“The word chaplain (italics in original) comes from the early history of the Christian church. Traditionally, a story relates the compassion of a fourth-century holy man named Martin who shared his cloak with a beggar. Upon the death of Bishop Marin, his cloak (capella in Latin) was enshrined as a reminder of the sacred act of compassion. The guardian of the capella became known as the chapelain, which transliterated into English became chaplain. Today the chaplain continues to guard the sacred and to share his or her cape out of compassion” (p.3).
Introduction

Course Objectives

• Provide Information On The Nature and Scope of Suicide In America
• Provide Information On The Nature and Scope of Suicide In The Law Enforcement Community
• Learn Risk Factors For Suicide
• Understand The Relationship Between Mental Illness and Suicide
• Understand The Limitations of Suicide Risk Assessment
• Learn To Conduct An Interview With A Person Threatening Suicide
• Learn How To Ask Appropriate Questions
• Increased Awareness and Familiarity In Assessing And Referring At Risk Individuals
• Proper Documentation For A First Level Suicide Risk Assessment
• Become Competent and Comfortable In Assessing And if Necessary Referring Suicidal Persons Either On The Phone Or In Person
Understanding and Preventing Suicide

30,000–34,000 kill themselves every year
Every 18 minutes someone attempts to kill themselves

Source: CDC; University of Southern Maine Task Force On Suicide Intervention
Can We Profile Suicide Ideation?
Can We Profile Suicide Ideation?

Previous Suicide Attempt
Psychiatric Disorder; Emphasis on Depression, Manic Depression, Schizophrenia
Alcohol or Substance Abuse (context Psychiatric Drugs and Prescribed Medications
Family History Of Suicide
Hopelessness
Impulsive or Aggressive Behaviors
Barriers To Mental Health Treatment
Relational, Social, or Financial Loss
Physical Illness
Easy Access to firearms or other lethal methods of self-destruction
An unwillingness to seek help due to stigma
Influence of celebrities, friends or family members that have committed suicide
Local epidemics of suicide—contagion
Isolation, a feeling of being disconnected from others

Several sources: (i.e. Mann 1998; Jacobs 1999; 1998 Conference by the Surgeon General of the
U.S. Department of Health 1999)
Experts forecast that 15% of people with depression kill themselves.

Suicide research and study are at best inconclusive and at worst contradictory.
In surveys there seems to be consensus that access to firearms does increase the risk for suicide. Keep in mind that 99.98% of law enforcement personnel who carry firearms do not kill themselves. Also keep in mind that dentists, doctors and entrepreneurs who do not carry firearms have higher suicide rates.
Nature & Scope of Suicide in America
Nature & Scope of Suicide in the Law Enforcement Community
Risk Assessment

The Employee is under investigation
The Person talks about harming himself/herself
Previous attempts to harm oneself
History of suicide in the family
Increased use of alcohol or drugs (including prescription medication)
Warnings to co-workers, friends, family indicating self harm
Sudden deterioration in physical health
Increased paranoia or expressions of revenge
Living alone with no evident or apparent support resources
Increased reluctance to communicate with peers or friends or family
Exhibiting symptoms of depression (i.e. profound feelings of helplessness)
Sleeplessness or consistent sleep deprivation
Sharp weight gain or weight loss
Loss of energy
Expressions of personal worthlessness
Social Isolation
Difficulty in concentrating
Anxiety
The inability to express pleasure
Law Enforcement Suicide

In a study entitled Police Suicides and Small Departments: A Survey (Campion) indicated 88% of Law Enforcement suicides included depression as a factor.

There is limited evidence or no evidence to suggest that Police Departments are covering up departmental suicides as accidental deaths. Inquiries by Law Enforcement investigators do not lend credence or evidence that departments are misclassifying suicide as accidental or undetermined death.
Current data suggests that the officer’s personality, life-style choices and personal choices are the major contributing factors in police officer suicide. This is not to suggest that on the job tasks play no part in depression or that PTSD has no effect on individual officers.
What are the Warning Signs?

What if someone is reaching out to you? If someone contacts you and are considering harming himself/herself; they may do so directly or indirectly.

Watch for talk about suicide or death.
Watch for verbal clues; “I wish I were dead” or “I am thinking about leaving”
Watch for indirect clues; “What’s the point of living” or “what happens to a person when they die” or “do you think a person can kill themselves and still go to heaven”. No one really cares if I am dead or alive.

Watch for isolating behavior--the person refuses to interact with family or friends or coworkers
The person expresses the deep conviction that life is meaningless, pointless, useless
Giving away cherished possessions

Exhibiting a sudden and unexplained improvement in mood after being depressed or withdrawn
Neglecting personal hygiene or personal appearance

If these warnings are present coupled with a history of self-destructive behavior; previous suicide attempts; diagnosed depression, alcohol or substance abuse; exposures to recent trauma; a ten-fold increase in risk for suicide is present (Violanti, 2004)

Sign an officer may harm himself or herself;

Announcing they are going to hurt themselves; threatening to ruin their careers, but they don’t care; admission they are out of control; appear hostile, blaming, argumentative, and insubordinate OR appear passive, defeated, and hopeless. Indicate that they are overwhelmed but cannot find solutions to their problems. Ask another officer to keep their weapons or inappropriately use or display their weapon.

Begin behaving recklessly and taking unnecessary risks; on the job or in their personal lives.
Carry more weapons than appropriate.
Exhibit deteriorating job performance (which may result from alcohol or drug abuse).
DO NOT TALK TO MEDIA OR JOURNALISTS UNDER
Citizen suicide is profoundly different than an officer involved suicide. The actions and reactions by the Special Agent In Charge or Chief or Sheriff down to the patrol officer will be remembered in specific detail by peers and family survivors. Trauma includes witnessing the suicide act or suicide scene; being improperly notified; rampant exposure to Department speculation or the perception that the department has failed to act with compassion towards the survivors.
Suicide In The Home

Trauma
Presence or absence of family members
Person survives briefly before expiring
Physical evidence on face hands or clothes
On scene officer separates survivors from the body
Note if the person is remains alive for a brief/prolonged time loved ones often will want to join loved ones; but must remain for interview.
During the interview survivors are in shock and may want to clean and change clothes. However procedures require most survivors to be transported to a police station for fingerprinting and GSR tests. Survivors do not understand this procedure. It is imperative that these tests be done quickly and appropriately so that survivors do not have to endure the sight and smell of blood for prolonged time periods.
Survivors may be overwhelmed by the number of officers on scene. If the officer worked in one jurisdiction and lived in another jurisdiction twice the amount of law enforcement officials are often present. Shock and the inability to think clearly is quite common. Standard police reports require the giving of specific information like social security number DOB; mother’s maiden name; but sometimes even basic information is difficult to recall.
Citizen Suicide

What Do The Bereaved Need?

Objective Information

Emotional Support

Church

Bereavement Groups

Some people find great comfort and hope in inspirational books. Some find great comfort in writing about their journey. Clearly some will find neither or both of these options of some benefit.
What are the symptoms of depression?

Feeling sad, anxious or helpless
Feeling worthless or guilty
Changes in appetite or weight
Thoughts of death, morbidity or suicide
Psychomotor retardation or agitation
Trouble concentrating, remembering or making decisions
Trouble sleeping or sleeping too long
Loss of interest in things you used to enjoy
Loss of energy or feeling tired or fatigued all the time
Major Depressive Disorders

- Bipolar disorders
- Dysthymia
- Substance Abuse And Suicide
- Abstracts
- Antidepressants Prevent Suicide
- Antidepressants Cause Suicide
Conclusion

Know What to Do
Resources

National Suicide Prevention Hotline: 1–800–273–TALK (8255)

Suicide Prevention Resource Center
www.sprc.org

Maine Youth Suicide Prevention
http://www.maine.gov/suicide
“Police Suicide—Where is the Piper?”

Taken from: http://www.youtube.com/watch?v=FKPPX_bfHDE&feature=player_embedded
Myth: If someone really wants to kill themselves, there is nothing that can be done.
Myths of Suicide

**Myth:** If someone really wants to kill themselves, there is nothing that can be done.

**Fact:** Most suicidal people are undecided about living or dying. A part of them wants to live, but death seems like the only way out of their pain and suffering. Suicide can be prevented. Many will seek help immediately after attempting to harm themselves.
Myth: Suicide happens without warning. People serious about suicide keep it to themselves.
Myth: Suicide happens without warning. People serious about suicide keep it to themselves.

Fact: Most suicidal people give many clues and warning signs that they are thinking about taking their lives. Most people communicate their intent in the weeks preceding their attempt.
Myth: Talking about suicide can put the idea in someone’s head or make them decide to take their life.
Myth: Talking about suicide can put the idea in someone’s head or make them decide to take their life.

Fact: Talking about suicide does not increase suicide risk—in fact, it is the best way to find out if someone is at risk and get them the help they need.
Myth: If you ask someone about their suicidal intentions, you will only encourage them to kill themselves.
Myth: If you ask someone about their suicidal intentions, you will only encourage them to kill themselves.

Fact: The opposite is true. Asking directly about suicidal intentions often lowers the person’s anxiety level. Encouraging someone to talk about pent up emotions through a frank discussion of their problems shows that you care and are willing to help. Talking about suicide can be an excellent prevention tool.
Myth: People who talk about killing themselves rarely complete suicide.
Myth: People who talk about killing themselves rarely complete suicide.

Fact: Many people who die by suicide give warnings of their intentions. Always take any comment about suicide seriously. Most people who die by suicide have talked about their intention.
Myths of Suicide

Myth: A particular individual, for instance a family member, a school, or a health service provider, in some way played a role in the victim’s death by suicide.
Myth: A particular individual, for instance a family member, a school, or a health service provider, in some way played a role in the victim’s death by suicide.

Fact: Thorough investigation almost always finds multiple causes for suicide and fails to corroborate a simple attribution of responsibility.
Myth: A suicidal youth will be angry when someone tries to intervene and will resent the attempt to help.
Myth: A suicidal youth will be angry when someone tries to intervene and will resent the attempt to help.

Fact: Most young people are relieved to have someone recognize their pain. Resistance may indicate lack of trust or a test to see how much you care!
Myth: All suicidal people are deeply depressed.
Myth: All suicidal people are deeply depressed.

Fact: Although depression is often closely associated with suicidal feelings, not all people who kill themselves are depressed.
Myths of Suicide

**Myth:** Suicidal people are mentally ill.
Myth: Suicidal people are mentally ill.

Fact: Although many suicidal people are depressed and distraught, not all have a diagnosed mental illness.
Myths of Suicide

**Myth:** Marked and sudden improvement in the mood of someone who has been depressed is a signal that the crisis period is over.
Myths of Suicide

**Myth:** Marked and sudden improvement in the mood of someone who has been depressed is a signal that the crisis period is over.

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**Fact:** Sudden improvement in mood may signify that a decision to commit suicide has been made to put an end to the pain. It is a critical time for direct intervention.
Myth: There is no link between alcohol use and suicide.
Myth: There is no link between alcohol use and suicide.

Fact: Alcohol and other drug use increase the risk of suicidal behavior. Even people who don’t usually drink will often drink alcohol shortly before killing themselves to lower their inhibitions.
Myth: People who threaten suicide are merely seeking attention and/or trying to manipulate others.
Myths of Suicide

**Myth:** People who threaten suicide are merely seeking attention and/or trying to manipulate others.

**Fact:** All suicide threats must be taken seriously. This behavior may be a sign of depression and professional help is needed. While it may, in fact, be a manipulative act, it’s one that can end in death. It is a cry for help.
Myths of Suicide

**Myth:** Once someone attempts suicide, they will always be suicidal.
Myth: Once someone attempts suicide, they will always be suicidal.

Fact: Four out of five persons who die by suicide have made at least one previous attempt. However, most suicidal crises last for only a very brief period. With support and assistance, there may never be another suicidal crisis.
Myths of Suicide

**Myth:** Suicide is more common among lower socioeconomic groups.
Myth: Suicide is more common among lower socioeconomic groups.

Fact: Suicide crosses all socioeconomic boundaries. People of all ages, races, faiths, cultures, and income levels die by suicide.
Myth: Suicidal youths cannot help themselves.
Myth: Suicidal youths cannot help themselves.

Fact: With appropriate support and treatment, most young people can gain the life skills, wisdom, and maturity to manage their lives.
Myth: A promise to keep a note unopened and unread should always be kept.
Myths of Suicide

**Myth:** A promise to keep a note unopened and unread should always be kept.

**Fact:** Promises and confidences cannot be maintained when the potential for harm exists. A sealed note can be a serious warning sign of imminent suicidal behavior.
Myth: Only professional therapists can help suicidal people.
Myth: Only professional therapists can help suicidal people.

Fact: Psychotherapeutic interventions are very important, but many suicidal individuals never see a therapist. A basic suicide intervention can be done by anyone who knows what to do. It is up to all of us to learn about suicide.
Myths of Suicide

**Myth:** Most suicidal youths never seek help with their problems.
Myth: Most suicidal youths never seek help with their problems.

Fact: Most do share their plans with their peers. Many see a school counselor or medical doctor during the three months before they kill themselves. Often, they have trouble expressing themselves directly and verbally. We all need to help, but it's especially important for peers to understand the crucial role they can play in saving a life by refusing to keep this secret and helping their friend find an adult who will help.
Myth: There is no significant difference between male and female adolescents regarding suicidal behavior.
Myth: There is no significant difference between male and female adolescents regarding suicidal behavior.

Fact: Adolescent females are significantly more likely than adolescent males to have thought about suicide and to have attempted suicide.
Myth: The most common method for adolescent suicide deaths is drug overdose.
Myths of Suicide

Myth: The most common method for adolescent suicide deaths is drug overdose.

Fact: Guns are the most frequently used method for deaths by suicide among adolescents. In 1994, guns accounted for 67% of all adolescent deaths by suicide while strangulation (via hanging), the second most frequently used method for adolescent suicide deaths, accounted for 18% of all adolescent deaths by suicide.
Myth: Because female adolescents die by suicide at a lower rate than male adolescents, their attempts should not be taken seriously.
Myths of Suicide

**Myth:** Because female adolescents die by suicide at a lower rate than male adolescents, their attempts should not be taken seriously.

**Fact:** One of the most powerful predictors of death by suicide is a prior suicide attempt. Adolescents who have attempted suicide are 8 times more likely than adolescents who have not attempted suicide to attempt again.
Myths of Suicide

**Myth:** Suicidal behavior is inherited.
Myths of Suicide

**Myth:** Suicidal behavior is inherited.

**Fact:** There is no specific suicide gene that has ever been identified.
Mental Illness & Suicide
Risk Assessment Models
How to Conduct an Interview with Suicidal Persons
How to Persuade People to Accept Help
How to Determine Immediate Risk for
Police Suicide: The Number One Cop Killer
Suicide is an unnecessary by-product of police work that needs to be eliminated.

According to organizations that track police suicide: the suicide rate for police officers is higher than the suicide rate for Americans in general; more officers commit suicide than are killed by assailants.

The media (especially through television cop shows) and even academy training do not make it easy for police officers to ask for or accept help. Officers are taught: be in control, have Command Presence, be part of the answer, not part of the problem.

A police officer’s protection is not a gun and body armor – it’s their “psychological protection.” At a crime scene, officers can’t cry with the victim’s mother. They can’t run away from an armed gunman who’s threatening a crowd. They need to be in control.
The result is that sometimes the officer must disassociate in order to avoid experiencing the emotions that everyone else is experiencing.

Disassociation is common in law enforcement, a short-term answer, and the build up of what can become a long-term problem.

Police officers will disassociate or hide their emotions. But, eventually there comes a time when they will need to deal with those emotions.

Failure to address those built up emotions can lead to a wide range of problems: increased Internal Complaints, substandard investigative work, increased absenteeism, failed relationships, poor health, termination, even suicide.
There are many forms of treatment for cumulative stress & PTSD.

If a police officer seeks help and it doesn’t “work,” they need to seek another doctor. After all, if you like steak and don’t like the steak at one particular restaurant, find another place to eat.

Police officers never think stress will be a factor for them. They certainly don’t think they’ll be the one to commit suicide. They spend their lives helping others yet they will nearly die before they accept help.

The loss of a friend or loved one is one of the worst pains a person will experience. But, that pain is made worse when the survivor knows that their loved one could have sought help and could still be alive today.

Thousands of police officers who have contemplated suicide and sought help are living happy, healthy lives today.

Police work is a great career. Even with its highs and lows, officers should finish their career with honor and happiness.
There are many forms of treatment for cumulative stress & PTSD.

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The Will to Live
Resources

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Suicide Prevention Resource Center
www.sprc.org

Maine Youth Suicide Prevention
http://www.maine.gov/suicide
In 2004, the FDA issued a Public Health Advisory that warned about the risks associated with the new generation of antidepressants including Prozac, Zoloft, Paxil, Luvox, Celexa, Lexapro, Wellbutrin, Effexor, Serzone, and Remeron. The FDA warned that antidepressants might cause suicide in a small percentage of children and adults. In addition, the FDA also warned that certain behaviors are known to be associated with these drugs—anxiety, agitation, panic attacks, insomnia, irritability, hostility, impulsivity, severe restlessness, hypomania, and mania.

These behaviors are identical to those induced by PCP, methamphetamine, and cocaine, and are a result of the drug’s impact on serotonin, a neurotransmitter found in the brain. This stimulation can lead to out-of-control behavior, including violence. In his viewpoint, Peter Breggin thus maintains that SSRIs can cause violence and suicide. These antidepressants have the same effect on the brain as PCP, methamphetamine, and cocaine. These illegal drugs are already known to cause violence and aggression. His conclusion: the use of these antidepressants should be avoided and the public more
Breggin has written in books and scientific reports about various studies pertaining to abnormal behavior produced by the newer antidepressants. In looking at mania specifically, manic individuals can become violent and they can also “crash” into depression and suicidal states. They can carry out elaborate but grandiose and doomed plans. Clinical trials have shown a 6% rate of manic reactions for depressed children on Prozac, a 0% rate of mania for those on a sugar pill;
Breggin concludes with two statements. Little will be lost by minimizing the use of the newer antidepressants. While there is strong evidence that they cause suicide, there is no convincing evidence that they can prevent it.

Severe depression is essentially a feeling of profound hopelessness and despair that can best be addressed by a variety of psychotherapeutic, education, spiritual, and religious interventions.

Edelson is a reporter for HealthDay. Simon is a psychiatrist and health care researcher. No specific occupation was included for Ballas. Breggin is a psychiatrist author founder of a center and a journal on psychiatry.
Shock

The first stage of acute grief is shock. In the first few days you ask yourself the questions that plague suicide survivors: Why did this happen? What did I do to cause this? Was it my fault? Could I have prevented it?

Feelings common in this stage:
- you feel numb and cold
- you feel far away from other people
- you feel out of touch with reality
- you feel as if you’re in a dream
- you feel helpless to change the events happening around you
- you just can’t believe what’s happening
- you have a general feeling of slowness in moving around
- you may refuse to believe that the death was caused by suicide even with evidence that it did

Physical symptoms are common in this stage:
- your mind is in shock; it anesthetizes you against the tremendous blow that has hit you
Relief

Feelings of relief about the suicide are common when the relationship was superficial or destructive. Now that the cause of their emotional turmoil is gone, many family members breathe silent sighs of relief after the suicide. When relief, rather than grief, follows suicide, people often bypass the emotional flood that follows shock.
Catharsis

Catharsis (Greek for “purging,” “purification”) follows shock in most grief experiences. The numbness begins to wear off, you realize the great loss that has occurred in your life, an emotional flood occurs and feels uncontrollable; you feel swept away, these feelings tend to peak at the funeral and are strong for another week or two when one emotion is let loose, others are soon to follow; a gut wrenching experience floods of fear, denial, guilt, anger, relief, depression happen all at once, these emotions will drain you until fatigue and sleep take over. Most suicide survivors are more emotional than those experiencing normal grief, you need to let these feelings come out now; if not, they’ll come out another way at another time find a “screaming room” where you can come “unglued,” coming unglued can be healthy and honestly good for you, especially if the “glue” was repression and denial.

During this stage, you’ll need to deal with two questions: whether to admit the death was a suicide, and whom to tell about it.
Depression

Depression comes with the realization that the suicide really did happen and that your loved one really is dead. Some common things you see in this stage:
- it usually lasts for about six months
- some survivors withdraw and isolate themselves
- some will even contemplate suicide themselves, especially after the third month
- you may not feel physically well: nervousness, fatigue, tiredness, rashes, hives, distorted vision, upset stomachs, spastic colons; even asthma and rheumatoid arthritis
- most physicians will tell you that your symptoms are psychosomatic or will give you a prescription for your nerves; you need to know whether such treatment is for you

A psychosomatic symptom is a physical problem brought on by an emotional reaction. It is real. Beware of medical treatment during this stage. Drugs may serve a purpose in your situation, but they won’t cure your grief. In fact, they may complicate the healing process. Grief is handled best when you’re awake, not drugged into sleepiness. Tranquilizers won’t end the pain—they mask it for a while. Resist zonking yourself out during this period. Grief work is done best when you’re alert, not off on a medicated cloud.
Guilt

Feelings of guilt are common in all grief but compounded among suicide survivors. Grief is complicated by massive guilt feelings. After the flood of emotions is past, the deep, haunting feelings of guilt really set in. You begin to deal with the primary question of responsibility. The most serious guilt feelings come to the spouses. Shame, failure, unworthiness, hopelessness wash over the spouse.

Guilt comes in many forms: your relive all the angry words and harsh encounters you had; you
Preoccupation with the Loss

In the depression stage, you’ll find your waking moments being dominated by thoughts of the suicide. This appears in a variety of ways that can be harmless or destructive:

Daydreaming—fantasizing about the death: pretending it didn’t happen, that you were able to prevent it, that the person is just away on a trip. This will fade with time if you don’t dwell on them.
Synopsis: After Suicide ~ Coping with Acute Grief: What

Anger
Anger shows that you’re coming out of the depths of depression. You can express your feelings again, without fear. Survivors report a great deal of anger in the months after a loved one’s suicide. That’s perfectly ok. Some factors/attitudes regarding anger:
- rage toward the deceased for publicly rejecting them
- rage over the one who “did this to you”
Suicide in Jewish Tradition

Suicide is merely reported in Hebrew scriptures: no approval or disapproval is given. Only in the Talmud is suicide condemned. Modern Jewish scholars believe that the harshest Jewish treatment of suicides was due partly to Christianity’s negative view on the subject. No moral comment is made about suicidal deaths in the OT. Rabbis considered suicide a grave sin. The only exceptions to a formal condemnation were situations where a Jew was forced to betray his faith under torture, commit another grave sin, or endanger his country in wartime.

Jews didn’t consider a self-inflicted death to be suicide unless it was announced beforehand and carried out in front of eyewitnesses. Even a person found hanging was given the benefit of the doubt—it could have been an accident! Minors and mentally ill persons were exempt from condemnation, no matter the situation. It was acceptable for a person to kill himself to make restitution for past sins. No recrimination toward the victim or the family occurs in modern Judaism. Although suicide is met with condemnation, the Jewish community recognizes the unique
Suicide in Christian Tradition

Suicide became a serious problem for the early church. Under great persecution for their beliefs, believers desired to die and be with the Lord. Suicidal desires for martyrdom reached a fever pitch in the early church. The early church fathers approved of suicide in order to avoid rape or forced denial of one’s faith.

Catholic Thought: Augustine and Thomas Aquinas led the church to adopt strict prohibitions and recriminations against suicide. They considered it a form of murder, and thus a mortal sin. It ruled out any opportunity for repentance. It was an attack upon society and upon the sovereignty of God. There is a distinction between direct and indirect suicide. Direct suicide is desired self-murder and is always a mortal sin. Indirect suicide results when death is not desired but allowed so that a greater good might occur (the soldier who throws himself on a grenade). This is lawful and worthy of praise by the church. Catholic law still prescribes severe penalties for suicides and attempted suicides. But in real practice, the church seldom makes judgments on those who kill themselves. The church usually allows full burial rites for the victim. The main focus must be a caring ministry to the survivors rather than punishment against the deceased and the family.
Thinking Straight About God

In the aftermath of a suicide, many religious questions are asked. Is suicide the unpardonable sin? To make the last millisecond of a person’s life so supremely important is to misunderstand the worth of our lives and the forgiveness of God. He judges our lives in their totality. All suicides do not go to hell.

Why did God do this to me? God didn’t “take” your family member. Suicide is a human act done for human reasons attempted and completed by humans. We have free will. The fact is that suicide is a rejection and desertion by a loved one. Those who say God did this to make you a stronger person offer cold comfort.

Where is God in this tragedy? In Night, a book by Elie Wiesel, he writes:

The SS hanged two Jewish men and a youth in front of the whole camp. The men died quickly, but the death throes of the youth lasted for half an hour. “Where is God? Where is He?” someone asked behind me. As the youth still hung in torment in the noose after a long time, I heard the man call again, “Where is God now?” And I heard a voice in myself answer, “Where is He? He
Thinking Straight About God

Another story is of a father asking his pastor where was God when his son stepped on a mine in Vietnam and was killed. The pastor answered, “The same place He was when His Son died.”

To say that God doesn’t feel things or suffers is a theology that is morally bankrupt. God suffers and He is not indifferent. To make Him so would make Him a demon. The cross remains our testimony to “where God is” in our personal tragedies. He hangs there before us, bearing our pain, feeling our hurt, conquering our death.

Suicide is a mystery. No one knows what goes on in the mind and heart of a person before suicide. The starting point for any religious statement about suicide must be the confession of mystery. Suicide is an act of solitude. We can’t always form a judgment, and we should not, about why a person chooses suicide.
Your Religious Life in the Aftermath

Suicide is also a religious issue. It will affect the survivor’s religious life. Some will turn away from the church, others will throw themselves into church “work.” Some recommendations:

- Allow God into your situation.
- Allow your church to care for you.
- Ask your theological questions when you’re ready.
- Express your emotions faith-fully.
- Take advantage of opportunities for worship.
- Practice the presence of God daily.
- Allow closure to come to your grief—in God’s presence.

Cite source!
“Police Suicide—Where is the Piper?”

Taken from: http://www.youtube.com/watch?v=FKPPX_bfHDE&feature=player_embedded
Suicide & Law Enforcement
Presentation by Chaplain Gino Geraci