

## The Suicidal Client/Parishioner: A Guide for Clergy, Pastoral Counselors, and Psychologists Who Advise Them

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### Background:

Clergy and pastoral counselors deal with suicidal parishioners and clients, and sometimes consult psychologists and other mental health professionals in high risk cases. As such it is worthwhile reviewing information that may be helpful to those in either the role of service provider or consultant to service providers.

In 2007, 571 Minnesotans died by suicide. This rate is nearly five times that of homicide. This rate has risen every year since 2000.

In Minnesota, more than 3,900 were hospitalized with self-inflicted injuries. 50% of suicide deaths in Minnesota were due to firearms. 90% of suicides occur in association with mental health problems (including substance abuse and alcoholism). 50% who die by suicide are struggling with major depression, and the suicide rate of people with major depression is eight times that of the general population.

- Twice as many women attempt suicide as men in Minnesota—
- But men are four times as likely to die by suicide than women, largely because they tend to use the most lethal means—self-inflicted gunshot.
- Death by suicide has been more common among Caucasians than any other group, but in 2006 the national rates for African Americans caught up, largely due to a climb in rates for young African American males.
- Native Americans have a rate twice as high as any other group.
- Suicide is the 2nd leading cause of death for persons ages 15-34, but in Minnesota the highest rate is for ages 50-64.
- Elderly people who die of suicide are often divorced or widowed and suffering from physical illness.

Go to [www.sprc.org](http://www.sprc.org) for more information about suicide. Each state has its own publications and prevention efforts.

### Evolving state of knowledge:

Although much has been written about suicide during the past 40 years and there has been considerable research world-wide, this does not mean that the field of suicidology or suicide prevention is a static field. The

reality is that new perspectives and models continue to evolve.

There are changes in patterns observed such as a major increase in suicide deaths among Hispanic women in Texas, attributed to the fact that a large number had begun making attempts using guns—a very lethal, and more typically “male” method. Patterns are shifting and changing for various minority groups, immigrants and refugees, etc. There is also a lack of knowledge about many aspects of the problem. Issues such as planned suicide in response to end-of-life illness or pain are not easily researched.

### Psychological pain/depression vs. end-of-life/chronic illness:

Secular therapists and counselors focus on those who attempt suicide due to depression or emotional pain. Discussions of suicide and books about it are focused on those situations and suicide prevention efforts are aimed at those who are depressed.

In fact, many of those who attempt suicide but live will indicate that they were not trying to kill themselves but simply responding to overpowering emotional pain. They are trying to get rid of the pain—not necessarily to die. When treatment is successful many survivors do not repeat their attempts, reporting that the pain is no longer there.

However, clergy and pastoral counselors also face situations where people have a chronic illness and/or chronic pain and seek to end life voluntarily. This can involve either suicide or assisted suicide. They or their family or any intended helpers may seek guidance or counseling from either secular professionals or clergy. There are many legal issues involving assisted suicide or euthanasia and there is an enormous literature on these issues. There is a World Federation of Right to Die Societies and there are many advocacy and support groups around the world concerning this issue. Laws vary considerably as regards assisted suicide (Humphrey, 2005) and can be found in Web sites such as [www.assistedsuicide.org](http://www.assistedsuicide.org).

Beyond the spiritual and religious issues involved in a decision to end one's own life there is always the question as to the role of depression or emotional upset. To what degree is the person viewing things through a lens clouded by depression?

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### Role and impact of religion

There is evidence that at least with hospitalized depressed persons, patients with religious affiliations have a lower history of suicide attempts (Dervic et al., 2004). The role of religion in suicide prevention has long been studied and consensus is that religion and religious beliefs can enhance suicide prevention (Van Praag, 2009) although it has been noted that this topic is complicated to research because religious views can also impact accurate reporting of suicide (Bhugra, 2010). The impact of religion varies not only with faith group, but with gender, and there are some complicated interactions in some groups studied (Spoerri et al., 2010).

### Special issues for clergy and/or pastoral counselors:

Unlike purely secular counselors for whom the views on suicide for a specific religion are of limited consequence, clergy or those practicing counseling that is connected with a given faith may have to deal with how a religion views suicide as a key issue in their work. (This is not to say that a secular professional does not need to pay attention to the views of a particular faith group as those may be key to what a client is struggling with.)

It is important to recognize the various roles that a clergyperson or pastoral counselor may play when suicide is an issue. While not unique, the fact that one is clergy or doing pastoral counseling work does change the perspective somewhat, depending on the type of situation:

- Parishioner or client is suicidal—the views of the faith about suicide may help prevent suicide, and ironically reassurance about them may increase the risk;
- The special case of end-of-life decisions with chronic illness or pain;
- Family or friends who are concerned may be struggling with fears and anxiety related to the potential religious consequences of suicide;
- Family or friends may struggle with accepting a suicide for fear of the consequences in terms of burial, etc.

It is important for clergy and pastoral counselors to be clear on the view on suicide embraced by their faith group as well as that of the client. It should be noted that the major public discussion of suicide has typically been concerned with physician-assisted suicide or euthanasia in the face of serious illness. Clergy may have spiritual advisors or other sources of both consultation and support

insofar as the religious aspects of suicide within their own faith group.

The general examples below are not definitive and a given congregation or group may have a different emphasis or focus. But to illustrate the variety of views concerning suicide in various faith groups, I offer these examples:

**Judiasm:** Suicide is forbidden by Jewish law (Talmud Bavli, B. Pesachim. 22b; B. Mo'ed Katan 5a, 17a; B. Bava Mezia 75b. & B. Nedarim 42b). It is seen as a serious sin.

**Christianity:** There is a good deal of variability in views. The Christian Bible includes stories of three suicides in the Old Testament (King Saul and his servant in I Samuel 31:4; King David's counselor Ahitophel in II Samuel 17:23) and one in the New Testament (Judas Iscariot in Matthew 27:3-5). St. Augustine first articulated the principle that this was a violation of the 5th commandment, and St. Thomas Aquinas reinforced this. Hume and Kant later challenged this view. Historically there has been a dispute about whether someone who commits suicide can be buried on hallowed ground.

**Roman Catholic:** Death by suicide is a grave or serious sin that is discussed in the Catechism of the Catholic Church, Article 5 (Fifth commandment), sections 2280-2283. However, 2283 provides some moderation: "We should not despair of the eternal salvation of persons who have taken their own lives. By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own lives."

**Eastern Orthodox:** Church burial can be prohibited unless it is shown that the person was not mentally sound.

**Lutheran:** Martin Luther commented, "I don't have the opinion that suicides are certainly to be damned," and had the view that suicide is caused by the devil overcoming the person. The ELCA, Missouri Synod, and most others have no official position on burial and leave judgment to God.

**Reformed, Presbyterian:** Judgment left to God.

**Methodist, Wesleyan:** Judgment left to God. Generally affirm the right of the individual to choose.

**United Church of Christ:** Individual choice is affirmed in terms of decisions about ending one's life.

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**Baptist:** Although a “grave sin,” this does not prevent salvation, which is in the hands of God. There is a dispute about whether one must declare Jesus as savior and be saved before death.

**Unitarian:** Individual choice is affirmed.

**Anglican, Episcopalian:** Generally it is held that the person will only be saved if they were irrational at the time they committed suicide.

**Evangelicals, Charismatics, Pentecostals:** Vary but often argue that suicide is self-murder and is thus a sin. Beliefs on salvation vary.

**Church of Jesus Christ of Latter Day Saints (Mormon):** Generally against suicide but allow for the fact that near the end of life the person may have some difficult decisions to make if they are dealing with illness and pain.

**Islam:** Suicide is viewed as one of the greatest sins and forbidden in the 4th chapter of the Quran (An-Nisaa 4:29: “And do not kill yourselves...”). In several places Muhammad is quoted on the subject. For example: Hadith-Bukhari 2:446 narrated Abu Huraira, quotes the Prophet as saying: “He who commits suicide by throttling shall keep on throttling himself in the Hell Fire (forever) and he who commits suicide by stabbing himself shall keep on stabbing himself in the Hell Fire.” A similar passage covering other methods of suicide can be found at Hadith-Bukhari 7:670. (This is perhaps the strongest stance against suicide of any organized religion. While martyrdom is allowed as it is with other Abrahamic religions such as Christianity and Judaism, the intent cannot be suicide but rather defense of the faith.)

**Jainism:** Non-violent fasting to death (Santhara) is permitted. Violently taking one’s own life is a violation of the tenets of the faith.

**Hinduism:** Non-violent fasting to death (Prayopavesa) is permitted but clearly restricted to people who have no responsibilities remaining in this life, and also no remaining ambition or desire. Otherwise, suicide is considered a violation and equivalent to murder. Some believe that those who die by their own hand become ghosts doomed to wander the earth in that form until the time when they otherwise would have died.

**Buddhism:** Suicide is seen as negative because it violates the prohibition against taking life. Suicide may be acceptable for some who have achieved a state of spiritual enlightenment, but not for others. Actions such as

suicide impact on karma which in turn affects what happens to the individual in the next life.

### **Challenges: Scope of responsibility**

One key question is what is expected of clergy or pastoral counselors. A major legal test as to whether there is such a thing as “clergy malpractice” was raised in a case involving the suicide of a man who was receiving pastoral counseling—*Nally v. Grace Community Church of the Valley*. The California Supreme Court, in 1988, concluded that a suit for “clergy malpractice” was not to be allowed. This case is discussed at length in *Clergy Malpractice in America* (Weitz, 2001).

In general, it would appear that a clergy person providing pastoral counseling in connection with pastoral duties is not deemed to have the same level of duty as a psychologist or psychiatrist. However, if one is both clergy and a trained mental health professional, or if one is offering pastoral counseling in a fashion similar to other types of professional counseling, there may be the same duty as other types of mental health counselors have.

### **Assisting a parishioner or client:**

**For the pastor engaging in spiritual guidance or pastoral care:** Support and assist the parishioner in obtaining the assistance of mental health professionals. This may include involving family or friends as support persons, or at times others in the congregation. If the parishioner is in crisis, the assistance of local crisis services may be key. In addition one may assist a parishioner or client dealing with issues of chronic pain or illness who is struggling with thoughts of ending his or her life.

**For those who are doing counseling with a mental health or family therapy focus:** What follows is offered for those whose work involves mental health counseling. For example, a pastoral counselor serving in a Samaritan Center or some other private clinic would need to be able to function as other professional counselors. While some of what follows below might be of assistance to a pastor doing counseling of a congregant, he or she would not be expected to be able to function at this level.

Studies of stressors on clinicians usually rate suicidal clients as among the top three stressors on practicing clinicians. Suicide has many impacts on clinicians (cf. Gulfi et al., 2010). As with all ethical dilemmas, the initial challenge is to determine: How urgent is the situation?

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The Suicide Prevention Resource Center Web site (<http://www.sprc.org>) permits printing out of customized guides to suicide designed for a variety of roles and professions. Some areas of consideration related to your own work or practice if you are functioning in a capacity that goes beyond spiritual guidance or pastoral care, are as follows:

1. Competence to Assess Risk:
  - a) There is an ethical duty to have periodic training or updating;
  - b) You should have available texts or manuals relative to judgment of suicide risk so that you can have a quick refresher.
2. Access to appropriate consultation in a timely fashion:
  - a) There is an ethical duty to have this in place before trouble happens;
  - b) You should always have a back-up consultant or two.
3. Competence to provide appropriate management for the chronically suicidal client (the ethical duty is to have appropriate training and any tools available).
4. Deciding when to breach confidentiality in order to prevent an imminent suicide:
  - a) Contacting the client at home or work to follow up on concerns;
  - b) Contacting, without a release, other service providers to alert them to the risk or to obtain additional information;
  - c) Contacting a family member or third party to alert them to the risk and ask for their assistance in intervention;
  - d) Having the police intervene and/or pursuing an emergency hold to involuntarily hospitalize the client.
5. Review of the situation in the event of an attempt or completion. If the client dies, a full review with an effort to understand why and how the suicide happened is worthwhile. It is sometimes called a Psychological Autopsy. This is helpful for sorting out what can be learned, but is also helpful to the clinician to process what happened.
6. Assistance to other clients, students, and affected parties. A suicide can have considerable impact on other clients, other staff, families, etc. This may be done in an individual session, or a group meeting.
7. Self care for the practitioner after a suicide attempt or completion: This is mostly a supervisory duty—

that is, to ensure that the practitioner has had any assistance needed to be able to deal with the impact on him or herself. A Web site which is a project of the Clinician Survivor Task Force of the American Association of Suicidology has a bibliography and annotated references, personal accounts, and clinician contacts: [http://mypage.iusb.edu/~jmcintos/therapists\\_mainpg.htm](http://mypage.iusb.edu/~jmcintos/therapists_mainpg.htm)

8. Reconsideration of practice parameters after a death of a client: the professional, and any supervisor, needs to consider whether any adjustment in practice is indicated by the impact of the suicide or suicide attempt.

### Some general factors in predicting risk:

1. Statements that the person plans to kill themselves (even if chronically made).
2. Existence of a plan: The more specific, more lethal, the higher the risk (a vague plan is less dangerous than a specific one; if one has actually practiced such actions as putting a gun to one's head, or if one has checked to see if there are enough pills to do it, the plan is more lethal).
3. Possession of the means to do it, e.g. having a loaded gun with bullets.
4. Past attempts: Approximately 80% of those who kill themselves have attempted it before.
5. Clinical depression: Approximately 15% of those with serious clinical depression kill themselves; the suicide rate for those with clinical depression is about 20 times that for the general population.
6. Feelings of hopelessness are the most significant depressive thoughts associated with suicide, and this is the best predictor variable.
7. Alcohol and drugs: 25-33% of suicides are associated with alcohol as a contributing factor; alcohol and drug abuse in general are risk factors.
8. Loss of a parent or other important person in one's life increases the risk, both acutely and on a longer term basis.
9. Serious health problems and pain can increase the risk, especially when chronic.
10. Loss of a job and unemployment increase the risk.
11. Risk is higher for those coming out of a depression or recently released from hospital care for depression.

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**Common errors in the handling of suicidal clients:**

The most common errors relate to a failure to obtain a good history, failure to follow-up on intuition or “soft signs” and statements with more inquiry, or a failure to deal with your own cynicism, anger, or frustration with a long-term and chronically suicidal client. Writing the threat off as “just manipulation” is always dangerous.

Another common error is over-reliance on a client promise to not suicide. Currently the major experts recommend against “no suicide contracts,” partly because they are not really negotiated with clients but represent therapist demands. Top experts prefer a crisis card which involves client-generated actions when the client is feeling suicidal. This also involves constructing a “hope box”—a suicide prevention tool box. (e.g. Jobes, 2006)

In all cultures, a personally humiliating event can be a precipitant for a suicide. There are cultural differences in what is likely to be the most humiliating event. For a Muslim immigrant from Africa, a young girl having an illegitimate child is most at risk. Mental illness may be humiliating. A man who falls in love and cannot afford a dowry is at risk.

Severe pain and chronic illness can, of course, also lead to suicidal thought or action.

A number of professionals who testify in wrongful death cases now consider it essential to question clients carefully about the presence of guns in the home which are accessible. Because some gun-owners do not consider them “weapons,” is important to specifically inquire about guns of any type.

Screening for the presence of guns as part of a clinical intake or risk assessment is now considered the standard of care by a number of experts. In many states, including Wisconsin, guns account for the largest percentage of suicide deaths. The removal of guns and/or ammunition is a very common intervention.

**The evolution in handling suicidal clients:**

Recently there has been a major shift in the standards for handling of suicidal clients. There is an excellent resource on this topic in the form of a recent overview, *Ethical and competent care of suicidal patients: Contemporary challenges, new developments, and considerations for clinical practice* (Jobes, 2006; Jobes, Overholser, Rudd, and Joiner, 2008).

A major shift has been occurring away from suicide risk factors to a focus on suicide warning signs which are specific to a given case. (cf. (Rudd, Berman et al., 2006). These include:

- Rage and reckless behavior,
- Feelings of hopelessness,
- Feeling trapped,
- Anxiety and/or agitation,
- Dramatic mood changes,
- Emotional and social withdrawal,
- Lack of a sense of purpose in life: “no reason to live.”

**The college campus**

There has always been a challenge concerning the suicidal student on a college or university campus. Such persons are typically of the age of majority and thus have full rights to their privacy, and yet they are often still supported by their parents and seen as sons and daughters who are not yet independent. As with the recent suicide by a student whose privacy was invaded when a roommate used a hidden camera to record and then broadcast him having sex with another man, these can occur in response to acute stressors. However, some are in counseling.

The challenge is whether to contact parents in the event of a significant emotional problem and/or suicidal thinking or potential. Parents often expect this; however, the legal and ethical threshold to breach confidentiality is quite high, as the student is an adult.

This situation has become controversial enough to rate a front page story in the *Wall Street Journal*. Published in the Saturday/Sunday Weekend Edition for March 24-25, 2007 (Vol. CCXLIX, No. 69, pages A1, A6-7), the story was entitled “After a suicide: Privacy on trial” by Elizabeth Bernstein. It examined the outcome of a jury trial in a wrongful death case brought in 2003 by the parents of Chuck Mahoney who took his own life in a fraternity house at Allegheny College in Meadville, Pennsylvania.

Among the claims in the case were that Allegheny College officials should have, among other things, breached their son’s confidentiality to get them involved in the situation. Since 1974 the FERPA (Family Educational Rights and Privacy Act), which protects the privacy of educational records, has allowed school officials to contact parents in the event of an emergency situation (health

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or safety related). Furthermore, the release used at the college made it clear that in the event of an immediate threat to the client or someone else that confidentiality can be broken.

The college did have a waiver that students can sign to allow communication with parents, but Chuck had not signed it nor had his parents pushed him to sign. Present in the case were the usual dynamics of the privacy of a young man vs. the desire of parents to be helpful. In this case there were a number of consultations among school officials and mental health professionals and the professionals were concerned that breaking the confidentiality could lead to a very negative response.

The jury voted 11-1 for the defendants. According to the story:

In interviews, many jurors said that as an adult, Mr. Mahoney was responsible for his own actions. They believed his parents should have recognized how sick their son was after he was hospitalized, and that they had a responsibility to make sure he signed the waiver form that would have freed the school to more easily share information. "If I am flipping the bill for college, you are signing the waiver," says Tom Yoder, 43, a tool-and-die maker. The lone dissenting juror, Barbara Collins Zurovchak, felt the suicide warnings required action. "I believe that safety must trump privacy," the retired high school teacher says. (Bernstein, 2007, p. A7)

In 2002 MIT settled with the parents of Elizabeth Shin, who set herself on fire in a dorm room in 2000. On the other side are cases in which colleges try to pressure students to take leaves of absence when they become troubled. Currently the dispute over this practice rages, with several successful suits against universities under the Americans With Disabilities Act (ADA). Some schools require that troubled students get counseling and pressure them to do so. Many who do kill themselves are not in any sort of counseling or therapy.

In 2007 the terrible mass killings at Virginia Tech University led to considerable national discussion and to an investigation as to how college officials handled the situation. In general the conclusions were that while campus police should have alerted the campus community to the situation earlier, it is possible that nothing would have prevented the killings.

Although newspaper editorials have tried to second-guess the situation and noted that various privacy laws and rules prevented some communication from service providers to the college, there is no convincing evidence that such communication would have made a difference.

The reality is that a very troubled young man—who had been referred for and received help of various types—ran amok and killed a number of people.

The Virginia Tech events are a stark reminder of the challenges faced by colleges and universities in dealing with young adults who have breakdowns. Furthermore, issues of access to care and some challenges in providing community mental health services seem as critical as the balancing of privacy rights with safety.

### Resources for support of family

There are numerous community support groups for families and friends of those who have committed suicide. Groups like Compassionate Friends provide support for parents who have lost a child—although not specific to suicide. Many other groups are focused on people dealing with the grief of having lost a family member to suicide. An internet search for support groups will help locate local ones.

Many books on the topic can be found through [www.amazon.com](http://www.amazon.com) or other bookstores. For example:

- Carla Fine (1999). *No Time to Say Goodbye: Surviving the suicide of a loved one*.
- Christopher Lukas and Henry M. Seiden (2007). *Silent Grief: Living in the wake of suicide* (revised edition).
- Beverly Cobain and Jean Larch (2006). *Dying to be Free: A healing guide for families after a suicide* (Hazelden also publishes an e-book version).
- Candy Weely Arrington (2003). *Aftershock: Help, hope, and healing in the wake of suicide*.
- Albert Hsu (2002). *Grieving a Suicide: A loved one's search for comfort, answers and hope*.
- Iris Bolton and Curtis Mitchell (1983). *My Son....My Son....A guide to healing after death, loss, or suicide* (in its 18th printing; Ms. Bolton has a Web site).

### Web sites and Internet resources for skill training

The Internet has a huge body of resources for learning more about suicide and suicide prevention, including:

**Suicide Prevention Resource Center** (<http://www.sprc.org>): Among the many resources on this site are a set of customized manuals for various types of people from teens to clinical social workers. You can download and print out a primer for a number of types of professionals.

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American Association of Suicidology (<http://www.suicidology.org>)

American Foundation for Suicide Prevention (<http://www.afsp.org>)

National Center for Injury Prevention and Control (<http://www.cdc.gov/injury/index.html/>): part of the Centers for Disease Control and Prevention.

National Suicide Prevention Lifeline (<http://www.suicidepreventionlifeline.org/>): Toll-free phone for information to providers at (800) 273-TALK (8255).

Suicide Prevention Action Network USA (<http://www.spanusa.org>): Dedicated to leveraging grassroots support among suicide survivors, including family members.

### Books, manuals, and articles: General or skill training

American Academy of Child and Adolescent Psychiatry (2001). Practice parameters for the assessment and treatment of children and adolescent with suicidal behavior. *J. of the Amer. Acad. of Child & Adol. Psychiatry*, 40 (7 Suppl), 24S-51S (members of the Academy can obtain the full text from the Academy Web site: <http://www.aacap.org>).

American Psychiatric Assn. (2003). *Practice Guidelines for the Assessment and Treatment of Patients With Suicidal Behaviors*. Arlington, VA: American Psychiatric Assn. [http://www.psych.org/psych\\_pract/treatg/pg/pg\\_suicidalbehaviors.pdf](http://www.psych.org/psych_pract/treatg/pg/pg_suicidalbehaviors.pdf).

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Wenzel, A., Brown, G.K., Beck, A.T. (2009). *Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications*. Washington, DC: American Psychological Assn.

### Videos and training films

*The Suicidal Patient: Assessment and care*. Developed by the American Foundation for Suicide Prevention and Kingsley Communications in 1999. See <http://library.sprc.org/item.php?id=64&catid=12>; retrieved March 11, 2011.

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