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Suicide Related Phenomena:
Suicide Risk, Suicidal Behavior, "Mimic" Suicidal Behavior

Important Disclaimer: There are thousands and thousands and thousands of pages written on the assessment and management of suicide risk. This essay is NOT a thorough or complete discussion of how to evaluate and care for suicidal risk. It cannot take the place of mental health training, and it cannot take the place of the discernment/clinical judgment of the minister/therapist actually working with each specific person receiving ministry.

Caveat: I have tried to write this essay for both lay ministers and mental health professionals. Mental health professionals may find some material that is too basic/repetitive. Lay ministers may find some material that is more detailed/technical than they need.

I. Introduction: Many people (and especially lay ministers) are intimidated if a person receiving ministry mentions suicide, or makes a comment that even *might* allude indirectly to the possibility of suicide. In some situations, suicide-related phenomena *are* very complicated, and understandably intimidating. Many different factors can contribute to suicide-related phenomena, including traumatic memories (with their associated truth-based pain, lies, disruption of personality structure, impairment of coping skills, etc.), sinful choices, truth-based pain and other stressors in the present, substance abuse, psychosis from mental illnesses such as schizophrenia, and demonic oppression. Difficult cases often involve many of these together.[1] In addition to some situations being complicated, suicide-related phenomena can also be very intense. Suicide-related phenomena can involve some of the most desperately unhappy, desperately wounded, desperately ill, desperately needy people in the world. And the stakes are high – the life of a person. There is no way to make the whole subject of suicide-related phenomena simple or easy. There will always be some situations where suicide-related issues are complex and difficult (even if you understand all the material in this essay).

Furthermore, the liability and other issues involved, the impossibility of being in control or guaranteeing safety, and the emotional intensity of suicide-related situations usually trigger the therapists/ministers involved. I know that in my own experience, being triggered by suicide-related issues makes it harder for me to think clearly, and thereby makes the issues seem more confusing and overwhelming. My expectation is that many people will be triggered just by reading the material in this essay.

Even so, as I have thought carefully about different aspects of suicide-related phenomena, carefully studied the research, and especially as I have worked with suicide-related phenomena in the

[1] We are personally familiar with only a small number of people who have actually completed suicide. Two of these people who completed suicide had major unresolved traumatic memories, lies, impaired coping skills, sinful choices, major truth-based pain and stressors in the present, demonic oppression, and schizophrenia with active psychosis. One of these two patients was also abusing crack cocaine.

context of more effective emotional healing ministry,[2] I have been pleasantly surprised to discover more understandable patterns and principles than I initially expected.

The general purpose of this essay is to dispel some of the confusion and intimidation regarding suicide-related phenomena by showing how some aspects of suicide-related phenomena are not as complicated, difficult, or dangerous as they are often perceived to be. I am also hoping that the reader will see that the *overall subject* isn't quite as overwhelming as he has thought it to be. Specific goals include:

- Help lay ministers understand and identify situations where the initial perception of suicide risk is usually greatly exaggerated, or where suicidal danger is completely illusory (the "safe" end of the suicide risk spectrum, and also "mimic" suicidal behaviors). Hopefully this will help lay ministers avoid unnecessary intimidation, unnecessary stress, and unnecessary referrals/interventions.

- Help lay ministers know when to obtain consultation from (and/or refer to) mental health professionals.

- Provide practical tools (ministry aids) that will be helpful to both lay ministers and mental health professionals in working with suicide-related phenomena.

II. True suicidal behavior vs. "mimic" suicidal behavior: One of the most important distinctions to help make sense out of suicide-related phenomena is to separate "mimic" suicidal behavior from "true" suicidal behavior.

A. "Mimic" suicidal behaviors: What I call "mimic" suicidal behaviors *appear* to be statements of suicide intent and/or suicide attempts, but actually have nothing to do with consideration of suicide, desire to commit suicide, or intent to commit suicide. As discussed below, mimic suicidal behaviors include self mutilation, "cry for help" statements of suicide intent/suicide gestures, relational leverage suicide threats/gestures, and hostile-punitive suicide threats/gestures.

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[2] By *more effective* emotional healing ministry, we mean Christian emotional healing ministry that consistently and reliably enables the person receiving ministry to get *experiential, permanent* resolution of their emotional and spiritual issues *at the level of root memories*. The clearest examples of this are Eye Movement Desensitization and Reprocessing (EMDR) in combination with healing prayer, and Theophostic® Ministry; however, "more effective emotional healing ministry" could also include other Christian healing ministries that include the same core "active ingredients." We specifically are *not* referring to emotional healing ministries and psychotherapy methods that do not include the core "active ingredients" of EMDR with prayer and Theophostic® ministry (in our experience, these other emotional healing ministries and psychotherapy methods yield only occasional and inconsistent results). We use "more effective emotional healing ministry," "effective emotional healing ministry," and "emotional healing ministry" interchangeably, and will specifically note if we are referring to other emotional healing ministries or psychotherapy methods. For a careful discussion of the similarities and differences between Theophostic® Ministry, EMDR with prayer, "traditional" emotional healing ministry, and other psychotherapy methods, see "Theophostic® Ministry: Assessment and Recommendations," "Theophostic®, What is Unique?," "Compare and Contrast: EMDR, 'Traditional' Prayer for Emotional Healing, Theophostic® Ministry, and Cognitive Therapy," "Cognitive Therapy and Theophostic® Ministry," "Exposure Therapy and Theophostic® Ministry" (forthcoming), and "Theophostic® and EMDR: FAQs and Common Misunderstandings," all on the Articles and FAQs page of www.kclehman.com.

It is very important to understand and recognize "mimic" suicidal behavior because *many* apparent statements of intent and apparent suicide attempts are actually not true suicidal behavior. The overall rate of suicide attempts is 10-20 times the overall rate of completed suicide. Furthermore, there are two[3] small groups of suicide attempters where completed suicide is highly concentrated: individuals over 65 years of age account for a small proportion of suicide attempts but a large proportion of completed suicides (women over 65 make only 3 attempts for each completed suicide, and for men over 65, almost 90% of suicide attempts end in completed suicides[4]); similarly, suicide attempts with firearms account for a small proportion of suicide attempts but a large proportion of completed suicides (80-90% of suicide attempts with firearms end in completed suicide[5], and in the United States, firearms account for more than half of all completed suicides – for more completed suicides than all other methods combined[6]). Note also that these two especially high risk groups are almost never the suicide attempters that we work with in therapy/ministry. Of the hundreds of apparent suicide attempts I have worked with, none of the people have been over 65 years old, and only one of the attempts was made with a firearm (a very serious, true suicide attempt). This means that, in my personal professional experience, less than 1% of the people who have made apparent suicide attempts were in these especially high risk groups. When these two groups where completed suicide is highly concentrated are removed from the pool, the ratio of apparent suicide attempts to completed suicides for the remaining suicide attempters is about 100 to 1. One study found that in 15-24 year old women in France, there was only 1 completed suicide for every 160 apparent attempted suicides.[7]

All unsuccessful attempts are not necessarily mimic suicidal behavior, since ambivalent attempts, accidental failure, and supernatural intervention contribute, but this 100 to1 ratio[8] is certainly consistent with many apparent suicide attempts actually being mimic suicidal behavior. Kaplan & Sadock's *Comprehensive Textbook of Psychiatry, sixth edition* states: "most attempters do not actually wish to commit suicide," and "Those who attempt suicide

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[3] There is partial overlap between these two groups. ¼ - a of firearm suicides are committed by persons over 65. See Romero MP; Wintemute GJ. "The epidemiology of firearm suicide in the United States." *J Urban Health* 2002 Mar; 79(1):39-48

[4] Kaplan, HI and Sadock, BJ. *Comprehensive Textbook of Psychiatry, Sixth Edition, CD ROM.* (Williams and Wilkins: Baltimore, MD) 1996; Chapter 30:1, Psychiatric emergencies: Suicide: Attempted suicide.

[5] One study shows 89% lethality (Cummings P; Le Mier M; Keck DB. "Trends in firearm-related injuries in Washington State, 1989-1995." *Ann Emerg Med* 1998 Jul; 32(1):37-43). Another shows 83% lethality (Beautrais AL; Joyce PR; Mulder RT. "Access to firearms and the risk of suicide: a case control study." *Aust N Z J Psychiatry* 1996 Dec; 30(6):741-8).

[6] One study of completed suicides in the U.S. found firearms as the method of death in over 50% (Miller M; Azrael D; Hemenway D. "Household firearm ownership and suicide rates in the United States." *Epidemiology* 2002 Sep;13(5):517-24). A study of completed suicides in Georgia found firearms as the means of death in **70%** of completed suicides (Birkhead GS; Galvin VG; Meehan PJ; O'Carroll PW; Mercy JA. "The emergency department in surveillance of attempted suicide: findings and methodologic considerations." Public Health Rep 1993 May-Jun;108(3): 323-31).

[7] Kaplan, HI and Sadock, BJ, Chapter 30:1, Psychiatric emergencies: Suicide: Attempted suicide.

[8] As noted above, this 100 to 1 ratio is for the remainder of suicide attempts, excluding attempts by individuals over 65 and attempts made using firearms.

and those who commit suicide represent different populations, with some overlap."[9] This is consistent with my personal professional experience. I have cared for hundreds of patients who have made suicide attempts, and cumulatively these patients have made thousands of apparent suicide attempts. Only two of these thousands of apparent suicide attempts have actually resulted in completed suicide.

Observing apparent suicide attempters carefully over time has provided clues and confirmations that many of these attempts were indeed mimic suicidal behavior. For example:

- I evaluated patients in the emergency room who adamantly claimed they were seriously depressed and suicidal, some just threatening suicide if they were not admitted, but others also claiming they had made a suicide attempt (for example, claiming medication overdose or displaying very superficial lacerations to their wrists). Amazingly, an hour later they appeared to be completely normal, happily settling into the psychiatry ward – enjoying their clean beds, television, and "free" food.

- I have worked with patients who had cut themselves literally hundreds of times. The lacerations were deep enough to leave significant scars, and sometimes even required stitches, but never caused life threatening bleeding. Most of these people clearly described self mutilation thoughts and emotions, and acknowledged that they had not wanted or intended to commit suicide. However, others insisted that the many, many episodes of self cutting had been true suicide attempts. One thought that would always come to me was "How could you think cutting in this way could have any chance of killing you, since you have already tested it hundreds of times and proven that it is not actually dangerous?"[10]

- I have worked with patients who were admitted many times for "overdose" suicide attempts, each time taking a large dose of the same "safe"[11] medication, and then immedi

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[9] Kaplan, HI and Sadock, BJ. *Comprehensive Textbook of Psychiatry, Sixth Edition, CD ROM.* (Williams and Wilkins: Baltimore, MD) 1996; Chapter 30:1, Psychiatric emergencies: Suicide: Attempted suicide

[10] Marked dissociation makes the clinical picture more complex and more confusing, and especially contributes to situations where all the other evidence indicates a mimic attempt, but the person insists they were truly attempting suicide. It is especially helpful, in these complex clinical situations, to realize that multiple unsuccessful suicide attempts still almost always indicate "mimic" suicide attempts. The "suicide part" (or the person's presenting consciousness when this part is forward) will insist "I really wanted to kill myself." But the person always chooses to get help after making the purported "true suicide attempt," and the person always chooses to use a "safe" method, where rescue is predictable and where the attempt does not cause significant lasting damage. To me, this indicates that the person's *whole mind* has clearly not decided to complete suicide. One way of interpreting this complex picture is to think of the person's *whole mind* as not truly wanting to commit suicide, but rather having a deeper, underlying purpose for allowing the "suicide part" to "attempt" suicide. This picture can appear so confusing because the person's usual presenting conscious mind may have the subjective experience of making "true" suicide attempts with the intent to die. The person's usual presenting conscious mind may not be aware that the attempts are mimic, and may not be aware of the true underlying agenda (for example, self punishment, cry for help, relational leverage, punishing others). The good news is that all of this will stop when the underlying issues are resolved.

[11] Some medications are absorbed and cause fatal effects quickly, making it difficult to "rescue" the person attempting suicide. Other medications are much less dangerous for overdoses, in that they can be removed from the stomach and/or their effects can be reversed, even hours after being ingested. Still

ately calling or coming to the ER for medical care. Again, I couldn't help noticing that these patients had already proven many times that this particular overdose scenario was quite "safe."[12]

- I have worked with patients who were initially assessed as suicide attempts, but then reported that they took a dangerously large dose of a medication they knew would "knock them out," not with the desire or intent to commit suicide, but rather as a desperate attempt to stop acute, unbearable emotional pain.

- I have worked with patients that initially insisted that they had made a true suicide attempt, but then after coming to trust me more acknowledged that they had not intended or wanted to die, but rather "attempted suicide" because they believed it was the only way they could get something they felt they desperately needed.

- I have observed several patients, admitted to the psychiatric hospital because of apparent suicide attempts, who immediately focused all of their attention and energy on contacting the partner that had just left them. My perception was that they presented an intensely melodramatic picture to the ex-partners, clearly portraying the recent breakup as the direct cause of their deciding to commit suicide. And finally, the whole clinical picture of emotional distress and suicide risk resolved completely when the ex-partner came to the hospital and decided to resume the relationship.

1. "Mimic" statements of suicide intent ("cry for help" statements of intent, hostile-punitive threats, relational leverage threats): As with true statements of suicide intent, mimic statements of intent are statements that directly or indirectly say "I *am going* to kill myself," as opposed to comments that indicate the person is just thinking about suicide.

   In our current society, a clear statement of suicide intent is essentially guaranteed to produce intervention attempts. This means that unless the person's judgment is severely impaired (for example, acute psychosis, mental retardation, marked intoxication), in any situation where others can intervene, a statement of intent *inherently* includes some other dynamic (cry for help, relational leverage, or hostile-punitive) *as the primary reason for making the statement of intent*.[13] That is, if killing yourself is the true and most important objective, you wouldn't tell somebody and thereby give them a chance to interfere[14]. These

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others have a huge safety margin, and will cause no significant dangerous effects even when an entire months supply is taken in a single dose.

[12] A relevant statistic is that 56% of those who actually complete suicide do so on their first attempt. Furthermore, of the remaining 44% – people who eventually complete suicide, but fail on their first attempt – almost all (82%) switch to a different method after an unsuccessful attempt. This means that suicide attempters who keep repeating with the same method account for almost no completed suicides (8%, less than 1 out of 10). (Isometsa ET; Lonnqvist JK. "Suicide attempts preceding completed suicide." *Br J Psychiatry* 1998 Dec;173:531-5)

[13] The only exception to this statement that I am aware of is the rare situation in which a true statement of suicide intent appears to simply be a way of saying "goodbye."

[14] Important note: Sometimes the person is truly intending to commit suicide, but still makes a true statement of suicide intent because the hostile-punitive dynamic is so strong that the person is willing to risk intervention in order to witness the effects of his punishment/revenge.

thoughts regarding the psychological dynamics of statements of suicide intent are consistent with the professional literature and my personal clinical experience, both of which indicate that a large percentage of apparent statements of suicide intent are actually mimic suicidal behavior. An especially significant clinical observation is that most statements of suicide intent *do* result in accomplishing other objectives (getting more help, and/or obtaining relationship leverage, and/or punishing the intended target), and *are not* followed by true suicide attempts.

Mimic statements of intent have the same "cry for help," relational leverage, and hostile/punitive dynamics as mimic suicide attempts (see below). The dynamics are exactly the same, but the message is slightly less desperate, the stakes aren't as high, and the effects tend to be less powerful. I use the term "suicide *threat*" to refer to mimic statements of intent where the true dynamic is relational leverage or hostile/punitive. The relational leverage dynamic is easiest to spot when the desired outcome is explicitly included in the threat: "I'm going to kill myself unless _____ ," but the desired outcome is usually implied indirectly as opposed to stated explicitly.

Sometimes a statement of suicide intent, such as "I am going to kill myself," can be the last communication of ambivalence before the person truly decides to commit suicide, essentially saying: "I'm slipping over the edge, I'm losing the last shreds of resistance. I am about to commit suicide, but I still want help – please stop me." I think of this "half true/half mimic" statement of intent as the "border zone" between a cry for help and making a true suicide attempt.

It is important to think carefully about both true and mimic statements of intent when responding to an apparent statement of suicide intent.

2. Self mutilation: The person *is* intentionally hurting him/herself, but is *not intending suicide*. Self mutilation is scary and upsetting, but is not a suicide attempt – when motivation is discussed, there is no desire or intent to die. The actual behavior can be quite variable, from the person burning himself with a cigarette to cutting his wrists (with lots of blood). It can *look*, externally, a lot like a true suicide attempt. But the key is that the person's internal thoughts correspond to self mutilation, not a suicide attempt. With respect to the actual risk of suicide, self mutilation is much less dangerous than it looks. I have worked with many patients who have engaged in self harm behavior, with a cumulative total of thousands of acts of self harm (including hundreds of wrist lacerations and many, many stitches). But out of all of this, not one of these people has actually killed him or herself. Once I came to understand self mutilation, I saved tremendous amounts of time and energy and resources by distinguishing between self mutilation and true suicide attempts. As soon as I realized that the person was self mutilating, as opposed to attempting suicide, I would make sure they obtained proper care for the specific injuries, but not pursue unnecessary measures to address the non-existent suicide risk (such as psychiatric hospitalization that would be appropriate in response to a true suicide attempt).

   People who self mutilate need appropriate medical care for their injuries, but they are not at significant risk for death by suicide. Many people self mutilate on a daily/weekly basis for months/years, even during the healing process and/or while in therapy. The internal motivation behind self mutilation can include:
   - Coping with unpleasant altered states of consciousness, such as dissociative trance/disconnection ("When I see the blood, it makes me feel real").

- Self medication via endorphins released by the self mutilation ("It makes me feel good").
- Self punishment as a part of penance or as an expression of self hatred ("I'm just giving myself what I deserve"), but no desire or intent to die.
- Anger at someone else, with self mutilation used to punish them ("I can utterly ruin my mother's day by cutting myself").
- The person may feel that her emotional and/or spiritual issues are invisible and unrecognized, and self mutilates so that others can "see" her pain ("I want people to know how much pain I am in, I want people to be able to *see* my wounds").

3. "Mimic" suicide attempts (suicide "gestures"): Suicide "gestures" are self destructive behaviors that are intended to *look like* suicide attempts in order to accomplish a secondary objective, but that don't actually involve any true desire to die or intent to die. You can often identify a suicidal gesture by thinking carefully about the apparent attempt (gesture). You probably have a suicide gesture when someone takes 10 aspirin and then immediately calls family/friends they know are available (confirmed if you talk to the person and they verify that they did not really intend or want to die). Note: This is even more clear if this is the tenth repetition of a "suicide attempt" that has never resulted in any serious harm (e.g., they have already repeatedly demonstrated to themselves at some level that this "suicide attempt" will not kill them). On rare and sad occasions a suicidal gesture will be accidentally fatal. In my experience, hostile-punitive gestures tend to have the highest risk for accidental serious injury/death (I think this is because people who are intensely angry tend to have impaired judgment, impaired behavioral control, and increased pain tolerance).

   "Cry for help" suicide gestures: Sometimes people come to the conclusion that the only way they can really get help is to "do something drastic." As mentioned above, when carefully discussed in a safe relationship, the person will acknowledge that they had no intent or desire to die. "I didn't really want to die, but I couldn't keep living like this – I just wanted something to change" is the kind of comment they will make. I perceive "cry for help" suicide gestures to be similar to, but not the same as relational leverage suicide gestures. With a "cry for help" gesture, the apparent suicide attempt is usually made in a more confused, desperate state of mind, and the objective is not clearly focused. With a relational leverage gesture, the secondary objective to be obtained via the apparent attempt is more clearly focused.

   Relational leverage suicide gestures: A painful reality is that many wounded individuals have discovered that suicide threats and suicidal behavior can be used as leverage to get care/attention that they believe they need and that they feel they cannot get any other way. When carefully discussed in a safe relationship, the person will acknowledge that they had no intent or desire to die, and will say things like "I couldn't live without her, and this is the only way I could get her back."

   Note: People who use suicide threats and/or suicidal behavior for relational leverage will often experience shame when these dynamics are exposed. They will often experience the "straightforward" approach presented in this essay, and the use of the ministry aids sheet, as shaming and as a threat to their "system." They will understandably respond with various forms of defensiveness, sometimes including withholding and/or distorting the truth. If this occurs, it is very important and helpful to realize that the real issue is *not* that the person receiving ministry is "manipulative" and "bad," but that he has ***guardian lies*** regarding his need for suicide threats and/or suicidal behavior as relational leverage tools. For example, "Nobody will listen to me unless I threaten to kill myself," "I only get taken care of when I

try to kill myself," or "I need to use suicide threats to get what I need." The person's "need" for suicide threats and/or suicidal behavior can sometimes be resolved if the minister/therapist can help the person address these guardian lies from a peaceful, calm, and non-judgmental perspective.[15] Using suicide threats/suicidal behavior as "leverage" is *very expensive*, and it is a *tremendous gift* to the person receiving ministry (and everybody else in his support network) to help him resolve the underlying guardian lies so that he can let go of this painful and expensive "tool."

It is *very important* to understand that people who have learned to use suicide threats and/or suicidal behavior in this way will *not* respond well to judgmental confrontation. If the therapist/emotional healing minister confronts the person in a judgmental and adversarial way, using the ministry aid sheets to "show" him that he's "not *really* dangerous," the person receiving ministry will probably escalate to more desperate behavior in order to maintain what he perceives to be a necessary defense mechanism.

Hostile-punitive suicide gestures: Another painful reality is that many wounded individuals have discovered that suicide threats and suicidal behavior can be used to punish others (especially others who care about them). When carefully discussed in a safe relationship, the person will acknowledge that they had no intent or desire to die, and then say things like "I just wanted to show him what will happen if he treats me like this," "I wanted to make them sorry for the way they treated me," or "I wanted to scare the hell out of her – to teach her a lesson."

Note: Much like people who use suicide threats and/or suicidal behavior as relational leverage, people who use suicide threats and/or suicidal behavior in hostile-punitive ways will often experience shame when these dynamics are exposed. They can also experience the material presented in this essay, and the use of the ministry aids sheet, as judgmental and/or shaming. They may respond with various forms of defensiveness, sometimes including withholding and/or distorting the truth. If this occurs, it is very important and helpful to realize that the real issue is *not* that the person receiving ministry is "bad," but that he has ***guardian lies*** regarding his need for suicide threats and/or suicidal behavior as weapons. For example, "He's so much bigger than me and he always wins. This is the only way I can fight back," "This is the only weapon I have – I will be powerless if I don't have this," or "There isn't any justice. I can't let her just her get away with it, and this is the only way I can hurt her." The person's "need" for suicide threats and/or suicidal behavior as a weapon can sometimes be resolved if the minister/therapist can help the person address these guardian lies from a peaceful, calm, and non-judgmental perspective.[16] Using suicide threats/suicidal behavior as hostile-punitive weapons is *very expensive*, and it is a *tremendous gift* to the person receiving ministry (and everybody else in his support network) to help him resolve the underlying guardian lies so that he can let go of this painful and expensive weapon.

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[15] If you find it difficult to remain peaceful, calm, and non-judgmental when working with suicidal people (especially those who seem "manipulative"), you are being triggered. *Please* press into your own healing for the issues that are getting stirred up in you.

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Again, it is *very important* to understand that people who have learned to use suicide threats and/or suicidal behavior in this way will *not* respond well to judgmental confrontation. If the therapist/emotional healing minister confronts the person in a judgmental and adversarial way, using the ministry aid sheets to "show" him that he's "not *really* dangerous," the person receiving ministry will probably escalate to more desperate behavior in order to maintain what he perceives to be a necessary defense mechanism.

One of the most important reasons to identify "mimic" suicidal behavior is to help the person and his support network to point their resources in the best direction. There is no need to spend time, energy, and finances to provide protection for suicide risk when the self mutilation, mimic statement of intent, or mimic suicide attempt actually had nothing to do with suicide. For example, if the person receiving ministry claims to have attempted suicide, and presents with a superficial scratch/cut on the wrist, but the lay minister correctly perceives that this is a relational leverage suicide gesture, a brief phone conference with the mental health professional already familiar with the person and providing primary care might adequately address the situation. It is a benefit to all concerned if the lay minister realizes this, and avoids an unnecessary 911 phone call, ambulance ride, emergency room visit, and psychiatric hospitalization (~$5,000-$10,000 hospital bill, lots of embarrassment, risk of losing employment).

Instead of investing a huge portion of their time, energy, and financial resources to address suicide risk (that doesn't exist), the person and his support network can invest their resources in actually dealing with the pain/issues underlying the mimic suicidal behavior.

Recommendations regarding mimic suicidal behaviors: *For each of the mimic suicidal behaviors, identify the thoughts and emotions driving the behavior, and then focus emotional healing ministry on the underlying issues that are causing these thoughts and emotions. It is very helpful for the facilitator to be free of triggering and/or judgment regarding mimic suicidal behavior. Please get your own healing if you feel triggered and/or judgmental when working with these issues.*

B. Para-suicidal risk taking behavior: I define para-suicidal risk taking behavior as intentional involvement in unnecessary high risk behavior in combination with a desire to die. The person is unsure whether he really wants to commit suicide, so he takes DANGEROUS risks, "and if I die, well then that's okay." One significant reason for para-suicidal risk taking behavior is an unconscious/semiconscious attempt to sneak around the Lord's rules about suicide – people who believe suicide is a mortal sin try to avoid getting "caught" by engaging in high risk behaviors instead of attempting suicide directly.[17] Examples of "unnecessary" high risk behavior would be things like reckless driving, rock climbing without ropes, or sexual promiscuity without protection (all situations where the risk can be dramatically and easily reduced – where the high risk is "optional," unnecessary). In contrast, "necessary" high risk behavior would include things like a fireman going into a burning building to attempt the rescue of people trapped inside.

Several points regarding para-suicidal behavior:

Although not as dangerous as direct suicide attempts, this kind of behavior is very dangerous

[17] A number of my Christian suicidal patients have admitted having thoughts like these.

over time. For example, many people get AIDS as a result of para-suicidal high risk sexual behavior.

It is important to realize that all high risk behavior is not necessarily para-suicidal behavior. Some people have no desire to die, but rather engage in high risk behavior as a part of "thrill seeking" (self medication with adrenaline). Some people have no desire to die, but engage in high risk behavior because it is fun, they don't want to take the trouble to take safety precautions, and they have very poor judgment about realistic risk. For example, adolescent guys sometimes go rock climbing without protection because it is fun, they don't want to deal with the hassle of using ropes, etc., and because they have an unrealistic sense that they are indestructible. "It could never happen to me." The key for making this assessment is to learn what the person is thinking and feeling in association with the high risk behavior.

Para-suicidal behavior seems to be somewhat of a blind-spot for mental health professionals. My own professional experience and review of the professional literature indicate that para-suicidal behavior as I define it here is almost never included in study or discussion of suicide related phenomena. I have never seen a clinical case where death as a result of this kind of para-suicidal behavior was considered suicide, and I have never seen a research study where deaths as a result of this kind of para-suicidal behavior were included as suicides.

The most important point is that para-suicidal risk taking behavior indicates that the person is at level 2 or above on the suicide risk spectrum (discussed in section IV, below). Para-suicidal risk taking behavior is a way of "flirting" with suicide, and can be thought of as an indirect suicide attempt. Underneath para-suicidal risk taking behavior there is always some degree of suicide risk – the person wants to escape his painful life, and is skating around the edges of making a direct suicide attempt.

Recommendations regarding para-suicidal high risk behavior: *Again, the key with para-suicidal high risk behavior is that it indicates suicide risk level of at least 2. Carefully evaluate factors contributing to suicide risk and suicide risk level, and then follow corresponding recommendations.*

C. True suicidal behavior: The key to true suicidal behavior is that it really does involve consideration of suicide, and/or desire to commit suicide, and/or intent to commit suicide. As discussed above, this is especially in contrast to "mimic" suicidal behavior, where the behavior *appear*s to be about suicide, but actually doesn't have anything to do with consideration of suicide, desire to commit suicide, or intent to commit suicide.

Statement of suicide intent: I use "statement of suicide intent" to refer to a clear statement along the lines of "I *am going* to kill myself," as opposed to statements like "I want to kill myself" or "I feel like killing myself," that indicate the person is *thinking about* suicide. A "true" statement of suicide intent is simply a statement of suicide intent made by a person who is truly intending to commit suicide. I think of a true statement of suicide intent as a form of suicidal behavior, one step before making an actual suicide attempt. As discussed above, many (most?), *but not all* apparent statements of suicide intent are actually "mimic" statements of intent, and it is important to think carefully about both possibilities when responding to an apparent statement of suicide intent.

True suicide attempt: In a true suicide attempt, to some degree the person truly wanted to die, intended to die, and believed that the method used in her suicide attempt could/would be

lethal.

People are often ambivalent, even as they are in the process of making the actual suicide attempt. The level of ambivalence can vary greatly, with higher levels of ambivalence indicating lower levels of true suicide risk. At the high ambivalence – low suicide risk end of the spectrum, a suicide attempt might be a mostly impulsive attempt from a baseline at level 3 (as defined in the "suicide risk spectrum" section below). At this high ambivalence end of the spectrum, the person almost always uses a method that is potentially fatal, but that is slow and reversible, leaving room for rescue. There is intent to die (or at least intent to risk death), at the impulsive moment of the attempt, but she quickly changes her mind, initiates rescue, cooperates with appropriate care, and is relieved and grateful to have "failed." For example, the person takes a potentially fatal overdose of medication, but at home with people present. After swallowing the pills, she quickly changes her mind, tells her family what she has done, and goes willingly to the hospital for appropriate medical care. After the attempt fails, she thanks the family and medical personnel who rescued her, and is relieved to be alive. At the low ambivalence – high suicide risk end of the spectrum, the person might make a carefully planned suicide attempt from a baseline at suicide risk level 6. At this low level of ambivalence and high suicide risk, the person usually uses a rapidly and irreversibly lethal method, makes the attempt away from potential rescuers, makes no effort to seek help after the attempt, and is disappointed/angry to have failed. For example, the person goes to a remote location, and shoots himself in the chest, fully intending to die. However, he accidentally hits a rib (instead of his heart), faints instead of dying, and then is accidentally found and rescued by weekend campers. When he "comes to" in the hospital, he is angry at those who rescued him, and angry and disappointed to be alive.

Ambivalence indicates that the true suicide risk is less than would be indicated by the same attempt without ambivalence, but true suicide attempts with ambivalence are still true suicide attempts.

I assess ambivalence by considering lethality and reversibility of the method, the person's role in and/or cooperation with rescue, and the person's thoughts around the suicide attempt:

Lethality and reversibility of method: It is fairly common for people to attempt suicide with methods that simply aren't lethal. For example, the person attempting suicide might take an "overdose" of only ten aspirin. Use of a non-lethal method usually indicates extreme ambivalence or a mimic attempt, *especially if the person has made similar attempts in the past*. People with marked – moderate ambivalence often choose a suicide method that is marginally lethal – a method that they believe *could* be lethal, but they are not *sure it will* be lethal. People with a lot of ambivalence also almost always choose a method that is "reversible," so that they have the option to abort the attempt by initiating rescue. The potentially lethal medication overdose described above is a good example. With decreasing ambivalence and increasing suicide risk, lethality steadily increases and reversibility steadily decreases. Eating a large amount of corrosive poison is an example of a more lethal, less reversible method consistent with intermediate ambivalence and suicide risk. Shooting oneself in the head in a remote location (away from rescuers) is an example of a very lethal, minimally reversible method consistent with minimal ambivalence and extreme suicide risk.

Initiating rescue, cooperation with rescue: On the "extreme to marked ambivalence" end of the spectrum, the person aborts her suicide attempt before rescue is necessary. For example,

she starts taking an overdose, but then stops after only several pills. A person with marked to moderate ambivalence might make an attempt he believes will be lethal, but then abort the attempt by initiating rescue and cooperating with appropriate care. For example, he might take an overdose of medication he believes will be lethal, but then when he starts feeling intensely ill, he calls 911 and cooperates with appropriate medical care. A person with minimal ambivalence makes no effort to initiate rescue, and will even resist rescue/appropriate care. The only reason he is alive is that the attempt failed accidentally and/or he was rescued accidentally.

Thoughts around suicide attempt: It is especially important to understand the person's thoughts immediately before, during, and after the attempt. First, did the person understand the lethality of the attempt? For example, consider a suicide attempt in which the person uses a very non-lethal method, such as taking an overdose of only ten aspirin. Clarifying her thoughts around the attempt will provide crucial additional information. If she is naive, and truly believed the overdose would be fatal, she could still be a serious suicide risk (occasionally a person who is naive will use a non-lethal method completely by accident, and will then change the method and succeed with the next attempt). On the other hand, if the person acknowledges knowing that the attempt would not be lethal, then the apparent attempt is actually a "mimic" attempt (see below), and suicide risk is minimal. Second, what was the person's reason for aborting the attempt/initiating rescue? For example, consider a suicide attempt in which the person takes a potentially fatal overdose, but then aborts the attempt by initiating rescue when she begins to feel sick an hour after taking the pills. Clarifying her thoughts around the attempt will provide crucial additional information: "I wanted to arrange things so that it would be least traumatic for my family, and at the last moment I realized that I had forgotten to finish some important business. I decided to wait until after I could take care of it," implies minimal ambivalence, "I got scared and chickened out at the last moment. I might try again if I find the courage," implies intermediate ambivalence, and "I realized that I didn't really want to die after all, and now I'm glad I didn't do it," indicates marked ambivalence. Finally, is the person relieved that he "failed"/was rescued, and grateful to be alive? Or is he angry that he "failed"/was rescued, and disappointed to be alive?

Recommendations regarding true suicide attempts: *Evaluate ambivalence of the suicide attempt by clarifying lethality and reversibility of method, initiation of and/or cooperation with rescue, and thoughts immediately before, during, and after suicide attempt. Evaluate current suicide risk in light of ambivalence and the person's current response to the suicide risk spectrum (section IV, below). Note: Even if the person says they are no longer suicidal, a mental health professional (MHP) should still be consulted for anyone who has made a true suicide attempt. Pursue MHP consultation in response to the person's report of true suicide attempt ("I truly wanted and intended to die"), but continue to consider the possibility of mimic suicidal behavior (mimic suicide attempts are often not acknowledged until more trust is developed).*

III. Factors contributing to suicide risk: Another part of making sense out of suicide related phenomena is to identify and understand the factors that contribute to suicide risk.

Special risk factors: I use the phrase "special risk factor" to refer to risk factors that are especially important in determining whether or not to obtain mental health consultation for people with baseline suicide risk level 2 or 3 (where consultation is otherwise usually *not* necessary). Special risk factors either cause periodic episodes during which suicide risk increases to levels where

mental health consultation is wise, or introduce enough lability and unpredictability so that mental health consultation is the best plan. My assessment is that the presence of one or more special risk factors *requires* mental health consultation, even for people at baseline suicide risk levels 2 or 3, *unless the special risk factors can be quickly resolved.* For example, demonic suicidal compulsions are a special risk factor. If a person is usually at a baseline suicide risk level of 2 or 3, but goes above 3 during acute episodes of demonic harassment, mental health consultation is recommended unless this concern can be quickly[18] resolved. In contrast, mental health consultation would *not* be necessary if the demonic suicidal compulsions *can* be quickly resolved. "Special risk factors" are clearly identified in the discussion below.

Brief summary of common and/or important risk factors: There are many factors that contribute to the complexity of suicide risk, and I can't discuss them all, but I have tried to include the most common and/or important. The length of this list and the amount of material in this section may seem overwhelming at first; however, if you take a step back you will realize that most of the material in this section makes sense and fits together intuitively, making it easier to understand and remember (as long as you're not triggered).

A. Pain: In my experience, severe and/or chronic pain (physical and/or emotional) is the "foundation" for most[19] suicide risk. If a person has pain that is severe enough and lasts long enough, he will usually eventually start to look for ways to escape the pain. If the pain is severe enough and lasts long enough, most people will usually eventually consider suicide as an escape option. The severity of the suicide risk usually increases steadily as the severity of the pain increases, as the duration of the pain increases, and as hope for relief decreases.

   Pain is *not* included as a special risk factor, because even severe and/or chronic pain does not *necessarily* introduce unpredictability or push risk levels 2 or 3 to higher levels requiring mental health consultation. For example, I experienced moderate to severe emotional pain almost continuously for most of the first two years of my psychiatric residency, and I spent most of this time with my baseline suicide risk at levels 2 or 3. At times when I was especially miserable, my suicide risk level would increase to 3.5+. However, in spite of the chronic, intense emotional pain, my suicide risk remained below 4 because I knew death would not be the end of the story, and I was profoundly convinced that suicide would only make things worse[20]. Also (as discussed in the "Hopelessness" section below), this pain

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[18] The specific meaning of "quickly" depends on the situation. For example, if the risk level only goes up to 4 during episodes of acute demonic oppression, and the person meets all the "It's okay to take longer" criteria described under level 2 in the "Suicide risk spectrum" section, "quickly" could be several weeks. If the risk level goes up to 6 during episodes of acute oppression, "quickly" means "before they have any opportunity to hurt themselves." See the "Suicide Risk Spectrum" section, below, for additional discussion of specific considerations regarding time urgency in the context of special risk factors and obtaining mental health consultation.

[19] I have encountered a few situations where pain does *not* seem to be the foundation/primary factor contributing to suicide risk. For example, patients with psychotic delusions about needing to die in order to be a part of some wonderful eternal plan, or patients who were otherwise not particularly miserable, but who had demonic oppression focused very specifically on suicide compulsions.

[20] I have read a number of accounts written by people who have been resuscitated from clinical death that had resulted from a suicide attempt. They all reported that the Lord told them, very clearly, that suicide was not acceptable. One person reported that he found himself in a room, with a large angel guarding the door, and that he was told he had to deal with all the pain and problems he had attempted

would not even have pushed my baseline risk level as high as it did if I had experienced one of the newer, more effective approaches to emotional healing ministry, and thereby had more hope that my pain would not last forever.

Recommendations regarding interventions, consultation/referral: Physical pain: Obtain appropriate medical care for physical pain. Use one of the newer, more effective approaches to emotional healing ministry to address emotional/spiritual issues triggered by the physical pain (addressing emotional issues triggered by the physical pain will dramatically reduce suffering associated with the pain). Also, I ***strongly*** recommend that anybody who has physical pain as an important part of their suffering read *The Gift of Pain*[21]. Emotional pain: Most emotional pain comes from truth-based pain that Jesus is willing to take, lies, or other unresolved emotional and/or spiritual issues. The newer, more effective approaches to emotional healing ministry can usually address all of these (sometimes quickly, and sometimes gradually over months/years).

B. Hopelessness: Hopelessness is a specific flavor of emotional pain that is especially potent in contributing to suicide risk[22] – not just discouragement, but true hopelessness/despair. The more profound the hopelessness, the more serious the suicide risk. People make true, serious suicide attempts when they perceive unsolvable problems – when they see no hope of any "solution" other than escape through suicide.

Decreased hopelessness with the discovery of a tool that works: Part of the good news is that the person receiving ministry often experiences dramatic decrease of hopelessness with the first several successful emotional healing ministry sessions, because he realizes there is a tool that works – there is hope that the pain won't go on forever. My own experience in internship and residency provides a good example. I spent much of my internship year at 3.5+ on the suicide risk spectrum, and the most significant driving force behind my suicidal thoughts was my perception that the pain would never get better. I believed that the pain I experienced every day was inherently connected to the way my whole personality structure interacted with many unavoidable aspects of my career, and this lead to the profoundly discouraging conclusion that I would probably be in pain every day for the rest of my adult life. My daily pain and stress was coming from a number of different lies and issues being triggered, and one or two successful emotional healing ministry sessions would only have made a small dent in the total pile. However, I would have been able to clearly perceive that there was hope. The real core of my suicide risk – the hopelessness that there was no way to fix the problem – would have been broken. Even though much of the daily pain would have continued, my hopelessness and acute suicide risk would have collapsed if I had had a tool that would produce steady and progressive resolution of the underlying roots of my pain.

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suicide to escape from before he would be allowed to do anything else. I decided that I preferred this life, where I could at least take breaks from the pain by watching a good movie or taking a nap.

[21] Brand, Paul; Yancey, Phillip. *Pain: The Gift Nobody Wants.* (HarperCollins: New York, NY), 1993.

[22] A number of studies identify hopelessness as one of the most important risk factors for suicide. See, for example, Beck AT; Brown G; Berchick RJ; Stewart BL; Steer RA. "Relationship between hopelessness and ultimate suicide: a replication with psychiatric outpatients." *Am J Psychiatry* 1990 Feb;147(2):190-5, and Kim CH; Jayathilake K; Meltzer HY, "Hopelessness, neurocognitive function, and insight in schizophrenia: relationship to suicidal behavior." *Schizophr Res* 2003 Mar 1;60(1):71-80. These results are certainly consistent with my personal professional experience.

Hopelessness from specific underlying sources: If receiving regular healing, with clear evidence that emotional pain is steadily decreasing, does not quickly resolve hopelessness, then there are specific lies and/or other issues directly contributing to the hopelessness. *Sudden flares* of intense, crisis hopelessness are always caused by specific "hopelessness lies" being triggered, or by other specific issues such as demonic oppression focusing directly on hopelessness. My personal experience with discouragement provides a good analogy. I have always found underlying lies and/or issues to be driving acute flares of discouragement. When discouraging events in the present have caused me to feel *intensely* discouraged, the intense, overwhelming discouragement has always gone back to lies and issues associated with specific memories. For example, deep discouragement about "The Lord won't come – no matter what I do, He won't come" went back to two year old memories of being separated from my parents for several weeks, and falling into despair that they would never come back. Deep discouragement about "I can't do it, I can't figure it out" went back to first grade memories of not being able to learn to read because of dyslexia.

Strategic resolution of "crisis" hopelessness: Strategic resolution of especially intense "crisis" hopelessness can often resolve acute, intense suicide risk. Now, when one of our clients is suicidal due to "crisis" hopelessness, I go for the specific lies and/or issues that have been triggered and that are driving the "crisis" hopelessness. The "crisis" suicide risk will resolve promptly if the underlying source of the "crisis" hopelessness is resolved. For example, one of our clients experienced overwhelming hopelessness/despair and intense suicidal thoughts in association with a medical ordeal in her present, adult life. In truth-based reality, the current adult medical ordeal was hard, but something she could handle, as an adult, with Jesus. However, the situation in her adult life triggered lies and issues from a childhood medical ordeal that she *had not* had the resources to handle. It had been way too big for her own emotional resources, her parents weren't able to help her in a way that provided healthy adult emotional resources, and she couldn't access the Lord's emotional resources because of other wounds and lies that were already in place. When the current situation triggered the lies and issues associated with her childhood memories, she would feel utterly overwhelmed, with associated lies and suicidal thoughts such as "It goes on forever, it will never end – the only way to escape the pain is suicide." She experienced complete resolution of this particular episode of intense, acute suicide risk in one "crisis intervention" emotional healing ministry session – the Lord helped her go to the childhood memories, focused the lies and issues associated with the despair and suicidal ideation, and resolved them. In the past, I would have spent the same amount of time with suicide risk management interventions (for example, using relaxation techniques and cognitive therapy to put the triggered memories, lies, and negative emotions back where they came from). The immediate crisis would have been resolved, but the underlying roots would have been unchanged, and would have continued to create the same overwhelmed/hopeless suicide risk crisis each time they were triggered.

Recommendations regarding interventions, consultation/referral: The best case scenario is that effective emotional healing ministry will quickly provide some degree of healing, and that hopelessness will dramatically decrease/resolve as soon as the person realizes that there is a ministry tool that can resolve the underlying sources of his pain. If there are "flares" of hopelessness, and/or hopelessness persists in the face of clear evidence that emotional pain is steadily decreasing, then focus emotional healing ministry especially on lies and/or other underlying issues contributing directly to the hopelessness. Implement suicide risk management interventions (see section VII, below) if hopelessness cannot be quickly reduced/ resolved through emotional healing ministry (and significant suicide risk continues). ***Special***

risk factor: Persistent hopelessness contributes directly to baseline suicide risk, and so is always inherently included when using the suicide risk spectrum to assess suicide risk level. Episodic flares of "crisis" hopelessness are a special risk factor when they are severe enough to produce suicide risk of level 4 or above (at the point of maximum risk during the episode of crisis hopelessness). Flares of crisis hopelessness are a good example of a special risk factor that can sometimes be "quickly" resolved with emotional healing ministry (and therefore, in the situations where quick resolution is possible, *not* contribute a "special risk factor consideration" requiring mental health consultation).

C. Intense negative emotions (other than hopelessness): This section and the next four sections ("Underlying issues," "Especially stressful/painful recent events," "Impaired coping ability," and "Impaired support system") are closely interrelated. For example, intense negative emotions can be caused by underlying issues being triggered and by truth-based pain from recent events; stressful/painful recent events can cause pain by triggering underlying issues and can also cause truth-based pain; impaired coping ability is often caused by underlying issues, increases the impact of any of the other factors, and increases the likelihood of stressful/painful events; and a poor support system increases the impact of each of the other four factors, and each of the other four factors can contribute to a person's support system being poor. A sobering implication of this interrelatedness is that a problem in any of these areas will exacerbate each of the others. An encouraging implication of this interconnectedness is that healing in any of these areas will benefit each of the others.

   Intense, "crisis" negative emotions are especially important with respect to sudden, unpredictable suicide attempts (my perception is that sudden, unpredictable suicide attempts are often angry-hostile responses from within rage that overwhelms the person's ability to cope, or desperate attempts to escape from painful emotions that are experienced as acutely overwhelming and unbearable[23]).

   As with hopelessness, strategic resolution of other especially intense "crisis" negative emotions,[24] can often resolve the source of acute, intense suicide risk. *Crisis* intervention for suicide risk should especially include emotional healing ministry addressing the direct, immediate causes of intense negative emotions (both emotional/spiritual issues being stirred up and truth-based pain[25]). *Long term* intervention for suicide risk should especially include emotional healing ministry addressing unresolved issues and impaired coping ability that contribute indirectly to the occurrence of episodes of intense negative emotions, and that exacerbate the total negative impact of each of these episodes.

   Recommendations regarding interventions, consultation/referral: For crisis intervention, attempt strategic resolution of "crisis" negative emotions by focusing emotional healing ministry on the direct, immediate causes of the intense negative emotions. Implement suicide

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[23] One study of adolescents who had attempted suicide found "The most frequently mentioned reasons for attempting suicide concerned the cessation of (an unbearable) consciousness." Kienhorst IC; De Wilde EJ; Diekstra RF; Wolters WH. "Adolescents' image of their suicide attempt." *J Am Acad Child Adolesc Psychiatry* 1995 May;34(5):623-8

[24] For example, intense, "overwhelming" and/or "unbearable" shame, rage, rejection, loneliness-grief, or fear/panic.

[25] See "Bereavement, Grief, and Mourning" on the "Ministry Aids" Page of www.kclehman.com for careful discussion of using emotional healing ministry with truth-based pain

risk management interventions if the crisis negative emotions cannot be quickly reduced/ resolved and significant suicide risk continues. Long term intervention should include focusing emotional healing ministry on unresolved issues and on impaired coping ability. ***Special risk factor:*** Persistent intense negative emotions contribute directly to baseline suicide risk, and so are always inherently included when using the suicide risk spectrum to assess suicide risk level. Episodic flares of "crisis" intense negative emotions are a special risk factor when they are severe enough to produce suicide risk of level 4 or above (at the point of maximum risk during the episode of crisis negative emotion). Flares of crisis negative emotions are another good example of a special risk factor that can sometimes be quickly resolved with emotional healing ministry (and therefore, in the situations where quick resolution is possible, *not* contribute a "special risk factor consideration" requiring mental health consultation).

D. Underlying issues (unresolved emotional and/or spiritual issues): I believe that unresolved emotional and/or spiritual issues are the most important contributors to suicide risk. In my assessment, triggering of unresolved emotional and/or spiritual issues is the single biggest *ongoing* contributor to persistent pain that fuels baseline suicide risk, the single biggest *immediate* contributor to acute intense negative emotions that fuel episodes of crisis suicide risk, and the single biggest contributor to impaired coping ability. Triggering of unresolved issues also increases the likelihood of stressful/painful events, and contributes to poor support systems.[26]

Recommendations regarding interventions, consultation/referral: For crisis intervention, focus emotional healing ministry on the underlying spiritual and emotional issues contributing strategically to crisis suicide risk[27]. If these key, strategic underlying issues cannot be quickly reduced through emotional healing ministry, and significant suicide risk continues, implement suicide risk management interventions. Long term intervention should include focusing emotional healing ministry on underlying issues that contribute to impaired coping and/or poor support system concerns. ***Special risk factor***: I consider underlying issues to be a special risk factor if, when stirred up, they cause other special risk factors (for example, crisis negative emotions or impaired coping ability to the point that these are special risk factors).

E. Especially stressful/painful recent events: Events in the present that cause truth-based and/or triggered intense negative emotions can contribute especially to an acute exacerbation of suicide risk. For example, people often make suicide attempts shortly after being left by a lover,[28] and the moment of decision to attempt suicide often seems to involve an intensely

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[26] Even though unresolved emotional and spiritual issues are most important, we should not ignore truth based pain in the present, practical concerns in the present, teaching regarding practical coping skills, support system concerns (unrelated to the person's unresolved issues), and maturity/discipleship issues. Wisdom and discernment are required to appropriately balance these different components of overall care.

[27] The underlying issues contributing strategically to crisis suicide risk can usually be found by focusing emotional healing ministry on the "crisis" negative emotions that are fueling the acute suicide risk.

[28] See, for example, Brent DA *et al.* "Stressful life events, psychopathology, and adolescent suicide: a case control study." *Suicide Life Threat Behav* 1993 Fall;23(3):179-87, and Beautrais AL; Joyce PR; Mulder RT. "Precipitating factors and life events in serious suicide attempts among youths aged 13 through 24 years." *J Am Acad Child Adolesc Psychiatry* 1997 Nov;36(11):1543-51.

angry desire to punish the person who left and/or an attempt to escape "unbearable" rejection pain. Research also shows that people often attempt suicide after major bereavement[29]. The risk is especially great if the person believes that death will reunite her with her lost loved one. Events like the stock market crash of 1929 provide "accidental" research regarding intense fear and/or feeling overwhelmed/"I can't face it." There was an exceptionally large increase in suicides in the hours and days following the stock market crash, as many investors and others involved in finance felt overwhelmed, and unable to face the consequences of the crash.

It is often difficult for the care provider to change the practical details of stressful/painful recent events experienced by the person receiving ministry (for example, death of a spouse or loss of employment), but working with the other four interrelated factors can dramatically decrease the impact of stressful/painful recent events. Furthermore, emotional healing ministry can dramatically speed the resolution of even truth-based pain, such as grief from the loss of a spouse.

Recommendations regarding interventions, consultation/referral: Focus emotional healing ministry on truth-based pain from the recent events and on the other four interrelated factors that increase the impact of stressful/painful events. If significant suicide risk continues, implement suicide risk management interventions. In situations where suicide risk has been assessed in the past, make sure to reassess suicide risk in light of the most recent crisis events.

F. Impaired coping ability: Coping ability affects the final negative impact of *all* other factors contributing to suicide risk. A person with strong coping ability can carry many risk factors without becoming seriously suicidal, while a person with severely impaired coping ability will become seriously suicidal with only a few suicide risk factors.

A major source of impulsive suicide attempts is sudden, triggered, overwhelming rage and/or unbearable painful emotions *which are acutely overwhelming/unbearable* ***because*** *the person has impaired coping ability*.

In my assessment, underlying issues being stirred up is the most important factor contributing to impaired coping ability, and this impairment is especially significant when the person is triggered into a child ego state. Effective emotional healing ministry will therefore provide dramatic benefit with respect to coping ability as it steadily resolves underlying emotional and spiritual issues (triggered impairment will occur less often and less intensely). Emotional healing ministry can also provide benefit for the baseline poor coping ability seen in personality disorders – it *can't* provide the remedial developmental work that people with personality disorders need to do, but it *can* resolve lie-based thinking and other issues that contribute to the baseline poor coping skills seen in personality disorders. Furthermore, underlying issues often block a person from learning and using healthy coping skills, and resolution of these underling issues will free the person to learn and use these appropriate coping skills.

Recommendations regarding interventions, consultation/referral: Crisis intervention: If it is

[29] See, for example, Rozenzweig A; Prigerson H; Miller MD; Reynolds CF. "Bereavement and late-life depression: grief and its complications in the elderly." *Annu Rev Med* 1997;48:421-8, and Morano CD; Cisler RA; Lemerond J. "Risk factors for adolescent suicidal behavior: loss, insufficient familial support, and hopelessness." *Adolescence* 1993 Winter; 28(112):851-65

not possible to quickly resolve the roots of strategic intense negative emotions, sometimes crisis suicide risk can be resolved by helping the person transition from a triggered child ego state back to the adult core self ego state (which resolves the crisis suicide risk by dramatically increasing the person's coping ability). Long term intervention: Focus emotional healing ministry on the underlying spiritual and emotional issues contributing to impaired coping ability. Disciple the person in appropriate coping skills as blockages are removed. ***Special risk factor:*** I consider impaired coping ability to be a special risk factor if the person's coping ability is impaired to the point where mild to moderately painful/stressful events precipitate episodes of suicide risk at level 4 or above.

G. Poor support system: I think of coping ability as a person's *internal* support system, whereas family, friends, mental health professionals, pastor, church small group, etc. are her *external* support system. As with coping ability, the strength of a person's external support system affects the final negative impact of *all* other factors contributing to suicide risk. A person with a strong support network can carry many risk factors without becoming seriously suicidal, while a person with a weak support network will become more suicidal with fewer suicide risk factors.

   "Systems" emotional healing ministry (working with key people in the person's life from a family systems perspective), can directly benefit his support network by increasing the ability of these people to provide healthy, appropriate support. Effective emotional healing ministry can also provide indirect benefit by addressing issues that hinder building and using a support network, and/or by addressing issues that erode support resources that might already be in place. For example, a person might have a poor support system because he has lies and vows that get in the way of building or leaning on relationships, such as "It's not safe to be in relationship," "I'm not worth being in a good relationship," "I will never trust anyone again," and "I will never tell." Or his support network might be at risk because triggered, reactive behavior and substance abuse are alienating his family, and/or jeopardizing employment/ financial resources that provide professional help.

   Recommendations regarding interventions, consultation/referral: Focus "systems" emotional healing ministry on any key people in the person's life who are willing to participate, and focus individual emotional healing ministry on behaviors that are especially destructive to the person's support system. ***Special risk factor:*** Poor support network is ***not*** a "must obtain consultation" special risk factor, but it should be carefully considered when making decisions about intervention and consultation/referral (as discussed in the "Suicide Risk Spectrum" section below).

H. "Combination" special risk factor: Intense negative emotions, underlying issues, especially painful/stressful recent events, poor coping ability, and poor support system are not only interrelated, but they can also interact and combine to create a "combination" special risk factor. A *steady series* of "crisis" episodes resulting in risk level 4 or above indicates a dangerous combination of intense negative emotions, underlying issues, precipitating events, poor coping abilities, and poor support system, and it is only a matter of time before the person has a "crisis" when crisis intervention emotional healing ministry is not available. The clearest indicator that the *combination* of intense negative emotions, underlying issues, impaired coping abilities, precipitating events, and poor support system is present as a special risk factor is that the person has already made impulsive, hard to predict suicide attempts (adequate crisis intervention was not available). The sudden, unpredictable attempts (discussed below) that erupt from a combination of overwhelming rage and/or unbearable painful

emotions, impaired coping ability, and poor support system, are an especially severe indicator of this "combination" special risk factor.

Recommendations regarding interventions, consultation/referral: This is a complicated and difficult clinical picture, but it will steadily improve, and eventually resolve, with persistent emotional healing ministry addressing each of the contributing factors (as discussed in each of the respective sections above). ***Special risk factor:*** As already discussed, this combination of intense negative emotions, underlying issues, especially painful/stressful recent events, poor coping ability, and poor support system is a special risk factor. This "combination" clinical picture is *not* a good example of a special risk factor that can often be quickly resolved with emotional healing ministry. When this picture is present, it is always good to obtain mental health consultation to help with a long term plan for addressing each of the contributing factors, and to help with suicide risk management in the mean time.

I. Substance use/abuse: Abuse of alcohol and/or other psychoactive substances is associated with a dramatic increase in suicide related phenomena. For example, 10-20% of chronic alcoholics eventually die from suicide[30]. This is as high a risk of death by suicide as any other demographic group, including major depression and schizophrenia. Substance abuse can cause both acute effects and chronic effects that contribute to the dramatically increased rate of completed suicides and other suicide-related phenomena associated with substance abuse. Acute effects can include destabilized mood, impaired judgment, disinhibited behavior, and increased vulnerability to demonic oppression, and these all especially increase the risk of making sudden, unpredictable suicide attempts. Chronic effects include brain chemistry changes that can cause and/or exacerbate depression and/or psychosis,[31] loss of meaningful employment, financial difficulty, relationship losses (progressive exhaustion of spouse, family, friends), and medical problems. The chronic effects increase baseline pain and hopelessness, erode the support network, and impair coping ability, thereby increasing the risk of both carefully considered and sudden, unpredictable suicide attempts. And having the abuse substance already present in the body increases the medical danger of any attempts by overdose.

The good news is that the newer, more effective emotional healing ministry approaches are very effective in addressing substance abuse. Substance abusers are almost always self medicating. That is, substance abuse is simply the way they have learned to deal with the pain of underlying unresolved spiritual and emotional issues. Self-medication substance abuse will usually resolve as these underlying issues are identified and resolved.

Suicide risk and substance use vs. abuse: Usually we make a distinction between alcohol *use* (using alcohol in a way that is *not* problematic), and alcohol *abuse* (using alcohol in a way that *is* problematic). However, it is important to note that mood, judgment, and behavioral inhibition are affected by even small amounts of alcohol and/or other street drugs. The person will be more affected with higher doses, but he will *begin to be affected* with even low doses. This is not a problem for the average person having a glass of wine with dinner, but for

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[30] Kendall RE. "Alcohol and suicide." Subst Alcohol Actions Misuse 1983;4(2-3):121-7.

[31] For example, chronic alcohol use produces brain chemistry changes that can cause and/or exacerbate major depression, and withdrawal from chronic alcohol abuse can produce brain chemistry changes that cause psychosis. Chronic amphetamine abuse can cause psychosis, and withdrawal from chronic amphetamine abuse can cause depression.

people who are already struggling with suicide risk, *even moderate amounts* of alcohol or other non-prescribed psychoactive substance can increase the risk.

Recommendations regarding interventions, consultation/referral: Focus emotional healing ministry on the negative emotions that precipitate substance abuse (that is, on the negative emotions that the person is self-medicating to avoid). ***Special risk factor:*** As noted above, mood, judgment, and behavioral inhibition are affected by even small amounts of alcohol or other street drugs. Therefore, *any* alcohol or non-prescribed psychoactive substance use is a special risk factor. Substance use, and especially acute intoxication, are such serious complicating factors that a mental health professional should always be involved in the care of someone who has any suicide risk and who does not stop using non-prescribed psychoactive substances in response to your request. To be very concrete: If a person is at suicide risk level 2 or 3, and is using alcohol and/or other non-prescribed psychoactive substances, mental health consultation is *not* necessitated by this concern if he stops when substance use is discussed as a special risk factor and he is asked to stop. Mental heath consultation *is recommended* if he does not agree to stop immediately, and/or if there is any follow-up evidence of continued use.

J. Variability, lability, and unpredictability: Another important part of making sense out of suicide-related phenomena, and an important part of assessing and caring for suicide risk, is understanding variability, lability, and unpredictability. Variability has to do with *how much* a person's suicide risk changes over time, lability has to do with *how easily* and *how rapidly* a person's suicide risk changes over time, and unpredictability has to do with how much you know (ahead of time) about the *timing* and *extent* of the suicide risk changes.

Variability, lability, and unpredictability are very interrelated. For example, if a person's suicide risk is very stable over time (as opposed to being variable), then it is also very predictable and minimally labile. Variability often contributes to unpredictability, but this is not always the case because variability can be predictable. For example, some people experience marked increase in suicide risk at certain times each year, such as the anniversary week of a spouse's death, but this variability is very regular and predictable. People who are labile (suicide risk changes easily and/or rapidly) are usually also unpredictable, but this is not always the case. For example, a person with marked dissociation may exhibit dramatic, sudden change when a suicidal part comes forward, but the triggers that bring this part forward and the suicide risk that this part carries may be well known and stable, so that suicide risk is stable and predictable *within the context of what is already known about the triggers and suicide risk associated with this part.*

Factors contributing to variability, lability, and unpredictability: Many different factors contribute to variability, lability, and unpredictability. For example, a bold/impulsive baseline personality style will often go along with baseline emotions and behavior that are more variable, labile, and unpredictable. Substance abuse and mental illnesses can impair the higher cognitive processes that normally help to maintain stability of emotions and behavior, and can also directly affect brain chemistry in ways that increase variability, lability, and unpredictability. "Crisis" triggering events, unresolved issues, and impaired coping ability contribute to variability, lability, and unpredictability because suicide risk flares suddenly in association with the acutely triggered emotions, as opposed to building gradually over time. Dissociative phenomena and demonic harassment can cause sudden changes in suicide risk,

and these changes can be smaller or larger, and easier or more difficult to trigger,[32] depending on the severity of the corresponding emotional wounds, dissociation, and demonic infection. The good news, as discussed elsewhere in this essay, is that effective emotional healing ministry can reduce or resolve many of these contributing factors.

Carefully considered, stable, predictable – variable, labile, unpredictable continuum: Some people carefully consider suicide as an "option" for solving a specific problem (for example, as a way to escape persistent pain or as a way to avoid some situation they don't want to face), and experience suicide risk that is relatively stable and predictable. This picture is seen in people with an experience like my own[33]. Their baseline personality style is cautious/ thoughtful, and their level of suicide risk during a given day, week, or even over the course of a month, will usually be relatively stable at one point on the suicide risk spectrum. When it changes, their suicide risk will usually move slowly and steadily from one point on the spectrum to the next[34]. In contrast to those who carefully consider the option of suicide, and experience stable and predictable suicide risk, some people experience variable, labile, unpredictable suicide risk, and make sudden, unpredictable suicide attempts.[35]

When the two end points are discussed, they seem like completely, qualitatively different subgroups within suicidal behavior. However, like most things in nature, in the real world there is a wide continuum, with "carefully considered," stable, predictable suicide risk at one end of the spectrum, and variable, labile, unpredictable suicide risk at the other end of the spectrum. This makes sense when one considers that the many different factors contributing to variability, lability, and unpredictability can be present to varying degrees, in any combination, in a given individual, and that each of these factors contributes to where the person will land on the continuum. A more cautious/thoughtful personality style will cause the person to lean towards the carefully considered, relatively stable, easier to predict end of the spectrum; while a bold/impulsive personality style will cause the person to lean towards the variable, labile, harder to predict end of the spectrum. No mental illness or minimal mental illness will cause the person to lean towards the carefully considered, stable, predictable end of the continuum; while more severe mental illness (especially if it includes psychosis) will cause the person to lean towards the variable, labile, harder to predict end of the continuum. No substance abuse or minimal substance abuse will cause the person to lean towards the

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[32] "Easier to trigger" means that smaller, more common, and more varied events will trigger the changes in suicide risk, and this results in increased lability and unpredictability.

[33] See "Case Study: Core Lies Can Be Expensive and Invisible" on the Case Studies page of www.kclehman.com for a description of my personal experience with suicidal thoughts.

[34] NOTE: My perception is that people with this profile usually complete suicide when they attempt suicide. For example, white male suicide attempters over 65 years of age usually fit this description, and they make almost no unsuccessful suicide attempts – 1.2 attempts for each completed suicide (Kaplan, HI and Sadock, BJ. *Comprehensive Textbook of Psychiatry, Sixth Edition, CD ROM.* (Williams and Wilkins: Baltimore, MD) 1996; Chapter 30:1, Psychiatric emergencies: Suicide: Attempted suicide). Therefore, for this group it is especially important to identify and address suicide risk before the person gets to the point of actually attempting suicide.

[35] My perception is that sudden, unpredictable suicide attempts are much more common, but also much less lethal. People who make sudden, unpredictable suicide attempts are usually more ambivalent, have not planned as carefully, and will usually (almost always?) reconsider and attempt rescue if the initial attempt is not immediately successful. I also think that many apparent "sudden, unpredictable suicide attempts" are actually mimic suicidal behavior.

stable...etc. end of the spectrum; while more severe substance abuse will cause the person to lean towards the variable...etc. end of the spectrum. And so on, for less or more unresolved issues, less or more difficulty with intense negative emotions, less or more severely impaired coping skills, less or more severe dissociative phenomena, and less or more severe demonic oppression. A person with all of these variables on the "less" side will be the "textbook" example of a person at the carefully considered, stable, easier to predict end of the spectrum. A person with all of these variables on the "more" side will be the "textbook" example of a person at the variable, labile, unpredictable end of the spectrum. A lot of discernment will be required in specific situations, but hopefully the discernment will be easier with contributing factors and the endpoints of the continuum clearly identified.

With suicide risk *variability* that is *predictable and known*, it is important to assess suicide risk and make decisions regarding MHP consultation based on the suicide risk at the peaks of the variability. For example, with dissociation, assess the parts that are most suicidal; with demonic oppression, assess peak suicide risk for the worst episodes of suicide-specific oppression; with clients who experience significant variation over their menstrual cycle, assess peak risk for the worst time of the month. Similarly, with suicide risk *lability* that is *known*, it is important to assess suicide risk and make decisions regarding MHP consultation based on suicide risk in light of the known lability. For example, a woman might have marked variability, with two especially bad days each month during which her suicide risk level goes over four. However, if her suicide risk does not change easily or suddenly (*lability known and low*), and if these especially bad days are very predictable, she can make special suicide risk management arrangements for this time each month. She might arrange to stay with a family member or friend during these two days each month, instead of being alone in her own apartment; she might plan therapy sessions, support group meetings, or other special resources for this time each month; and she can also schedule especially stressful events away from this time each month. *In the context of these special arrangements made possible by predictable variability and low lability*, the overall suicide risk is much less and MHP consultation may not be needed. In contrast, a person with high lability might have child ego states, unresolved issues, intense negative emotions, and episodes of suicide risk above level 4 that are *easily triggered and come on rapidly*. His episodes of crisis suicide risk will be *frequent, sudden, and more difficult to predict*. It is very hard to make special suicide risk management arrangements in this kind of situation, and it is only a matter of time until he has one of these episodes in a situation where adequate care is not available. The overall suicide risk is much greater, and MHP consultation should be obtained.

The combination of variability, lability, and unpredictability is a special risk factor if you don't know enough about the variability, lability, and/or other factors involved to assess suicide risk for the worst situations, and/or if suicide risk changes so dramatically, rapidly, and unpredictably that the person experiences episodes of suicide risk of level 4 or above in situations where adequate care is not available. The woman with predictable bad days and special suicide risk management arrangements would be a good example of variability, lability, and unpredictability that is *not* a special risk factor. The man with child ego states and intense unresolved issues, that are easily triggered and come on rapidly, is an example of the most important clinical situation where variability, lability, and unpredictability often *are* a special risk factor. Substance abuse, traumatic brain injury, and psychosis are several other important clinical situations where this combination is often a special risk factor. The strongest indicator that the combination of variability, lability, and unpredictability is a special risk factor is that the person has already experienced suicide risk crises that have resulted in sudden, unpredictable, true suicide attempts.

People who make sudden, unpredictable suicide attempts usually report thinking about suicide for less than an hour before making the actual attempt,[36] and this provides only a small window for intervention during the actual crisis. Sometimes "crisis" triggered painful emotions can be dealt with as a part of crisis intervention, as described in "B" and "C" above, but when variability, lability, and unpredictability are severe enough, you often get a suicide attempt before intervention is possible. When dealing with sudden, unpredictable suicide attempts, the best *inter*vention is *pre*vention. With persistent work over time, effective emotional healing ministry can help prevent sudden, unpredictable suicide attempts by reducing/resolving many of the factors that contribute to them.

Recommendations regarding interventions, consultation/referral: For variability and lability that is known and predictable, assess suicide risk and make decisions regarding MHP consultation based on the suicide risk for the worst situations. Long term care for suicide risk should include focusing emotional healing ministry on factors contributing to variability, lability, and unpredictability. ***Special risk factor:*** As discussed above, the combination of variability, lability, and unpredictability is a special risk factor (and therefore mental health consultation should always be obtained) if: 1. You don't know enough about the variability, lability, and/or other factors involved to assess suicide risk for the worst situations, and/or 2. Suicide risk changes so dramatically, rapidly, and unpredictably that the person experiences episodes of crisis suicide risk of level 4 or above in situations where adequate care is not available. NOTE: The suicide risk spectrum, below, should only be used as an adjunctive tool if the combination of variability, lability, and unpredictability is severe enough to be a special risk factor.

K. Mental illnesses: "Mental illnesses" are obviously a huge topic, and a thorough discussion of "mental illnesses and suicide related phenomena" is beyond the scope of this essay. However, I have tried to include a handful of key points that I think will enable lay-ministers to deal with mental illnesses as they contribute to suicide risk factors. I am hoping that some of the information presented here will also be helpful to mental health professionals as they work with mental illnesses, emotional healing, and suicide related phenomena.

Possibly the most important point is that mental illnesses *do not* cause suicide risk directly, but rather can contribute indirectly to suicide risk by sometimes causing/contributing to many of the suicide risk factors discussed here. These suicide risk factors then *do* contribute directly to suicide risk. For example, the particular brain chemistry imbalances of major depression seem to make a person especially vulnerable to hopelessness, and hopelessness is a suicide risk factor (as discussed above); the particular brain chemistry imbalances of bipolar disorder seem to make a person especially labile and unpredictable, and these are suicide risk factors (as discussed above); the particular brain chemistry imbalances of panic disorder seem to make a person especially vulnerable to sudden episodes of intense, "unbearable" negative emotions, and episodes of intense negative emotions are a suicide risk factor (as discussed above); and the particular brain chemistry imbalances of schizophrenia seem to make a person especially vulnerable to episodes of psychosis, and psychosis is a suicide risk factor (as discussed below).

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[36] Kaplan, HI and Sadock, BJ. *Comprehensive Textbook of Psychiatry, Sixth Edition, CD ROM.* (Williams and Wilkins: Baltimore, MD) 1996; Chapter 30:1, psychiatric emergencies: suicide: attempted suicide: motivations, explanations, and consequences.

Therefore, because mental illnesses don't cause suicide risk directly, lay ministers assessing suicide risk don't need to worry about identifying or diagnosing mental illnesses, but rather can simply focus on the suicide risk factors that the mental illnesses contribute to. For example, don't worry about diagnosing panic disorder, but rather simply pay attention to whether suicide risk level goes to 4 or above during sudden episodes of intense, "unbearable" anxiety. Don't worry about diagnosing major depression, but rather simply pay attention to whether hopelessness and/or impaired coping ability are pushing the suicide risk above level 3. Note that even though the lay minister doesn't need to know anything about identifying or diagnosing mental illnesses, she will indirectly identify many[37] mental illnesses for which mental health consultation would be appropriate *through identifying and assessing the suicide risk factors caused by the mental illnesses*. The person receiving ministry will be referred to a mental health professional because of the suicide risk, and the mental health professional can then diagnose the mental illness and make sure the person receiving ministry gets appropriate treatment.

Three exceptions – schizophrenia, schizoaffective disorder, and true bipolar disorder: I would encourage lay ministers to know the names of three mental illnesses – schizophrenia, schizoaffective disorder, and bipolar disorder. As with all other mental illnesses, these three mental illnesses don't cause suicide risk directly, but they have such important genetic, biological, brain chemistry components, and contribute to suicide risk factors in such important ways, that a mental health professional should always be involved in the care of anybody with one of these mental illnesses. Even though these mental illnesses are not *direct* suicide risk factors in the same way as the other risk factors discussed here, for the sake of the decision-making logic in the suicide risk spectrum section below, I consider these three mental illnesses to be "special risk factors" because their presence always indicates the need for mental health consultation. Therefore, it *is* useful for lay ministers to be aware of these three specific mental illnesses.

In the ideal world, lay ministers would be able to accurately identify these three illnesses so that they could always make appropriate referrals; however, I don't think it is reasonable to ask lay ministers to be able to make diagnostic assessments regarding these complex illnesses. Fortunately, there are several factors that make it possible for lay ministers to be part of what I consider an acceptable plan (less than the ideal world, but good enough for the real world).

Already diagnosed: Schizophrenia, schizoaffective disorder, and bipolar disorder tend to be life long illnesses, and are usually diagnosed in adolescence or young adulthood. This means that the illness will already have been identified in most people with one of these diagnoses. The person receiving ministry should be able to tell you if you ask them whether they have ever been diagnosed with one of these three illnesses. NOTE: The comments in this essay refer to accurate diagnoses of schizophrenia, schizoaffective disorder, and bipolar disorder. Unfortunately, people with PTSD (Post Traumatic Stress Disorder), dissociation, and demonic oppression are often misdiagnosed as having one of these three illnesses, especially when the mental health professionals performing the evaluations do not under-

[37] For those who care about careful logic: I say "many" instead of "all" because mental illnesses sometimes cause *disability* requiring mental health consultation without necessarily contributing to significant *suicide risk*. In these situations, mental health consultation and/or psychiatric medication would be appropriate to help moderate the disability, even though they are not required on account of suicide risk.

stand PTSD, dissociative phenomena, or demonic phenomena[38]. In light of both the frequency of misdiagnosis, and the importance of including ongoing mental health care if one of these illnesses are present, anybody who has carried one of these diagnoses should at least be evaluated by a mental health professional who understands Post Traumatic Stress disorder (PTSD), dissociative phenomena, and demonic phenomena. A mental health professional does not need to continue as a part of the team if it is determined that the diagnosis was erroneous (unless MHP involvement is indicated for some other reason).

"Special risk factors" and/or suicide risk level at or above 4: As already mentioned above, lay ministers will often indirectly identify mental illnesses by making appropriate referrals for "special risk factors" and/or suicide risk level at or above 4. This will provide a "safety net" for lay ministers regarding schizophrenia, schizoaffective disorder, and bipolar disorder, since these illnesses will often produce "special risk factors" and/or marked suicide risk when they are severe enough to require urgent mental health care. That is, even though a lay minister doesn't know how to identify/diagnose these three illnesses, she will appropriately refer people with these diagnoses if she follows the referral recommendations in the "Suicide Risk Spectrum" section (below) regarding suicide risk and "special risk factors."

Strange and/or alarming: The final "safety net" for lay ministers is to obtain mental health consultation any time your client is displaying symptoms that are significantly strange and/or alarming (and that you don't understand or know what to do with[39]). This is actually a good safety net for all mental illnesses,[40] but schizophrenia, schizoaffective disorder, and bipolar disorder are especially likely to cause strange and/or alarming symptoms – strange and/or alarming symptoms that a lay ministers would notice, even if he doesn't know enough to identify or diagnose the mental illness that is causing the symptoms.

"Other" mental illnesses are *not* special risk factors: Just to make sure this is *very* clear, mental illnesses other than schizophrenia, schizoaffective disorder, and bipolar disorder are *not* special risk factors. That is, other mental illnesses, such as dysthymia, depression, panic

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[38] For additional discussion of these diagnostic issues, see "Psychosis/psychotic symptoms and Theophostic®: General Comments and Frequently Asked Questions," and "Bipolar (manic depressive) disorder and Theophostic®: General Comments and Frequently Asked Questions" in the "Emotional Healing Ministry and Mental Illness" section on the "Articles and FAQs" page of www.kclehman.com.

[39] I include "and that you don't understand or know what to do with" because strange and/or alarming symptoms don't require mental health consultation if you understand them and know what to do about them. For example, demonic oppression can cause dramatic, strange, and alarming symptoms, but these do not require mental health consultation if you understand them and binding prayer and/or emotional healing ministry resolves the problem. Dissociation provides another good example. It can cause dramatic, strange, and/or alarming symptoms, but mental health consultation is not needed if the lay minister recognizes the dissociative phenomena and knows how to work with it in the context of emotional healing ministry.

[40] NOTE: I think that lay ministers can identify essentially all situations where mental health consultation would be appropriate by identifying: 1. Suicide risk level above four; 2. Suicide risk "special risk factors;" 3. Significant disability; 4. Thoughts that the person *cannot control* (obsessive and/or racing); 5. Thoughts that feel so bogged down in a "tar pit" that the person has *difficulty thinking at all*; and 6. Strange and/or alarming symptoms that the lay minister doesn't understand or know what to do with.

disorder, phobias, Post traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), eating disorders, and attention deficit disorder (ADD) *do not necessarily require mental health consultation*. For example, a person can have panic disorder and be at a baseline suicide risk level of 2, with peaks to 3 during panic attacks. An emotional healing minister can use one of the newer, more effective approaches to help the person address the underlying issues causing the panic attacks, and the person receiving ministry would *not* need mental health consultation as long as the emotional healing work is moving forward and his suicide risk level remains below 4. Or a person might have major depression and be at a baseline suicide risk level of 2, with peaks to 3 during times of increased hopelessness. An emotional healing minister can use one of the newer, more effective approaches to help the person address the underlying issues causing the depression, and the person receiving ministry would *not* need mental health consultation as long as the emotional healing work is moving forward and his suicide risk level remains below 4. Note also that although these other mental illnesses are not special risk factors in and of themselves, they can be the *source* of factors that can sometimes become severe enough to be special risk factors. For example, the brain chemistry imbalances of major depression and several of the anxiety disorders can cause a person's thoughts to race out of control, and this loss of thought control can sometimes interfere with his coping ability to the point that *impaired coping ability is a special risk factor*.

Recommendations regarding interventions, consultation/referral: Identify mental illnesses that call for the involvement of a mental health professional by asking whether the person has ever been diagnosed with schizophrenia, schizoaffective disorder, or true bipolar disorder, and by obtaining mental health consultation for 1. Suicide risk level above four; 2. Suicide risk "special risk factors; 3. Significant disability; 4. Thoughts that the person *cannot control* (obsessive and/or racing); 5. Thoughts that feel so "bogged down," as if in a mental "tar pit," that the person has *difficulty thinking at all*; and 6. Strange and/or alarming symptoms that the lay minister doesn't understand or know what to do with.

Psychiatric medications are *usually* a necessary part of the overall treatment plan for people with schizophrenia, schizoaffective disorder, and true bipolar disorder (this is one of the reasons I recommend that a mental health professional always be involved in their care). People with schizophrenia, schizoaffective disorder, and true bipolar disorder also have truth-based pain and unresolved emotional/spiritual issues, and will usually benefit from emotional healing ministry. Psychiatric medications can *sometimes* be helpful for the other mental illnesses, and are *usually* helpful when any of the other mental illnesses become *severe enough to cause special risk factors or significant disability*[41]. Most of the mental illnesses other than schizophrenia, schizoaffective disorder, and true bipolar disorder are caused primarily by underlying emotional/spiritual issues. They will almost always benefit from work with one of the newer, more effective emotional healing approaches, and can often eventually be completely resolved. ***Special risk factor:*** As discussed above, schizophrenia, schizoaffective disorder, and bipolar disorder are special risk factors, and a mental health professional should always be a part of the treatment team if the person receiving ministry carries one of these diagnoses. As also discussed above, other mental illnesses are *not* special risk factors, and mental health consultation is needed only when they cause suicide risk

[41] See "Depression and Theophostic®: General Questions and Frequently Asked Questions," and "Mind Before Brain, Big Picture" on the "Articles and FAQs" page of www.kclehman.com for additional discussion of the appropriate place of medication in the treatment of mental illnesses.

and/or disability severe enough to require the involvement of a mental health professional.

L. Psychosis: Psychosis is *not* a mental illness, but rather a specific clinical picture (collection of symptoms) that can be present as a part of a number of different mental illnesses. Active psychosis includes a number of acute clinical phenomena that contribute to suicide risk, such as disruption of ability to think logically (thought disorder), dramatically impaired judgment, command hallucinations to self harm, delusional thought content, and dramatically increased vulnerability to demonic influence. Psychosis is often also associated with chronic effects that contribute to suicide risk, since the chronic mental illnesses that include psychosis often cause loss of meaningful employment, financial difficulty, and relationship difficulties. The acute factors included in active psychosis especially contribute to the risk of unpredictable/impulsive suicide attempts. As with substance abuse, the chronic effects increase baseline pain and hopelessness, erode the support network, and impair coping skills, thereby increasing the risk of both unpredictable/impulsive and carefully considered suicide attempts.

Schizophrenia provides painful examples of the comments regarding psychosis as a suicide risk factor. Schizophrenia is one of the most important causes of psychosis, and always includes active psychosis at some point in the illness. It almost always also includes chronic effects, such as preventing or disrupting marriage, interfering with family and friendship support networks, and causing chronic unemployment and poverty. Research shows that ~15% of schizophrenics eventually die from suicide,[42] and also indicates that more than three quarters of the schizophrenics who die from suicide were acutely psychotic at the time they committed suicide[43]. As mentioned above, two of the few people we know who have completed suicide had schizophrenia and were actively psychotic at the time they committed suicide.

Note for lay ministers who are feeling overwhelmed by the thought of dealing with psychosis: You don't need to understand how psychosis works, you don't need to know about the mental health concerns that can cause psychosis, and you don't need to know how to treat psychosis. You just need to know how to recognize psychosis so you can obtain appropriate mental health consultation when you see it (See "Psychosis/Psychotic Symptoms and Theophostic Ministry: General Comments and Frequently Asked Questions" on the Articles and FAQs page of www.kclehman.com for a definition and brief discussion of psychosis). Once you know how to recognize it, and know to obtain consultation whenever you see it, you no longer need to be fearful regarding psychosis as you facilitate emotional healing ministry.

Dr. Lehman takes another step into the real world: As with schizophrenia, schizoaffective disorder, and bipolar disorder, in the ideal world lay ministers would be able to accurately identify psychosis so that they could always make appropriate referrals. However, I realize that many won't be able to do this (even if they do have time to read my excellent essay ☺ mentioned above). Fortunately, I think it is also possible for lay ministers to be part of what I consider an acceptable plan with respect to psychosis. My assessment is that lay people can

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[42] Kaplan, HI and Sadock, BJ, Chapter 30:1, Psychiatric emergencies: Suicide: Psychiatric Patients: Schizophrenia.

[43] Heila H, et al. "Suicide and schizophrenia: a nationwide psychological autopsy study on age- and sex-specific clinical characteristics of 92 suicide victims with schizophrenia." *Am J Psychiatry* 1997 Sep;154(9):1235-42.

identify almost all psychosis by obtaining mental health consultation for the same criteria as for "mental illnesses that call for the involvement of a mental health professional:" 1. Suicide risk level above 4; 2. Suicide risk "special risk factors; 3. Significant disability; 4. Thoughts that the person *cannot control* (obsessive and/or racing); 5. Thoughts that feel so "bogged down," as if in a mental "tar pit," that the person has *difficulty thinking at all*; and 6. Strange and/or alarming symptoms that the lay minister doesn't understand or know what to do with.

Emotional healing ministry can be helpful: It is important to realize that emotional healing ministry can be helpful, even for people with psychosis. Care providers often seem to follow strange logic along the lines of "the person needs psychiatric medication for his/her psychosis, so therefore emotional healing ministry would not be helpful." *Note: I recommend that a mental health professional be a part of the team whenever emotional healing ministry is attempted with a person who has psychosis, since this is especially difficult and can sometimes cause clinical exacerbation (make things worse).* However, emotional healing ministry can also sometimes be very helpful for a person with psychosis. As just discussed above, people with schizophrenia, schizoaffective disorder, and true bipolar disorder (the most important causes of psychosis), also carry unresolved emotional and spiritual issues, and can often benefit from emotional healing ministry. Furthermore, psychosis can sometimes be caused by problems such as dissociative PTSD, substance abuse, or demonic harassment – problems that can be resolved with effective emotional healing ministry.

Recommendations regarding interventions, consultation/referral: Identify psychosis by obtaining mental health consultation for 1. Suicide risk level above four; 2. Suicide risk "special risk factors; 3. Significant disability; 4. Thoughts that the person *cannot control* (obsessive and/or racing); 5. Thoughts that feel so "bogged down," as if in a mental "tar pit," that the person has *difficulty thinking at all*; and 6. Strange and/or alarming symptoms that the lay minister doesn't understand or know what to do with. Psychiatric medications (antipsychotics) are often[44] helpful, so this option should always be considered. Use emotional healing ministry to reduce/resolve the causes of psychosis (as appropriate, with a mental health professional). ***Special risk factor:*** Psychosis almost always indicates a serious underlying mental health concern (such as severe dissociative Post Traumatic Stress Disorder, severe substance abuse, bipolar disorder, schizoaffective disorder, or schizophrenia), or a serious medical illness (such as brain tumor or other serious neurological problem). Both the acute and chronic effects of psychosis can contribute dramatically to unpredictability. A mental health professional should always be consulted if the person receiving ministry is experiencing active psychosis.

M. Demonic oppression: Demonic spirits seem to have a long term plan of increasing baseline misery and hopelessness in every way they can, and this increases the risk of both impulsive and carefully considered suicide attempts. Acute attacks, focusing specifically on the compulsion to commit suicide, especially increase the risk of sudden, unpredictable suicide

[44] As discussed in "Psychosis/Psychotic Symptoms and Theophostic Ministry: General Comments and Frequently Asked Questions" (Articles and FAQs page, www.kclehman.com), several phenomena seen in severe dissociative PTSD can be mistaken for psychotic symptoms, and it is important to consider this differential diagnosis carefully. PTSD *can* include true psychotic symptoms as a part of flashbacks and/or system overload, but my experience is that antipsychotic medications are usually *not* helpful for these clients. Antipsychotic medications usually *are* helpful for psychotic symptoms from most other sources (for example, schizophrenia, bipolar disorder, drug abuse, brain cancer, etc.).

attempts.[45]

This issue is not discussed in the professional literature or in psychiatric text books, but in my personal professional experience, demonic spirits actively pushing for suicide are one of the most serious suicide risk factors. This specific suicidal oppression has been present in all of the most dangerously suicidal people with whom I have worked. Of all the suicidal patients I have worked with (hundreds and hundreds), only a very small number have actually completed suicide. Almost all of those who actually completed suicide had demonic spirits pushing for suicide[46]. The good news is that this kind of demonic oppression can often be resolved with simple commands in the name of Jesus[47]. If demonic spirits initially resist simple commands, there are always reasons that they are able to stay, and they can always be removed if the underlying issues are identified and resolved. Another piece of good news is that the person receiving ministry can usually dramatically reduce suicidal oppression between sessions by learning to use simple binding prayers. For example, one of our clients reported that he had been waking up at 1:00 a.m. "Almost every night for years," and that he would then spend an hour or two wrestling with intense thoughts encouraging/pushing him to commit suicide. I suspected demonic oppression, and suggested that he try our sample prayer for binding demonic harassment[48]. He came back two weeks later and reported "This is amazing! I keep that prayer by my bed, and use it whenever I wake up with the suicidal thoughts. I go through it once – it only takes about three minutes – and the thoughts are gone and I go back to sleep."

Recommendations regarding interventions, consultation/referral: Use the 1 John test (and other tools if necessary)[49] to discern between demonic spirits and internal parts. If these diagnostic tools indicate demonic spirits, then start with asking the person whether or not she wants those spirits to remain. Ask whether she feels any internal resistance to not having the demon(s) there promoting the suicide option. If she says she does not want the demon(s) there, and is willing to live without having their "assistance" in managing her pain, then try simple deliverance commands. If there is resistance, use one of the more effective approaches to emotional healing ministry to address underlying issues. Teach the person receiving ministry to use binding prayers to deal with demonic suicidal oppression between sessions.

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[45] See "Case Study: Major Mental Illness, Spiritual Oppression, and Deliverance" on the Case Studies page of www.kclehman.com for the case study description of Charlotte's grandmother's experience with demonic oppression and suicidal behavior (34 years of a combination of both the acute and chronic aspects of demonic oppression regarding suicide risk).

[46] Unfortunately, at the time I was working with these clients I did not know as much about dealing with this kind of demonic oppression. Also, dealing with demonic oppression was complicated in these two cases because they were both schizophrenics, with active psychosis at the time they killed themselves.

[47] See "Major Mental Illness, Spiritual Oppression, and Deliverance" on the Case Studies page of www.kclehman.com for an example of longstanding, serious suicidal risk being resolved with simple deliverance commands.

[48] See "'Binding' the Enemy: Prayers and Commands to Alleviate Demonic Harassment and/or Oppression" on the Ministry Aids page of www.kclehman.com

[49] See "Distinguishing Between Demonic Spirits and Internal Parts" on the "Ministry Aids" page of www.kclehman.com for discussion of the 1 John test and other tools for discerning between demonic spirits and internal parts.

Special risk factor: *Severe*[50] demonic oppression specifically pushing for suicide is a special risk factor. Suicidal demonic oppression is another good example of a special risk factor that can sometimes be resolved quickly (and therefore *not* contribute a "special risk factor consideration" requiring mental health consultation in the situations where quick resolution is possible).

N. Dissociative phenomena: People with moderate-severe dissociation can change dramatically and suddenly, and this can contribute to suicide risk by increasing variability. If you don't know the internal parts well, and/or the internal system is very complex, dissociation can contribute to suicide risk by contributing unpredictability in addition to variability (see below for additional discussion of variability and unpredictability). Internal parts can also specifically and directly push for suicide, but in my experience they are much less dangerous than demonic spirits. Their push for suicide tends to be less compelling, and usually also less hateful (although sometimes internal parts can have intense self-hatred). If internal parts are encouraging suicide, it will *always* be because they truly believe suicide is the best option for the person. The problem of internal parts encouraging suicide can be resolved by working with Jesus to expose and resolve the lie-based thinking behind their reasons for encouraging suicide.

   In the short term, emotional healing ministry can address specific parts carrying specific lies regarding the need for suicide. Over time, emotional healing ministry addresses the whole dissociative phenomena, with corresponding steady decrease in suicide risk variability and unpredictability.

   Recommendations regarding interventions, consultation/referral: Use the 1 John test (and other tools if necessary) to discern between demonic spirits and internal parts. If these diagnostic tools indicate internal parts, they will always have a reason they believe suicide is actually the best plan for the person. Use emotional healing ministry to address their lie-based beliefs regarding suicide. ***Special risk factor:*** Dissociation is a special risk factor if there are any parts causing episodes of suicide risk level 4 or higher, and/or if the dissociative phenomena introduces severe unpredictability.

O. Availability of easy, fast, and irreversibly deadly method: Extensive research shows that access to a "convenient" and irreversibly lethal suicide method (such as firearms) significantly increases the risk of completed suicide[51]. The key here is that in a moment of especially intense negative emotions, a *sudden, impulsive* suicide attempt is much more likely to be lethal. For example, if a person has an especially intense suicidal impulse, and then picks up a pistol, puts it in his mouth, and pulls the trigger, he will usually end up dead. There isn't much opportunity for second thoughts or "rescue" with this kind of suicide attempt. On the other hand, many people take an impulsive medication overdose, but then decide they don't really want to commit suicide. If a person takes an overdose of aspirin in response to an especially intense suicidal impulse, 30 minutes later he will still be alive (usually vomiting), and usually thinking intensely about whether or not he really wants to commit suicide. If he

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[50] I define demonic compulsion to commit suicide as *severe* if the suicide risk level goes to 4 or above during the episodes of acute compulsion to suicide.

[51] See, for example, Brent DA. "Firearms and suicide." *Ann N Y Acad Sci* 2001 Apr;932:225-39; discussion; 239-40 and Miller M; Azrael D; Hemenway D. "Household firearm ownership and suicide rates in the United States." *Epidemiology* 2002 Sep;13(5):517-24

changes his mind, asks for help, and receives appropriate medical care, he will probably be okay – usually with no permanent injury whatsoever. It is easy to rescue someone who changes his mind after an impulsive suicide attempt with an aspirin overdose. <u>You can significantly reduce the risk of completed suicide by taking the single, simple step of removing easily accessible firearms</u>.[52]

Recommendations regarding interventions, consultation/referral: In case it's not already abundantly clear, a simple step, that should always be taken, is to remove firearms from the home of anybody who is suicidal. ***Special risk factor:*** If a person is at suicide risk level 2 or 3, mental health consultation is *not* necessitated by this concern if firearms are immediately removed from the home. Mental heath consultation *is recommended* if firearms are not immediately removed from the home.

IV. Suicide risk spectrum: This suicide risk spectrum, and the accompanying recommendations regarding interventions and consultation/referral, are especially designed for people at the "carefully considered," stable, predictable end of the continuum just discussed in section III(J)[53]. For those with variable suicide risk, make sure to determine the risk level for conditions of highest risk, and make decisions regarding intervention and consultation/referral based on this highest risk level. This suicide risk spectrum and the accompanying recommendations become less valid, and should be used with increasing caution, as there is more variability, lability, and unpredictability. Make sure to include combined variability, lability, and unpredictability in the assessment of overall suicide risk and in decision making about interventions and consultation/referral. At the variable, labile, hard to predict end of the continuum, this suicide risk spectrum should be used only as an adjunctive resource, not as the primary assessment tool.

Level 1 – Wish to escape pain, but no thoughts of actual suicide: At some point in their lives, 99.9% of the population (maybe more?) wish for an easy escape from the pain they are in. Many of these people have thoughts, or make comments, along the lines of "I wish I could go to sleep tonight and wake up in Heaven," "Jesus, take me home," "I wish I were dead," or even "I want to die." I often had thoughts like this during miserable moments in college, medical school, internship, and residency. For example, when I had a big exam in the morning, I would have thoughts like "Lord Jesus, if You are trying to figure out when to return, this would be a good time. It would be very okay with me if you would come back before my advanced engineering mathematics exam tomorrow morning." The key to level one (essentially no suicide risk) is that careful questioning reveals that the person wishes to escape from the pain he is in, *but does not have thoughts about actually committing suicide*. This says the person is hurting, and wishes he

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[52] Brent DA et. al. "The presence and accessibility of firearms in the homes of adolescent suicides. A case-control study." JAMA 1991 Dec 4;266(21):2989-95

[53] This suicide risk spectrum would have very accurately assessed my suicide risk during my medical training. I remained steady at level 1 for most of the last two years of medical school, and then moved slowly and steadily to level 2, then to level 3, then to 3.9 (almost to level 4) during the first 6 months of my internship. I remained half way between level 3 and level 4 pretty much every day for the next 12 months, and then steadily decreased back to level 1 as I began to see the light at the end of the tunnel and as the intensity of my daily emotional pain subsided. The recommendations would also have been very accurate and helpful. Mental health consultation would have been appropriate in the absence of effective emotional healing ministry. With effective emotional healing ministry, my hopelessness would have resolved quickly, and my other pain would have steadily resolved over time as underlying issues were addressed. Again, See "Case Study: Core Lies Can Be Expensive and Invisible" on the Case Studies page of www.kclehman.com for a description of my personal experience with suicidal thoughts.

weren't in pain, but there is ***no real suicide risk.***

From one perspective, level 1 shouldn't even be on the suicide risk spectrum, since people in this category aren't really suicidal at all. The reason I am including this clinical picture as the beginning of the suicide risk spectrum is that people often move from this place to level 2 as the pain becomes more intense, and/or the pain lasts longer, and/or the person becomes more hopeless about the prospect of relief from the pain. Also, a lay minister who hears someone he is ministering to make a comment such as those typical of this level might get anxious and wonder whether some sort of intervention is necessary.

Recommendations regarding interventions, consultation/referral: One of the most important points about people at level 1 is that they are ***not*** at any significant risk for suicide, and identifying this is important in order to avoid unnecessary stress, interventions, or referrals. In my experience, people stable at level 1 do ***not*** need mental health consultation regarding suicide risk. My assessment is that lay ministers can provide the primary care/ministry for people at level 1 as long as other special risk factors (as discussed above) are not present. The most important intervention is to use effective emotional healing ministry to resolve underlying issues that are contributing to the person's pain. Other interventions to help decrease pain are described under level 2, below. There is no emergency at level 1, but if one waits too long to address the pain at level 1, the person will often eventually start to slide into higher levels of suicide risk.

Level 2 – Brief, occasional suicidal thoughts: If the pain is severe enough, and/or if the pain lasts long enough, and/or if the person begins to lose hope of relief, he will often begin to think about suicide as a way to escape the pain. At level 2, thoughts like "What if I killed myself?" or "I could just kill myself, and end all of this pain" come into the person's mind occasionally. The person actually thinks about killing himself. The possibility of suicide is briefly considered, but is dismissed quickly. This says "I am really hurting," and is an early warning signal that something needs to change.

Recommendations regarding interventions, consultation/referral: One of the most important points about people at level 2 is that they are ***not*** at immediate suicide risk, and identifying this is important in order to avoid unnecessary stress, interventions, or referrals. As with level 1, there is no emergency at level 2, but the person will usually eventually slide into higher levels of suicide risk if the pain continues without relief or hope of relief. In my experience, people stable at level 2 do ***not*** need mental health consultation regarding suicide risk. My assessment is that lay ministers can provide the primary care/ministry for people stable at level 2 as long as special risk factors are not present.

Pursue interventions to help reduce pain and hopelessness: The most important intervention is to use effective emotional healing ministry to address underlying issues that are contributing to the person's pain. The best possible scenario is that emotional healing ministry quickly resolves the underlying sources of pain, or at least provides significant immediate relief and clear hope of additional relief in the future[54]. When this occurs, the suicide risk usually decreases quickly and dramatically. Other options to help reduce pain and hopelessness include (these are especially important if effective emotional healing ministry is not immediately available):

- If the person does not have immediate access to effective emotional healing ministry (such as Theophostic® or EMDR with prayer), these options can be discussed as a source of hope.

[54] As describe below, this would have been very helpful in my own experience with suicide risk.

- Listen to them. Most people report that it feels very good just to know they have been heard. I think the key here is that if you really hear what they are saying about their pain, they don't feel *alone* in the pain any more.
- Pursue options for enhancing their support network (family, friends, church small group, etc.). This can provide concrete help to reduce acute pain/stress, such as child care to give the person respite. More importantly, this addresses the "alone" factor that increases the subjective experience of pain from any source.

"Quick" resolution of special risk factors as an especially strategic target: As mentioned at several places in the "Factors contributing to suicide risk" section, special risk factors can sometimes be resolved quickly. Quick resolution of special risk factors is an important strategic target *at every level of suicide risk*, because quick resolution of special risk factors can often "downgrade" the interventions that are needed. For example, if you discover that the person's suicide risk level goes up to 6 in association with demonic suicidal compulsions, but then this demonic oppression is resolved before you finish the session and the suicide risk drops back down to level 4, you can work on a plan to obtain consultation sometime in the next couple weeks instead of driving the person to the emergency room this afternoon. For people who are otherwise at a baseline suicide risk level of 2 or 3, quick resolution of special risk factors eliminates the need for mental health consultation.

Level 3 – Frequent, longer lasting thoughts of suicide: For levels 3 through 8, the level of suicide risk increases steadily as the intensity of pain, and/or the duration of pain, and/or the depth of hopelessness continue to increase. At level 3, thoughts of suicide become frequent, and are entertained much longer. People in this stage are weighing the pros and cons as they seriously consider suicide as a real option. After weighing the pros and cons, they are still concluding, clearly and consistently, that it is not a good/acceptable plan. This says "I am REALLY hurting." In my experience, people stable at level 3 are *not in immediate danger of committing suicide*, but this is a warning sign that indicates something REALLY needs to change.

Recommendations regarding interventions, consultation/referral: As with level 2, one of the most important points about people at level 3 is that they are ***not*** an immediate suicide risk, and identifying this is important in order to avoid unnecessary stress, interventions, or referrals. In my experience, people stable at level 3 do ***not*** need psychiatric hospitalization or mental health consultation regarding suicide risk, as long as special risk factors are not present, and as long as they are receiving regular ministry (weekly or more is ideal), with clear evidence of steady progress. My assessment is that lay ministers can provide the primary care/ministry even for people at level 3, as long as the person meets the criteria just mentioned. There is no immediate suicide risk at level 3, but the person will usually eventually slide into higher levels of suicide risk if the pain continues without relief or hope of relief. Mental health consultation regarding suicide risk ***should*** be obtained if effective emotional healing ministry is not immediately available, if the emotional healing work seems stuck, if special risk factors are present, or if the person fluctuates to level 4 at any time.

Time urgency: Time urgency for obtaining mental health consultation is an especially difficult question. It often takes weeks, or even months, to get an appointment with a competent Christian mental health professional. Going to the emergency room is one of the most reliable ways to obtain an immediate mental health consultation, but this is very expensive (stigma and stress, as well as financial cost). Careful and painful discernment is required. The time urgency can vary greatly. For example, taking weeks to obtain consultation is probably okay if the risk level is high 3 or low 4, the person has a very good support system (family and friends that can spend a lot of

time with him, and at least check in every day), the person has immediate access to effective emotional healing ministry, and the person looks you in the eye and agrees not to hurt himself before the consultation (and you know him well and trust his word). On the other hand, you should do everything you can to obtain consultation today if the risk level is 4-but-leaning-towards-5, the person has a poor support system, the person does not have immediate access to effective emotional healing ministry, and you do not know the person well enough to trust any promises he makes about personal safety.

Pursue interventions to help reduce pain and hopelessness: Same as for level 2, with the following additional comments:

- A person seriously considering suicide almost always has some component of hopelessness. She believes, to some degree, "There's no way I can make it/There's no way it will work out/There's no real chance that my life will ever be okay." If receiving regular healing, with clear evidence that emotional pain is steadily decreasing, does not quickly resolve hopelessness, then there are underlying issues directly contributing to hopelessness. When this is the case, focus emotional healing ministry especially on lies and/or other underlying issues contributing directly to the hopelessness.
- If effective emotional healing ministry is not immediately available, discussion of this option can still be used to provide hope, but mental health consultation should be obtained (as mentioned above).
- The "Other" options for reducing pain and hopelessness should be more actively pursued, as augmentation to the emotional healing ministry, for people with more complicated problems and/or for people who are more seriously suicidal.
- People at level 3 or above often have components of mental illness that include disrupted brain chemistry, that can impair the person's ability to participate in other interventions, and that can require treatment with medication (at least as temporary assistance). Even though a person stable at level 3 does *not* require mental health consultation on the basis of suicide risk, the *ideal* situation would be for everyone at level 3 to obtain a mental health evaluation in order to screen for mental illnesses that could benefit from treatment with medication[55]. If the person does not have significant mental illness, and meets the other conditions described above, then lay ministers could continue as the primary ministry/care providers.

Level 4 – Scales tipping back and forth: At level 4, the pro and con analysis is becoming unclear. The arguments against suicide that have felt adequate in the past are starting to feel less convincing. The person is no longer sure that suicide is a bad plan. This is a difficult gray zone between level 3 and level 5.

Recommendations regarding interventions, consultation/referral: A person at level 4 may or may not be an immediate suicide risk. She definitely needs mental health consultation regarding suicide risk. A mental health professional may or may not need to be involved in the person's *ongoing* care (to help deal with suicide risk), and the person may or may not need psychiatric hospitalization. Time urgency considerations for obtaining consultation are as described above under level 3. Pursue interventions to help reduce pain and hopelessness: Same as for level 3.

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[55] Unfortunately, it is not always possible to obtain mental health evaluations for everybody at level 3. In these situations, it is important to prioritize available resources for those who are most likely to benefit from them. Important clues indicating mental illnesses that need treatment with medication are: 1. Significant disability; 2. Thoughts that the person *cannot control* (obsessive and/or racing), or thoughts that feel so bogged down in a depression "tar pit" that the person has *difficulty thinking at all*; and 3. Strange and/or alarming symptoms that the lay minister doesn't understand or know what to do with.

Level 5 – Scales tipping towards suicide, planning fatal attempt: At level 5 the person is thinking frequently/constantly about suicide. He is planning (or has already planned) the details of an attempt that is intended to be fatal, and is trying to decide whether he really wants to go through with it. The person is going through a last round of decision making – "Am I really sure?"

Recommendations regarding interventions, consultation/referral: A person at level 5 may or may not be an immediate suicide risk. She could linger at this "last round of decision making" for months, or she could be dead in an hour. A mental health consultation should be obtained as soon as possible, and a mental health professional should be involved in the person's ongoing care (at least to help deal with the risk of suicide). Time urgency considerations for obtaining consultation are similar to those for levels 3 and 4, except that everything should lean more towards "Do everything you can to obtain consultation today." If the person is at level 5-leaning-towards-6, effective emotional healing ministry is not immediately available, they have a poor support system, and/or any of the special risk factors are present, then have someone stay with the person until consultation is obtained. Use the emergency room if this is the only way to obtain immediate consultation. Pursue interventions to help reduce pain and hopelessness: Same as for levels 3 and 4.

Level 6 – Planning and Intending fatal attempt, has needed materials: At level 6, the person is planning a suicide attempt that he intends to be fatal, and has the needed materials already available. The only reason the person has not already attempted suicide is that he has not yet had the opportunity and/or "doesn't have the courage." NOTE: If the person has actually taken action to prepare, this is an additional warning sign (for example, purchased ammunition and loaded the gun in preparation for suicide).

Recommendations regarding interventions, consultation/referral: A person at level 6 is definitely an immediate suicide risk. Someone (family, friend, pastor, etc.) should stay with the person until mental health consultation has been obtained. Use the emergency room if this is the only way to obtain immediate consultation (even call the police to escort him to the emergency room if this is necessary). A mental health professional should be involved in the person's ongoing care (at least to help deal with the risk of suicide). Psychiatric hospitalization is usually, but not always, required. For example, the person may not need hospitalization if they have a *very* good support system (including a good working relationship with a mental health professional), if they already had marked ambivalence about committing suicide, and if effective emotional healing ministry is immediately available and the person agrees to try this as an alternative to suicide. Pursue interventions to help reduce pain and hopelessness: Same as for levels 3-5.

Level 7 – True suicide attempt, but with some degree of ambivalence: At level 7, the person truly wanted to die and intended to die at the initiation of the attempt, but then aborted the attempt by initiating rescue. For example, took an overdose that she believed would be fatal, with initial intent to die, but then changed her mind and called for help.

Recommendations regarding interventions, consultation/referral: A person at level 7 is definitely an immediate suicide risk. Someone should stay with the person until mental health consultation has been obtained. Use the emergency room if this is the only way to obtain immediate consultation (even call the police to escort her to the emergency room if this is necessary). A mental health professional should be involved in the person's ongoing care (at least to help deal with the risk of suicide). Psychiatric hospitalization is usually, but not always, required. For example, the person may not need hospitalization if she has a *very* good support system (including a good working relationship with a mental health professional), if the suicide attempt demonstrated

marked ambivalence, and if effective emotional healing ministry is immediately available and she agrees to try this as an alternative to suicide. Pursue interventions to help reduce pain and hopelessness: Same as for levels 3-6.

Level 8 – True suicide attempt, accidental survival: At level 8, the only reason the person is alive is that he accidentally failed. For example, he believed the method would be fatal, planned the attempt to avoid potential rescuers, and did not try to get help after making the attempt. There was no perceivable ambivalence, and he failed and/or was rescued accidentally.

Recommendations regarding interventions, consultation/referral: A person at level 8 is an intensely severe and immediate suicide risk. Psychiatric hospitalization is definitely necessary, and someone should stay with the person until he can be admitted. If necessary, call the police to escort him to the hospital. Pursue interventions to help reduce pain and hopelessness: Same as for levels 3-7.

VI. Resolution of suicide risk: One of the most exciting aspects of effective emotional healing ministry is that it can usually provide *resolution* of suicide risk, as opposed to just *management* of suicide risk. Successful emotional healing ministry can sometimes quickly provide resolution of the underlying roots of the suicide risk, and effective emotional healing ministry over time can almost always eventually provide resolution of the underlying roots of suicide risk. Most of this material has already been discussed in other sections, but I thought it would be helpful to summarize, in one section, all of the ways emotional healing ministry can contribute to the *resolution* of suicide risk.

A. Reduction of total pain: Successful emotional healing ministry produces progressive resolution of multiple sources of pain, so that the size of the pain pile steadily decreases. The person's suicide risk begins to resolve as the size of the overall pain pile feels more and more bearable. The suicide risk resolves completely when the person is stable at the place of no longer feeling like he has to commit suicide to escape unbearable pain.

B. Resolution of hopelessness: Even a few successful emotional healing ministry sessions can sometimes resolve hopelessness by demonstrating that the pain will not go on forever – that we have a tool that will consistently resolve the underlying sources of pain. Emotional healing ministry can also resolve hopelessness by directly addressing specific sources of triggered hopelessness.

C. Resolution of intense negative emotions (other than hopelessness): Effective emotional healing ministry can resolve "triggered" intense negative emotions coming from underlying spiritual and/or emotional issues, and can also resolve/reduce intense negative emotions coming from truth-based pain.

D. Resolution of underlying issues (unresolved emotional and/or spiritual issues): Effective emotional healing ministry can resolve the underlying spiritual and/or emotional issues that drive most of the other factors contributing to suicide risk.

E. Prevention of "crisis" events that trigger intense negative emotions: "Systems" emotional healing ministry with family, or other key people in the persons life, can be an important part of decreasing dysfunctional interactions that cause pain (both truth-based pain and triggered, lie-based pain). Emotional healing ministry can also provide indirect benefit by addressing issues that often precipitate "crisis" events, such as substance abuse and triggered, reactive

behavior.

F. Improvement of coping ability: Impaired coping ability increases the final impact of every other factor contributing to suicide risk, and underlying issues being stirred up is the most important factor contributing to impaired coping ability. This triggered impairment will occur less often and less intensely as emotional healing ministry resolves more of the underlying spiritual and emotional issues. Furthermore, resolution of underlying issues frees a person to learn and use healthy coping skills.

G. Improving/repairing poor support system: "Systems" emotional healing ministry with key people in the person's life can directly benefit his support network by increasing the ability of these people to provide healthy, appropriate support. Effective emotional healing ministry can also provide indirect benefit by addressing issues that hinder building and using a support network, and/or issues that erode relationships and other support resources that might already be in place.

H. Resolution of substance abuse: Substance abuse causes both acute and chronic problems that contribute to both carefully considered suicide attempts and sudden, unpredictable suicide attempts. Effective emotional healing ministry can truly and permanently resolve substance abuse by addressing the underlying issues causing the pain for which the person is self medicating.

I. Resolution/reduction of variability, lability, and unpredictability: Variability, lability, and unpredictability make suicide risk harder to assess and care for, and especially contribute to sudden, unpredictable suicide attempts. Effective emotional healing ministry will reduce/ resolve many of the factors that contribute to variability, lability, and unpredictability.

J. Resolution/reduction of mental illnesses: Mental illnesses can cause/contribute to many of the other factors that contribute to suicide risk. People with schizophrenia, schizoaffective disorder, and true bipolar disorder *also* have truth-based pain and unresolved emotional/ spiritual issues, and will usually benefit from emotional healing ministry. Most of the mental illnesses other than schizophrenia, schizoaffective disorder, and true bipolar disorder are caused primarily by underlying emotional/spiritual issues. They will almost always benefit from work with one of the newer, more effective emotional healing approaches, and can often eventually be completely resolved.

K. Reduction/resolution of psychosis: People with schizophrenia, schizoaffective disorder, and true bipolar disorder (the most important causes of psychosis), also carry unresolved emotional and spiritual issues, and can often benefit from emotional healing ministry. Psychosis can sometimes be caused by problems such as dissociative PTSD, substance abuse, or demonic harassment, and these problems can often be resolved with effective emotional healing ministry.

L. Resolution of demonic oppression: Demonic spirits contribute to baseline misery and hopelessness, and also come with acute attacks focusing specifically on the compulsion to commit suicide. Suicide risk from demonic spirits can sometimes be resolved with simple commands in the name of Jesus, and can always be resolved as the underlying issues are identified and resolved. The person receiving ministry can also dramatically reduce suicidal oppression between sessions by learning to use simple binding prayers.

M. Resolution of dissociation related factors: Variability, lability, and unpredictability due to dissociative phenomena will steadily resolve as the underlying dissociated traumatic memories are resolved. The problem of specific internal parts carrying severe suicide risk and/or encouraging suicide can be resolved by working with Jesus to expose and resolve the lie-based thinking behind their reasons for wanting suicide.

N. Prevention of sudden, unpredictable suicide attempts: Sometimes "crisis" intense painful emotions can be dealt with as a part of crisis intervention, as described in "B" and "C" above, but when variability, lability, and unpredictability factors are severe, you often get a sudden, unpredictable suicide attempt before intervention is possible. When dealing with sudden, unpredictable suicide attempts, the best *inter*vention is *pre*vention. With persistent work over time, effective emotional healing ministry can help prevent sudden, unpredictable suicide attempts by addressing the factors that contribute to them.

O. Resolution of mimic suicidal behavior: Although mimic suicidal behavior does not indicate true suicide risk, it can sure get in the way of caring for true suicide risk by causing confusion and intimidation regarding suicide related phenomena, and by causing important resources to be used unnecessarily. Resolving mimic suicidal behavior definitely benefits the overall task of caring for true suicide risk, and effective emotional healing ministry can resolve the different kinds of mimic suicidal behavior by identifying and resolving the underlying issues and/or guardian lies that drive them.

VII. Management of suicide risk: Suicide risk *management* is necessary in situations where it is not possible to immediately resolve the underlying source(s) of the suicide risk. For example, if somebody is suicidal because she is in intense emotional pain, but she is not yet willing to participate in emotional healing ministry to resolve the roots of her pain, then other interventions need to be made so that she doesn't kill herself before she gets healing. Or a person may be suicidal due to intense emotional pain, and be participating in emotional healing ministry, but have a very large pile of traumatic memories that cannot be quickly resolved. Other interventions need to be made so that she doesn't commit suicide before the emotional pain is reduced enough to resolve the temptation to suicide. Or a person may be suicidal because of intense hopelessness lies that are anchored in specific traumatic memories (as described above), but she is unable to get through to complete resolution by the end of the time available for emotional healing ministry, and therefore needs care regarding her suicide risk until further ministry can be obtained.

There are many books and hundreds of professional journal articles written on ways to manage suicide risk, and I will not even try to summarize this material in this short essay. Examples of suicide risk management interventions include:

- Developing a support network of people that are willing to provide immediate contact during times of crisis, so that the person can call or be with somebody when she is intensely suicidal.
- "Systems" emotional healing ministry intervention: Emotional healing ministry with family members, and/or other members of the support network, to enable them to function more effectively in caring for the person's suicidal risk.
- No-self harm contract: This is an agreement made with the person receiving ministry that he will not harm himself; it may have various clauses and specifics which the minister and person receiving ministry negotiate about.
- Cognitive therapy and/or theological discussions to identify other options and to focus the costs of suicide (challenging the conclusion that suicide is the only option/best option).
- Brief contact, not to resolve the underlying pain, but to help the person get back to an adult ego

state where he can hold onto the reality that progress is being made, and that his pain will steadily decrease as he continues to receive emotional healing ministry.
- Teaching the person self-soothing tools, such as relaxation techniques, that she can use to help decrease the intensity of painful negative emotions during times of crisis.
- Psychiatric medication to moderate the intensity of the painful negative emotions.
- Psychiatric hospitalization to provide 24 hour/day protection during times of especially intense and dangerous suicide risk.

Most mental health professionals have received extensive training regarding how to manage suicide risk. As discussed below, in the ideal situation a mental health professional will provide expertise and leadership regarding suicide risk management in situations where significant suicide risk continues between emotional healing ministry sessions.

VII. Obtaining consultation "back-up" from and/or referring to mental health professionals:

Again, one of the most important objectives of this essay is to help avoid unnecessary concern on the part of the minister, and/or unnecessary cost to the person receiving ministry, for people at the "safe" end of the suicide risk spectrum and/or people who are displaying "mimic" suicidal behavior[56]. I won't make simplistic, absolute statements (because people are too complex, and there are always exceptions), and I can't take responsibility for the final discernment that each emotional healing minister must make regarding suicide risk and the need for referral, but what I can say is that none of the people I have worked with that met the following criteria would have needed care from a mental health professional on the basis of suicide risk concerns:[57]

- Relatively stable at suicide risk level three or below.
- Special risk factors are not present (or are quickly resolved).
- (For level 3) Receiving regular ministry, with clear evidence of steady progress.

A second important objective of this essay is to help non-mental health professionals determine when to obtain consultation from, and/or refer to, a mental health professional. As the reader has already noted, recommendations regarding consultation/referral have been included at many points in several of the above sections, and are also included in the ministry aids below. The short summary[58] is "Obtain consultation from, and/or refer to, a mental health professional if the person receiving ministry meets any the following criteria:"

Related to suicide risk:
- Suicide risk is between levels 1 and 3 at the moment, but is *not* relatively stable over time. The combination of variability, lability, and unpredictability is present as a special risk factor (risk

[56] In my experience, the large majority of people initially identified as "suicidal" are either at the "safe" end of the suicide risk spectrum (with or without associated "mimic" suicidal behavior), or are not suicidal at all, but rather have "mimic" suicidal behavior that has been mistaken for true suicide attempts.

[57] Again, it is important to remember that self harm "mimic" suicidal behavior and true suicide risk are two independent phenomena. "Safe for lay ministers" with respect to suicide risk can include even people with self harm "mimic" suicidal behavior, as long as they still meet the other criteria described here.

[58] In actual clinical situations, it is important to follow the more detailed recommendations included above and in the ministry aids.

level changes rapidly and unpredictably, and sometimes increases to 4 or above in situations where adequate care is not available).
- Suicide risk level 4 or above.
- Special risk factors *are* present and cannot be quickly resolved.
- (For level 3) *Not* receiving regular ministry with clear evidence of steady progress.
- You are not comfortable/secure regarding your ability to work with the level of suicide risk present in the person receiving ministry.

Other reasons for mental health professional consultation/referral (not related to suicide risk):

- Obtain consultation/referral if the person is significantly impaired by their symptoms.
- Obtain consultation/referral if there is something going on that is strange and/or alarming, and that you don't understand or know what to do with.

Ideal world vs. real world: The recommendations in this essay, including recommendations about time urgency, are my recommendations for the ideal world. This brings us to a painful discussion of the ideal world vs. the real world. In the ideal world, competent, trusted Christian mental health professionals familiar with effective emotional healing ministry approaches would be quickly and conveniently available for consultation and/or referral whenever a lay minister encounters a person with significant suicide risk. Furthermore, in the ideal world the person receiving ministry would be able to *afford* consultation and/or ongoing work with said mental health professional.

In the real world, one of the most painful, challenging realities is the lack of availability of mental health professionals who can provide effective emotional healing ministry for those with serious suicide risk, and/or who can provide consultation "back up" for lay ministers working with these seriously suicidal people. This is especially true as emotional healing ministry is spreading across the world, even to remote areas that may not have access to mental health care (for example, our e-mail ministry aids go to remote villages in New Zealand and missionaries in the jungles of Thailand). In some situations, there are simply no mental health professionals within reasonable travel distance. In other situations, the person receiving ministry does not feel safe with the mental health professionals that *are* available. For example, I have worked with mental health professionals who were not just atheists, but also intensely bitter towards Christianity due to traumatic childhood experiences with Christians/Christianity. Even though these professionals are not "supposed" to bring their personal beliefs and agenda into their client care, the reality of traumas and triggers is that beliefs and emotions from old wounds leak into every area of life. I have personally observed mental health professionals display hostility towards a patient's Christian beliefs, and openly oppose the inclusion of Christianity in the patient's care. Does one insist that the person receiving ministry submit to care from a professional who is hostile to his faith and who will oppose Christian emotional healing ministry? We are also aware of situations where there are competent, safe Christian mental health professionals, but they are swamped. Somebody with a six month waiting list is not realistically "available" for a person who is urgently suicidal today. And finally, there are many situations where the person receiving ministry can't afford mental health consultation and/or referral, even if it is available.[59]

[59] I have often heard comments along the lines of "Christian mental health professionals should just see these people for free – that's what Jesus would do...etc." This sounds good, but I would encourage others to consider how their jobs/businesses would go if they said to their bosses/customers "You only have to pay as much for my services/groceries/cars/furniture as you feel you can afford." Especially in economically depressed areas, it is impossible for the mental health professionals to provide charity care

What this boils down to is that there are lay ministers providing primary care in many situations where it is not possible to obtain mental health consultation/referral as I recommended in this essay. This is difficult. This is stressful. This is risky. And unfortunately, this is the real world. I am hoping that the emotional healing ministry community will keep pushing persistently towards the ideal world, where competent, trusted, affordable, Theophostic®-informed, Christian mental health professionals are conveniently available for appropriate consultation and/or referral. Certainly try to follow the recommendations regarding consultation/referral whenever this is possible. But I think it is also important to talk honestly about the reality we are currently living in.

God's plan?: I would like to tentatively and humbly propose that the Lord's plan/intention is for us to get involved as the Spirit leads. Take risks as the Spirit leads. Be a part of meeting the real and overwhelming needs in this world, even when this requires getting involved in situations where the ideal scenario is simply not possible.

"Safe" plan: The "safe" plan is to make all decisions based on legal advice regarding liability. Don't get involved in any situation that does not fit the ideal scenario. NOTE that this option is "safe" in the *short term* perspective (this life). The most significant risk with this plan is what will happen when you stand before the Lord to account for your stewardship.

VIII. Triggering and/or judgments in the therapist/emotional healing minister: A very important contributor to suicide related phenomena seeming unusually complicated, and feeling *so* intimidating and overwhelming, is triggering in the therapist/ministry facilitator. As mentioned above, suicide related phenomena can involve very intense situations, with some of the most desperately unhappy, wounded, ill, and needy people in the world. The stakes are high, with the life of a person at risk. There are liability and other issues involved, and it is impossible to be in control or guarantee safety. Furthermore, the person receiving ministry may try to use suicide related phenomena to attack, punish, or manipulate the therapist/minister. This is a recipe for triggering. Most people – both lay ministers and mental health professionals – are triggered by suicide related phenomena. Feeling manipulated and/or attacked is especially effective for triggering judgment and anger towards the person receiving ministry.

For example, a scenario involving suicide-related phenomena might go something like this: A long awaited and repeatedly promised "special family night" has just begun when your pager goes off. You get a sinking feeling in your stomach, and your wife and children all immediately look at the floor with that "we are expecting to be disappointed" look. The sinking feeling in your stomach turns quickly to a sick feeling in your stomach when you look at your pager and recognize the return call number for one of your most difficult clients. This particular client was horribly abused as a child, so you have real compassion for him, but he can also be angry and abusive, and he will do anything to get his perceived needs met when he is feeling desperate. He has made many apparent suicide attempts over the past ten years, and your personal assessment is that most of them have been mimic attempts, but that several have been dangerous, true suicide attempts. You say "I have to take this call," and then with a mixture of self-deception and hope that it might truly be a simple question, you add "I'll make it short – I promise." The response from your family is not enthusiastic; your wife keeps looking at the floor and doesn't say anything, your son offers a pessimistic groan, and you quickly glance downward and turn away as your oldest daughter looks at you and comments angrily, "Yeah, right." You're already feeling discouraged, anxious, and angry, and you haven't even picked up the phone. When you dial the

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for all those who need care but can't afford it (or perceive they can't afford it).

number, your client picks up immediately, and starts with "Oh, man, I'm so glad you called back. I really need to talk. A lot of bad stuff has happened, and I just don't know if I can take it any more – I feel like killing myself."

Triggered lie-based thinking in this situation might include: "I can't say 'no,'" "If I say 'no' I am a failure as a Christian," "I'm not allowed to say 'no'," "They will get angry/hurt me if I say 'no,'" "I don't have a choice – I have to do it," "No matter what, I have to make sure he doesn't get angry," "It's my responsibility," "I can't stop/leave/get off the phone until he is okay," "If I mess up, something bad will happen and it will be my fault," "I'm too stupid, I won't be able to figure out what to do," "I will get sucked in over my head and drown," "My needs aren't important, and aren't going to be met," "I'm powerless and helpless – there's nothing I can do to protect my time with my family," or "He always gets what he wants, and there's nothing I can do about it."

The most basic, foundational lie that gets triggered with respect to suicide-related phenomena is "It's my responsibility to make sure that the person doesn't commit suicide." This lie is especially difficult because our society reinforces it. For example, when someone commits suicide, people often quickly begin asking "Who is responsible for this?" (other than the person who made the choice), "Who is *liable* – who should have stopped her, but failed to do so?" The truth is that this issue is ultimately between God and the person who is considering suicide. At the most fundamental level, God is responsible for caring for His children, and the person who is considering suicide is responsible for his or her free will choice.

If you feel overwhelmed by suicide related phenomena, you are being triggered. If you are anxious/fearful in suicide related situations, you are being triggered. If you feel controlled and/or manipulated by suicidal behavior, you are being triggered. If you are angry when dealing with a suicide-related situation, you are probably being triggered. And if you are feeling judgment towards the person receiving ministry, you are certainly being triggered.

Triggering will always impair intuitive discernment and the ability to thinking logically/clearly, both of which are desperately needed when dealing with suicide related phenomena. Triggering will also impair the strength and resolve necessary to set appropriate limits[60]. Clarification of the true dynamics (for example, true suicide risk vs. relational leverage mimic behavior) requires the person receiving ministry to be very vulnerable and surrender precious defenses/tools, and this will be tremendously hindered by triggering and judgment on the part of the therapist/minister. Working with suicide-related phenomena is an area where it is especially helpful for the therapist/facilitator to identify and deal with their own triggering.

Painful honesty and realistic perspective: I would like to share more about my own experience in order to provide realistic perspective. My father was a senior leader in our church for many years, and is also an Licensed Clinical Social Worker. Throughout my childhood he was a therapist/ pastoral counselor for many people that were hurting very deeply. I have many, many memories of counseling "emergencies" disrupting our meal times and family times. One particular person

[60] For example, if you are having triggered thoughts such as "I can't say 'no'" and "It's my responsibility, it will be my fault if something happens," then you won't be able to set limits such as "I am spending time with my family right now, so I can't talk more than 2 minutes. I can pray with you, but then I need to go. If you can use your other coping tools for the next two hours, I can call you at 9:00. If you feel like that isn't working, and you aren't safe, then I want you to go to the emergency room. I would like to pray now – are there any special requests you would like me to include?"

would often call on the phone, or even come to the door, and tell Dad that she was going to kill herself unless he saw her immediately. Furthermore, this person later apologized to me for taking Dad away from our family, and confessed that she had fabricated the content of many of her emergency sessions. It seems clear that she felt so desperate that she decided to do whatever would get her the care she felt she needed, and that she learned she could obtain more care by threatening suicide. Not surprisingly, I had/have a few triggers and judgments regarding suicidal behavior, and especially towards people who use the possibility of suicide as relationship leverage to get things they feel they need.

The painful truth is that I have carried many triggers and judgments regarding suicidal behavior (and especially mimic suicidal behavior) through most of my psychiatric career, and I am still working to find and resolve triggers and judgments regarding suicidal behavior. Nevertheless, I have worked with hundreds of people with suicidal behavior in spite of these triggers and judgments. These triggers and judgments made this work more difficult and expensive than it needed to be, but they did not prevent me from providing any effective care. For example, if I got triggered to the lies and issues in the childhood memories described above, I would see the person with suicidal behavior as the enemy, trying to use the threat of suicide to steal my family time/personal time. Not surprisingly, this got in the way of building trust with these people and impaired my discernment, which made it more difficult for them to be completely honest about what was really going on and made it more difficult for me to discern what was really going on. This slowed the process of dealing with the real issues, and sometimes resulted in unnecessary, costly interventions (such as hospitalization). Eventually, as real relationship grew, compassion and connection would usually overcome my initial triggering and judgments, and we could work together effectively – even regarding any mimic suicidal behavior and associated underlying issues. But the whole process was slower, more difficult, and more expensive than it would have been if my triggering and judgments had not gotten in the way.

It would be nice if we could be fully competent and completely healed before going into the field to do actual therapy/ministry, but unfortunately this is not possible. Do the best you can with who you are now. Watch for triggering and/or judgments regarding mimic suicidal behavior or other suicide-related phenomena, and work diligently to resolve them when you find them.

X. Ministry aid sheets, practical comments:

These ministry aid sheets are especially intended as a tool to help assess suicide risk. When somebody makes a comment that indicates he may be thinking about suicide, you can go over the “Spectrum of Suicide Risk” sheet with him and ask him to identify where he is at. The “Suicidal/self harm behavior” and “Special Risk Factors” pages can be used in the same way, to help clarify the meaning of any behavior associated with the question of suicide risk, and to help identify special risk factors, respectively.

Two versions (with and without comments about treatment recommendations): The version of the ministry aids written for the person receiving ministry was designed to be maximally gentle, especially trying to avoid wording that might be misunderstood or cause triggering. Omitting the comments about treatment recommendations will also hopefully make it less cluttered, and therefore easier for the person receiving ministry to use. The version written for the facilitator was designed to be maximally clear and efficient, and assumes the user has read the explanatory essay. It is also especially written to assist in decision making regarding treatment options and the possibility of referral.

Important disclaimer: These ministry aid sheets will hopefully provide a helpful tool, but they DO NOT take the place of your discernment and clinical judgment. It is very important to remember that you must always take final responsibility for the situations you are dealing with. If there is an intuitive warning light in your mind telling you that something is not right, or you feel the Lord telling you that the person needs immediate care regarding suicidal risk, PLEASE don't ignore these sources of discernment just because our ministry aid sheet says the person receiving ministry is only at level 3, and therefore can be considered "safe."

Regarding our place in the Theophostic® community, and the place of our ministry aids in Theophostic® Ministry: Dr. Ed Smith, developer of Theophostic® Ministry, reports an increasing number of people who seem to be confused about our place in the Theophostic® community. We ask that people carefully read and remember our "Home Page" disclaimer (see www.kclehman.com) regarding our relationship with Alathia and Dr. Smith. Dr. Smith has specifically mentioned people who think that our ministry aids are a required/necessary part of Theophostic® Ministry. We want to be very clear about this: In the explanatory essay (above), we discuss the thoughts, personal experiences, other references, and principles behind the ministry aids at the end of the document. Please consider our discussion, consider for yourself how to interpret the experiences we describe, and then decide whether/how to use these ministry aid tools. Many have found our ministry aids to be helpful tools as a part of various forms of emotional healing ministry, but it is *not* necessary to use our ministry aids in order to do Theophostic® prayer ministry.

We also want to be clear that our emotional healing ministry is built around a core of Theophostic® principles and techniques, but that we also include "non-Theophostic®" material. For example, our material on medical psychiatry, our material on EMDR, our material on dealing with curses, our material on dealing with spiritual strongholds, our material on dealing with generational problems, our material on journaling, our material on spiritual disciplines, and much of this material regarding suicide related phenomena are not a part of what we understand Dr. Smith to define as Theophostic® prayer ministry.

Spectrum of Suicide Risk (notes for person receiving ministry)

Level 1 – Wish to escape pain, but no thoughts of actual suicide: Comments like "Jesus, take me home," "I wish I could go to sleep tonight and wake up in Heaven," "I wish I could die," but no thoughts about actual suicide.

Level 2 – Brief, occasional thoughts of suicide: Thoughts like "What if I killed myself?" come into his mind occasionally. Actually thinks about killing himself. The possibility of suicide is briefly considered as a way to escape the pain and end all his problems, but is dismissed quickly.

Level 3 – Frequent, longer lasting thoughts of suicide: Thoughts of suicide become frequent, and are entertained much longer. Weighing the pros and cons as she seriously considers suicide as a real option. After weighing the pros and cons, still concluding, clearly and consistently, that suicide is not a good/acceptable plan.

Level 4 – Scales tipping back and forth: The pro and con analysis is becoming unclear. The previous arguments against suicide are feeling less convincing. No longer sure that suicide is a bad plan.

Level 5 – Scales tipping towards suicide, planning fatal attempt: Thinking frequently/constantly about suicide. Has planned details of attempt that is intended to be fatal, and is trying to decide whether she really wants to go through with it. Last round of decision making – "Am I really sure?"

Level 6 – Planning and Intending fatal attempt, has needed materials: Only reason he has not done it is he has not yet had the opportunity and/or "doesn't have the courage." NOTE: If the person has actually taken action to prepare, this is an additional warning sign (for example, purchased ammunition and loaded gun in preparation for suicide).

Level 7 – True suicide attempt, but with some degree of ambivalence: Truly wanted to die and intended to die at the initiation of attempt, but then aborted the attempt by initiating rescue. For example, took an overdose that she believed would be fatal, with initial intent to die, but then changed her mind and called for help.

Level 8 – Serious suicide attempt, accidental survival: The only reason he is alive is that he accidentally failed. For example, believed method would be fatal, planned in absence of help, did not tell anybody. Failed and/or found accidentally.

Factors Contributing to Suicide Risk (questions for person receiving ministry)

It is very important that you and your therapist/emotional healing minister identify any special risk factors. Please think carefully about each of the special risk factors mentioned below.

Pain: What are the most important and/or persistent causes of pain in your life? Are there any sources of emotional or physical pain that you feel especially contribute to your temptation to commit suicide?

Hopelessness: Do you feel persistently hopeless? Yes ___ No ___. Do you have episodes where you suddenly feel especially hopeless? Yes ___ No ___

Intense negative emotions: Do you have episodes of especially intense negative emotions (for example, rage, rejection, loneliness, grief, despair, or feeling "I can't face it")? Yes ___ No ___.

Recent events: Has anything happened recently that is causing especially intense anger, rejection, loneliness, grief, despair, or feeling "I can't face it?" Yes ___ No ___

Coping ability: How well do you cope with difficult situations? More able to cope than most others ___, Average ___, Less able to cope than most others ___.

Support system: How would you rate your support system? Very strong ___, Strong ___, Average ___, Poor ___, Very poor ___.

Variability, lability, and/or unpredictability: Do you experience sudden, marked, unpredictable changes in your temptation to commit suicide? Yes ___ No ___.

Previous sudden, impulsive, unpredictable suicide attempts: Have you ever made sudden, impulsive, unpredictable suicide attempts? Yes ___ No ___.

Mental illnesses: Have you ever been diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder? Yes ___ No ___. Do your symptoms cause significant disability? Yes ___ No ___. Do you sometimes have difficulty controlling your own thoughts? Yes ___ No ___. Are your thoughts sometimes so "bogged down" (like you are in a "mental tar pit") that you can't think at all?

Drug and/or alcohol use: Substance use, even in moderate quantities, impairs judgment, affects mood, decreases inhibitions, and decreases behavioral control. Are you currently using any alcohol and/or non-prescribed psychoactive substances? Yes: ___ No: ___

Demonic spirits and/or internal parts: Do you have episodes where you suddenly feel very suicidal, and/or do you have thoughts and/or voices inside your head telling/pushing you to kill yourself? Yes ___ No ___

Access to easy, irreversible, deadly method: Are there any firearms in your home? Yes: ___ No ___ . Do you have other easy access to firearms? Yes: ___ No: ___ . Is there any other easy, irreversible, deadly method that you have been considering and that you have access to? Yes: ___ No ___.

Suicidal/Self harm behavior (notes/questions for person receiving ministry)

It is *very* important for you and your therapist/emotional healing minister to correctly understand the meaning of any self harm behavior. If you made a true suicide attempt, with the desire to die and the intent to die, then you and your therapist/emotional healing minister need to work together to be especially careful about ongoing suicide risk. If you did *not* desire to die or intend to die, then it is very important that your therapist/emotional healing minister accurately understand this, so he or she can help you deal with the true underlying issues, and so he or she doesn't make unnecessary interventions to care for suicide risk that isn't really there. I realize that it will be especially difficult and vulnerable to acknowledge if your suicide attempt was actually a "cry for help" suicide gesture, an attempt to get relational leverage, or an attempt to punish others. I promise you that Jesus can help you sort this out. If you don't feel safe talking to your therapist/emotional healing minister about this, tell him/her that there is something you are afraid to talk about, and ask him/her to use emotional healing ministry tools to help you address this fear. If this doesn't work, and you feel that the therapist/minister will be angry and/or judgmental towards you if you tell him or her the truth, then consider working with a different therapist/ministry facilitator.

I. True suicide attempt: A true suicide attempt is when you harm yourself with the desire to die and the intent to die. When you hurt yourself, did you truly desire to die and intend to kill yourself? Yes ___ No ___

Initiating rescue, cooperation with rescue: Did you call for help after the attempt? Yes ___ No ____. Did you make the attempt at a place and time so it was possible/likely others would find and rescue you? Yes ___ No ___. Did you cooperate with rescue/appropriate care after the attempt? Yes ___ No ___.

Thoughts around attempt: At the time you made the attempt, what did you believe about the method you used? (For example, "I was pretty sure it wouldn't kill me, but thought there was a small chance it might," or "I thought it might kill me, but wasn't sure," or "I was pretty sure it would kill me," or "I was sure it would kill me"). Why did you abort the attempt/initiate rescue? (For example, "I realized there were some things I needed to take care of first," "I got scared," or "I realized I didn't really want to"). Now, are you relieved and grateful to be alive, or disappointed and angry?

II. Para-suicidal high risk behavior: Para-suicidal behavior is not a direct suicide attempt, but rather high risk behavior where you know you might die, but don't care. Do you engage in any very dangerous/high risk behavior, where you know you might die, and have thoughts like "It's fine with me if I die," or "I know I might die – if I do, that's okay"? Yes ___ No ___

III. Self harm behavior, but no desire to die or intent to die:

- Did the internal motivation for your self harm behavior have nothing to do with suicide or the appearance of suicide (for example, cutting yourself to relieve tension, to punish yourself, or to make sure you were still real)? Yes ___ No ___
- Were you trying to create the appearance of a suicide attempt as a way to get help, but actually you have no desire to die or intent to die? Yes ___ No ___
- Were you trying to create the appearance of a suicide attempt to get relational leverage, but actually you have no desire to die or intent to die? Yes ___ No ___
- Were you trying to create the appearance of a suicide attempt to punish someone, but actually you have no desire to die or intent to die? Yes ___ No ___

Suicide Risk Spectrum (notes for therapist/ministry facilitator):

Note: This ministry aid is most valid for people with stable and predictable suicide risk. For predictable variable suicide risk, determine risk level and make intervention decisions based on conditions of highest risk. Use with increasing caution as variability, lability, and unpredictability increase. At variable, labile, "hard to predict" end of predictability continuum, use only as adjunctive resource (not primary assessment tool).

Level 1 – Wish to escape pain, but no thoughts of actual suicide: Comments like "Jesus, take me home," "I wish I could go to sleep tonight and wake up in Heaven," "I wish I could die," but careful questioning reveals no thoughts about actually committing suicide. ***Assessment/ recommendations:*** Almost everybody feels this way at times. If stable at level 1, and no special risk factors, then (in my experience) **not** a significant suicide risk, and does **not** need mental health professional (MHP) consultation regarding suicide risk. Use emotional healing ministry (EHM) to address underlying issues causing pain. See also interventions for pain (under level 2). Can progress to level 2 if pain becomes too severe and/or continues too long.

Level 2 – Brief, occasional suicidal thoughts: Thoughts like "What if I killed myself?" or "I could just kill myself, and end all of this pain" come into the person's mind occasionally. Actually thinks about killing himself. Possibility of suicide briefly considered, but dismissed quickly. ***Assessment/recommendations:*** "I am really hurting." No emergency, but an early warning signal that something needs to change. Will usually eventually progress to higher levels of suicide risk if pain continues without relief or hope of relief (for levels 2 through 8, suicide risk increases steadily as intensity of pain, and/or duration of pain, and/or depth of hopelessness increase). If stable at level 2, no special risk factors, then (in my experience) **not** an immediate suicide risk, and does **not** need MHP consultation regarding suicide risk. Use EHM to address underlying issues causing pain and to reduce hopelessness. Other options to reduce pain and hopelessness (especially important if EHM not immediately available):

- If the person does not have immediate access to EHM, discuss it as source of hope.
- Listen. If the person knows he has been heard he won't feel *alone* in the pain.
- Enhance support network (family, friends, church small group, etc). Provides concrete help to reduce acute pain/stress (e.g., respite child care). Addresses "alone in the pain" factor.

Level 3 – Frequent, longer lasting thoughts of suicide: Thoughts of suicide frequent, no longer immediately dismissed. Weighing pros and cons as suicide seriously considered as real option. Still concluding, clearly and consistently, that suicide is not an acceptable plan. **Assessment/ recommendations:** "I am REALLY hurting." No emergency, but a *serious* warning sign that something needs to change. Needs regular ministry (weekly or more is ideal). Ideal: MHP consultation to screen for possibility that medication is needed for mental illness. To focus resources, watch for: 1. Significant disability; 2. Thoughts the person *cannot control* (obsessive and/or racing), or thoughts so bogged down the person has *difficulty thinking at all*; 3. Strange or alarming symptoms you don't understand or know what to do with. If stable at level 3, no special risk factors, and receiving regular ministry with clear evidence of steady progress, (in my experience) **not** an immediate suicide risk, does **not** need MHP consultation regarding suicide risk. Consultation regarding suicide risk ***should*** be obtained if EHM not immediately available, EHM seems stuck, special risk factors are present, or risk fluctuates to level 4 at any time. See explanatory essay for comments regarding time urgency for MHP consultation. Interventions to reduce pain and hopelessness as for level 2, with the following additional comments:

- If hopelessness does not quickly resolve with regular healing and clear evidence of fruit, focus EHM especially on lies and/or other issues contributing directly to hopelessness.

- If EHM not immediately available, discuss EHM as source of hope, but also consult MHP.
- "Other" options for reducing pain and hopelessness should be more actively pursued, as augmentation to EHM, with more complicated problems and/or more serious suicide risk.

Level 4 – Scales tipping back and forth: Pro and con analysis becoming unclear. Previous arguments against suicide feeling less convincing. No longer sure that suicide is bad plan. Gray zone between 3 and 5. ***Assessment/recommendations:*** Definitely need MHP consultation regarding suicide risk. May be emergency. Read full discussion in explanatory essay regarding time urgency. MHP may need to be involved in ongoing care (to help with suicide risk), may need psychiatric hospitalization. Reduce pain and hopelessness: as for level 3.

Level 5 – Scales tipping towards suicide, planning fatal attempt: Thinking frequently – constantly about suicide. Has planned details of attempt intended to be fatal, trying to decide whether to go through with it. Last round of decision making – "Am I really sure?" **Assessment/ recommendations:** Could linger at "last round of decision making" for months, or could be dead in an hour. Obtain MHP consultation regarding suicide risk. Time urgency considerations as for level 4, except lean more towards "obtain consultation today." MHP should be involved in ongoing care (at least to help with suicide risk). May need Psych hospitalization. If leaning towards level 6, EHM not immediately available, poor support system, and/or any special risk factors, have someone stay with person until consultation obtained. Use ER if necessary. Reduce pain and hopelessness: as for level 3.

Level 6 – Planning and <u>Intending</u> fatal attempt, has needed materials: Has not yet had the opportunity and/or "doesn't have the courage" are only reasons has not already attempted suicide. Action to prepare is additional warning sign (for example, purchased ammunition and loaded gun). ***Assessment/recommendations:*** Immediate suicide risk. Someone stay with person until MHP consultation obtained. Use ER and/or police escort to ER if necessary. MHP should be involved in ongoing care (at least to help with suicide risk). Usually needs Psych hospitalization, but not always (e.g., may not need hospitalization if *very* good support system – including good working relationship with MHP, marked ambivalence about suicide, EHM immediately available and person agrees to EHM as alternative to suicide). Reduce pain and hopelessness: as for level 3.

Level 7 – True suicide attempt, but with ambivalence: Wanted to die and intended to die at initiation of attempt, but then aborted attempt by initiating rescue. For example, took overdose believed would be fatal, with initial intent to die, but changed mind and called for help. ***Assessment/recommendations:*** Immediate suicide risk. Someone stay with person until MHP consultation obtained. Use ER and/or police escort to ER if necessary. MHP should be involved in ongoing care (at least to help with suicide risk). Usually needs Psych hospitalization, but not always (e.g., very good support system – including good working relationship with MHP, suicide attempt demonstrated marked ambivalence, EHM is immediately available and person agrees to try EHM as alternative to suicide). Reduce pain and hopelessness: as for level 3.

Level 8 – True suicide attempt, accidental survival: No perceivable ambivalence. Only reason person is alive is <u>accidental</u> failure and/or rescue. For example, believed method would be fatal, planned attempt to avoid rescue, no attempt to get help after attempt. ***Assessment/ recommendations:*** Intensely severe and immediate suicide risk. Consultation, ongoing MHP care, and Psych hospitalization definitely necessary. Someone should stay with person until admitted. Police escort to hospital if necessary. Reduce pain and hopelessness: as for level 3.

Factors Contributing to Suicide Risk (notes for therapist/ministry facilitator)

Special risk factors: Either cause periodic episodes during which suicide risk increases to levels where mental health consultation is wise, or introduce enough lability and unpredictability so mental health consultation is best plan. Presence of special risk factor(s) indicates need for mental health consultation, even for people at baseline suicide risk levels 2 or 3, *unless special risk factors quickly resolved.*

A. Pain: Severity of suicide risk usually increases steadily as severity of pain increases, duration of pain increases, hope for relief decreases. ***Recommendations:*** Physical pain: Appropriate medical care. Effective emotional healing ministry to address emotional/spiritual issues triggered by physical pain. Read *The Gift of Pain.* Emotional pain: focus effective emotional healing ministry on unresolved emotional and/or spiritual issues.

B. Hopelessness: Specific emotional pain especially potent in contributing to suicide risk. Severity of suicide risk increases with severity of hopelessness. Strategic resolution of "crisis" hopelessness can resolve "crisis" suicide risk. ***Recommendations:*** If "flares" of hopelessness and/or hopelessness persists in face of clear healing, focus emotional healing ministry (EHM) especially on lies and/or other underlying issues contributing directly to hopelessness. Flares of hopelessness are ***special risk factor*** when severe enough to produce suicide risk of level 4 or above.

C. Intense negative emotions (other than hopelessness): "Crisis" negative emotions are especially important with respect to sudden, unpredictable suicide attempts. Strategic resolution of "crisis" negative emotions can resolve crisis suicide risk**.** ***Recommendations:*** Crisis: focus EHM (emotional healing ministry) on issues directly contributing to crisis negative emotions. Long term: focus EHM on issues impairing coping ability. ***Special risk factor*** when severe enough to produce episodes of "crisis" suicide risk of level 4 or above.

D. Underlying issues (unresolved emotional and/or spiritual issues): Single biggest *ongoing* contributor to persistent pain, *immediate* contributor to acute intense negative emotions, contributor to impaired coping ability. Also increases likelihood of stressful/painful events, contributes to poor support systems. ***Recommendations:*** Crisis: focus EHM on underlying issues contributing strategically to crisis suicide risk. Long term intervention: focus EHM on issues that contribute to impaired coping and/or poor support system. ***Special risk factor*** if cause other special risk factors (e.g., severe hopelessness or impaired coping ability).

E. Especially stressful/painful recent events: Can contribute especially to acute exacerbation of suicide risk. ***Recommendations***: Focus EHM on truth-based pain from the recent events and on other four interrelated factors that increase impact of stressful/painful events. In situations where suicide risk has been assessed in the past, make sure to reassess suicide risk in light of the most recent crisis events.

F. Impaired coping ability: Coping ability affects the final negative impact of *all* other factors contributing to suicide risk. ***Recommendations:*** Crisis: sometimes crisis suicide risk can be resolved by helping person transition from triggered child ego state back to adult core self ego state (which dramatically increases coping ability). Long term: focus EHM on underlying issues contributing to impaired coping ability. Disciple in appropriate coping skills as blockages are removed. ***Special risk factor*** if impaired to point where mild to moderately painful/stressful events precipitate episodes of suicide risk level 4 or above.

G. Poor support system: Strength of support system affects the final negative impact of *all* other

factors contributing to suicide risk. ***Recommendations:*** Focus "systems" EHM on key people in person's life who are willing to participate. Focus individual EHM on behaviors that are especially destructive to the person's support system. ***Not*** a "must obtain consultation" ***special risk factor***, but should be carefully considered when making decisions about intervention and consultation/referral.

H. "Combination" ***special risk factor***: The combination of intense negative emotions, underlying issues, especially painful/stressful recent events, poor coping ability, and poor support system is a special risk factor. The clearest indicator of this "combination" special risk factor is that the person has already made impulsive, hard to predict suicide attempts. This complicated and difficult clinical picture will steadily improve, and eventually resolve, with persistent EHM addressing each of the contributing factors. ***Recommendations:*** EHM addressing each of the contributing factors. Obtain mental health consultation to help with a long term plan for addressing each of the contributing factors, and to help with suicide risk management in the mean time.

I. Substance use/abuse: Substance abuse can cause both acute effects and chronic effects that contribute to suicide risk. Mood, judgment, and behavioral inhibition are affected by even small amounts of alcohol or street drugs. ***Recommendations:*** Focus EHM on negative emotions the person is self-medicating to avoid. Ask all persons with suicide risk to stop all alcohol and/or street drug use. Non-prescribed psychoactive substance use is such serious complicating factor that it is ***special risk factor*** if not stopped immediately.

J. Variability, lability, and unpredictability: Many different factors contribute to variability, lability, and unpredictability, and effective EHM can reduce or resolve many of these contributing factors. ***Recommendations:*** For variability, lability that is know and predictable, assess suicide risk and make decisions based on worst situations. Focus EHM on factors contributing to variability, lability, and unpredictability. ***Special risk factor:*** Combination of variability, lability, and unpredictability is special risk factor if: 1. You don't know enough about variability, lability, other factors to assess suicide risk for worst situations, and/or 2. Suicide risk changes so dramatically, rapidly, unpredictably that episodes of crisis suicide risk of level 4 or above occur in situations where adequate care not available. NOTE: Use suicide risk spectrum ministry aid only as adjunctive tool if variability, lability, unpredictability are severe enough to be special risk factor.

K. Mental illnesses: Mental illnesses contribute *indirectly* to suicide risk by causing/contributing to suicide risk factors. Therefore, lay ministers assessing suicide risk can simply focus on suicide risk factors. Schizophrenia, schizoaffective disorder, and true bipolar disorder are exceptions. Even though they are not *direct* suicide risk factors in the same way as other risk factors, they contribute to suicide risk factors in such important ways that a mental health professional should always be involved, and are therefore ***special risk factors*** for the sake of "suicide risk spectrum" ministry aid decision-making logic. ***Recommendations:*** Identify mental illnesses that call for involvement of mental health professional by: 1. Asking whether person has ever been diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder; and 2. Obtaining mental health consultation for suicide risk level above four, suicide risk "special risk factors," significant disability, thoughts that the person *cannot control* (obsessive and/or racing), thoughts so "bogged down" that person has *difficulty thinking at all*, and strange and/or alarming symptoms that lay minister doesn't understand or know what to do with. Psychiatric medications *usually* necessary for schizophrenia, schizoaffective disorder, true bipolar disorder. These people also have truth-based pain and unresolved issues, and will usually benefit from emotional healing ministry (EHM). Psychiatric medications *sometimes* helpful for other mental illnesses, *usually* helpful when mental illness *severe enough to cause special risk factors or significant disability*. Most other mental illnesses almost always benefit from EHM.

L. Psychosis: Psychosis is a collection of symptoms that can be part of many different mental illnesses. Psychosis almost always indicates serious underlying mental health concern and/or medical illness. Both acute and chronic effects of psychosis can contribute dramatically to suicide risk and unpredictability. ***Recommendations***: Identify psychosis by obtaining MHP consultation for 1. Suicide risk level above four; 2. Suicide risk "special risk factors;" 3. Significant disability; 4. Thoughts person *cannot control* (obsessive and/or racing); 5. Thoughts so "bogged down" person has *difficulty thinking at all*; and 6. Strange and/or alarming symptoms lay minister doesn't understand or know what to do with. Psychiatric medications often helpful. Emotional healing ministry to reduce/resolve causes of psychosis (as appropriate, with mental health professional on team). ***Special risk factor:*** MHP should always be on team.

M. Demonic oppression: In the long term, seems to be promote increasing baseline misery and hopelessness in every way possible. Acute attacks, focusing specifically on the compulsion to commit suicide, especially increase risk of sudden, unpredictable suicide attempts. ***Recommendations:*** Use the 1 John test (and other tools if necessary) to discern between demonic spirits and internal parts. If these diagnostic tools indicate demonic spirits, then start with addressing choices that give place, and try simple deliverance commands. If there is resistance, use one of the more effective approaches to emotional healing ministry to address underlying issues. Teach the person receiving ministry to use binding prayers to deal with demonic suicidal oppression between sessions. ***Special risk factor:*** *Severe* demonic oppression specifically pushing for suicide is a special risk factor. Suicidal demonic oppression is another good example of a special risk factor that can sometimes be resolved quickly (and therefore *not* contribute a "special risk factor consideration" requiring mental health consultation in the situations where quick resolution is possible).

N. Dissociative phenomena: Moderate-severe dissociation increases variability and lability, can also increase unpredictability. Internal parts can specifically and directly push for suicide. ***Recommendations:*** Crisis intervention for voices/thoughts pushing for suicide: Use 1 John test (and other tools) to discern between demonic spirits and internal parts. If internal parts, they will always have reasons they believe suicide is best plan. Use EHM to address lie-based beliefs regarding suicide. Long term: variability, lability, unpredictability will steadily resolve over time as EHM addresses dissociative phenomena. ***Special risk factor*** if parts cause episodes of suicide risk level 4 or higher, and/or dissociative phenomena introduces severe unpredictability.

O. Availability of easy, fast, and irreversibly deadly method: Access to "convenient" and irreversibly lethal suicide method (such as firearms) significantly increases risk of completed suicide. A *sudden, impulsive* suicide attempt is much more likely to be lethal. <u>You can significantly reduce the risk of completed suicide by taking the single, simple step of removing easily accessible firearms</u>. ***Recommendations:*** Eliminate easy access to firearms (especially remove from home). ***Special risk factor*** if at suicide risk level 2 or 3, mental health consultation is *not* necessitated if easy access to firearms immediately eliminated. Mental heath consultation *is recommended* if easy access to firearms not immediately eliminated.

Assessment of Suicidal/Self Harm Behavior (notes for therapist/ministry facilitator)

I. True suicidal behavior: Harmed self, with desire to die and intent to die.

Lethality, reversibility of method: Non-lethal method usually indicates extreme ambivalence or a mimic attempt, *especially if similar attempts in the past*. Marginally lethal, easily reversible method usually indicates marked – moderate ambivalence. Lethality steadily increases, reversibility steadily decreases with decreasing ambivalence, increasing suicide risk. Very lethal, minimally reversible method usually indicates minimal ambivalence, extreme suicide risk.

Initiating rescue, cooperation with rescue: Aborted attempt before rescue needed usually indicates extreme ambivalence. Aborted attempt by initiating rescue, cooperation with appropriate care usually indicates marked – moderate ambivalence. Accidental survival – no effort to initiate rescue, resists rescue/appropriate care indicates minimal ambivalence.

Thoughts around attempt: Understood lethality/non-lethality of method? Reason for aborting attempt/initiating rescue? Relieved & grateful to be alive, or disappointed and angry?

Recommendations: *Evaluate current suicide risk level: lethality & reversibility of method, initiation and/or cooperation with rescue, thoughts around attempt, current response to suicide risk spectrum. Obtain MHP consultation even if person claims no longer suicidal. Pursue MHP consultation in response to report of true suicide attempt ("I truly wanted and intended to die"), but continue to consider possibility of mimic suicidal behavior (often not acknowledged until more trust developed).*

II. Para-suicidal high risk behavior: Not direct suicide attempt. Intentional, *unnecessary* high risk behavior. Knows he might die, but doesn't care. Thoughts like "It's fine with me if I die."

Recommendations: *Indicates suicide risk level of at least 2. Evaluate factors contributing to suicide risk and suicide risk level, follow corresponding recommendations.*

III. Mimic suicidal behavior: Self harm, but no desire to die or intent to die.

- Self mutilation: Self injury, but no desire to die, intent to die. Internal motivation has nothing to do with suicide or appearance of suicide (e.g., cutting to relieve tension, punish self).
- "Cry for help" gesture: Intentionally creates appearance of suicide attempt as a way to get help, but no true desire to die or intent to die.
- Relational leverage gesture: Intentionally creates appearance of suicide attempt to obtain relational leverage of some kind, but no true desire to die or intent to die.
- Hostile-punitive gesture: Intentionally creates appearance of suicide attempt as relational punishment/revenge of some kind, but no true desire to die or intent to die.

Recommendations: *identify thoughts and emotions driving behavior, focus emotional healing ministry on underlying issues causing the thoughts and emotions.* ***Very*** *important for facilitator to be free of triggering, judgment.* ***Please*** *get healing if you have triggering, judgment around mimic suicidal behavior.*