favor of Biblical worldview as the former, according to their

findings, defined this view as merely doing good or having good intentions rather than the latter which represents a closer connection to Biblical tenets, including a relationship with Jesus Christ, and warns against the assumption that pastors have a biblical worldview (Barna, 2022).

This idea was certainly supported by this research, where it was suggested there are multiple Christian worldviews, one pastor revealing that persecution of the Christian was not a part of their Christian faith even though it is demonstrable within the Biblical worldview. Another could not understand why holding the Christian worldview was presented versus the term Christian, as if these were competing and opposing outlooks. These responses show evidence of what Barna (2022) describes as syncretism, where people pick and choose from opposing worldviews without concern for the contradictions.

Years of researching suicide, reviewing modern suicide models, and months of collecting survey results from American pastors, has only strengthened this researcher's conclusion that God is the One who cares. This entire research process has been reminiscent of an excruciatingly long mathematical calculation that was performed by my high school math teacher on the blackboard. When he heard me muttering under my breath, he asked if there was a difficulty. When presented with a two-step solution and asked why the problem had to be more complicated, he looked at it and exclaimed with an expletive that it beat his solution without question, and he pardoned my interruption to his teaching.

This is not to suggest there is only a one-size-fits-all approach to reach hurting people who are considering suicide. But the Bible assures us there is only one way to reach the one source of all healing and that is through Jesus Christ. Therefore, the inclusion of this spiritual component to the suicide model seems to be a necessary addition.

Still, we begin to see why there has been little success in integrating Biblical truth with

psychotherapy. While Christians have compromised with culture and the media has played a role in reducing stigmas for one group, attacks against those who disagree based on biblical teachings are now on the receiving end. As more pastors change their views regarding what the Bible teaches, it makes sense that more referrals will be made to outside counseling, resulting in less overall help-seeking by Christians.

That said, another possible reason for the high number of responses that said they would choose to refer to outside counselors rather than counseling the individual themselves is faking good. Knowing this survey originated from a doctoral candidate at Liberty University may have prompted a reply based on expectations that mental health referrals would be considered the correct answer.

Recommendations for Further Research

The current suicide statistics need to be updated; however, recent events have created distrust in regard to the reliability of such statistics as every area of our lives continues to be politicized. The term mental illness has crept back into the discussion of suicide involving famous people such as Naomi Judd. What this will do to the trend away from mental illness as a suicide explanation has yet to be seen, particularly given the fatal outcome of Naomi's struggle. Outspoken dialogue may lessen the stigma surrounding mental illness, but the general term may also increase its diagnosis, doing little to pinpoint specific causes and symptoms or providing effective treatment. For self-proclaimed Christians, where might their spiritual battles fit into the mental illness designation? Future studies should seek to answer this question.

As discussed earlier in Chapter Five, the distinction between Christian and Biblical worldview needs to be clarified. Even so, there may be different interpretations within the Biblical worldview community as well that would need to be clearly defined before a new study

was attempted. McMartin (2015) states therapy is not eternally oriented. This is a problem, especially for believers in Christ.

Summary

To create a one-size-fits-all model of suicide prevention, the biblical perspective is required; yet this is impossible for those who do not believe. The topic of this research is suicide and Christian pastoral intervention. The common suicidal signs of isolation, loneliness, failed perfection, thwarted belongingness, and perceived burdensomeness are all addressed when faced with the living Christ. The culture does not define Christians, Christ does. He *is* the motivating moderator. The challenge of creating a suicide model that includes a preventative spiritual component is met with sharing the gospel. Knowing there is a God that loves us so much that He sent His son Jesus to earth to be born of a virgin, to teach and heal people, then to die on a cross for our sins, rising on the third day that we might receive salvation through the forgiveness of our sins if we repent and turn from those sins changes everything. Believing in Him is the beginning of the healing process.

Who cares? God is the One who cares. Jesus is His intervention. He gives grace and mercy and protection to those who are blessed to know His Son Jesus as their Lord and Savior. Without that hope, there is no end to pain and suffering. The last part of Psalm 2:12 from an English translation of the Hebrew language may best describe Christ's intervention: "O the blessings of all who are fleeing to Him for refuge!" (Green, 1985/2011).

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APPENDIX A: Consent Form

Dear (Recipient):

As a graduate student in the School of Community Care and Pastoral Counseling at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The purpose of my research is to research whether pastors feel equipped to recognize and counsel those with suicidal symptoms and how they distinguish between spiritual experiences and psychotic symptoms, and I am writing to invite eligible participants to join my study.

Participants must be 18 years of age or older and currently pastor a Christian/Biblical worldview church. Participants, if willing, will be asked to complete a short survey received and then submitted via email. It should take approximately ten minutes to complete the procedure listed. For practical purposes, names and email addresses will be used during this research, but the information will remain confidential.

In order to participate, please complete the attached survey and return it by (date).
A consent document is provided as the first page of the survey. The consent document contains additional information about my research. You do not need to sign and return the consent document, simply read and continue on to the survey to indicate that you have read the consent information and would like to take part in the survey.

Please forward this email to the appropriate members of your organization for their consideration.

Sincerely,

Debra Averitt
Doctoral Candidate
[redacted]

Informed Consent

Invitation

Your participation in a research study about the education and experience of pastors and how it relates to counseling church members who seek help for depression and mental distress, particularly those who express suicidal ideation is requested. This invitation is for adults who are currently pastoring a Christian/Biblical worldview church.

Implementation

This study is being implemented by Debra Averitt, Doctoral Candidate, Liberty University.

Purpose

The purpose of this study is to survey American pastors regarding their education, beliefs, and spiritual experiences as they relate to the Christian worldview and how it predicts their interventions for suicide.

Private Survey

If you consent to participate in this study, you will be asked to answer a short survey delivered by email and returned by the specified date. Information obtained will be separated from email address to assure anonymity. Some questions represented in the study are as follows:

1. What is your current denomination? _____
2. What is your education level? _____

In addition, there are questions that you answer using a scale:

1. I have counseled someone who has experienced a prophetic dream: _____

   Never-1, Rarely-2, Sometimes-3, Often-4, Constantly-5

2. The Bible illustrates how to heal people with mental illness _____

   Strongly Agree-SA, Moderately Agree-MA, Agree-A, Strongly Disagree-SD,

   Moderately Disagree-MD, Disagree-D

Voluntary Participation

Participation in this study is voluntary. You may decline to answer any questions that are disagreeable to you. You may discontinue participation at any time if you feel discomfort.

Risks and Benefits

The risks of this study are related to your own experiences regarding the subject of suicide. Daily

life introduces this topic in movies or on TV shows, or as real events reported in the news. Similarly, being asked questions about depression and suicide in this survey may trigger an unanticipated response that is distressing due to past experiences and unresolved issues related to them. If this occurs, you may discontinue your participation in this study and are encouraged to seek help.

The potential benefit of this study is increased awareness of suicide ideation and decreased stigmatization that encourages improved communication and the development of new Christian interventions to address and prevent suicide. There is no other direct benefit or compensation.

Contacts

If you have any questions or concerns regarding this study, you may email Debra Averitt at (personal email removed for publication). Should you wish to speak with someone else regarding concerns or questions you may have, you may contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Your Consent

By answering and returning the attached survey by email, you are agreeing to participate in this study and are acknowledging that you have read and understood this document of informed consent.

Thank you for your consideration to participate in this important research study.