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Caring Connections

An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling

Ministry and Suicide

The Purpose of Caring Connections

Caring Connections: An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling is written by and for Lutheran practitioners and educators in the fields of pastoral care, counseling, and education. Seeking to promote both breadth and depth of reflection on the theology and practice of ministry in the Lutheran tradition, *Caring Connections* intends to be academically informed, yet readable; solidly grounded in the practice of ministry; and theologically probing. *Caring Connections* seeks to reach a broad readership, including chaplains, pastoral counselors, seminary faculty and other teachers in academic settings, clinical educators, synod and district leaders, others in specialized ministries and — not least — concerned congregational pastors and laity.

Caring Connections also provides news and information about activities, events and opportunities of interest to diverse constituencies in specialized ministries.

Scholarships

When the Inter Lutheran Coordinating Committee disbanded a few years ago, the money from the "Give Something Back" Scholarship Fund was divided between the ELCA and the LCMS. The ELCA has retained the name "Give Something Back" for their fund, and the LCMS calls theirs "The SPM Scholarship Endowment Fund." These endowments make a limited number of financial awards available to individuals seeking ecclesiastical endorsement and certification/credentialing in ministries of chaplaincy, pastoral counseling, and clinical education.

Applicants must:

- have completed one [1] unit of CPE.
- be rostered or eligible for active roster status in the ELCA or the LCMS.
- not already be receiving funds from either the ELCA or LCMS national offices.
- submit an application, along with a financial data form, for committee review.

Applicants must complete the Scholarship Application forms that are available from Judy Simonson [ELCA] or Joel Hempel [LCMS]. Consideration is given to scholarship requests after each application deadline. LCMS deadlines are April 1, July 1 and November 1, with awards generally made by the end of the month. ELCA deadline is December 31. Email items to Judith Simonson at *jsimonson@aol.com* and to Joel Hempel at *Joel.Hempel@lcms.org*.

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Please notify us of that change by re-subscribing at *lutheranservices.org/newsletters#cc*.

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News, Announcements, Events: E-mail items to Judith Simonson at *jsimonson@aol.com* or Joel Hempel at *Joel.Hempel@lcms.org*

Contents

Call for Articles

Caring Connections seeks to provide Lutheran Pastoral Care Providers the opportunity to share expertise and insight with the wider community. We want to invite anyone interested in writing an article to please contact one of the co-editors, Diane Greve at *dkgreve@gmail.com* or Lee Joesten at *lee.joesten@gmail.com*. Specifically, we invite articles for the upcoming issue on the following themes:

2019.2 Best Practices/Evidence Based Spiritual Care;
2019. 3 The Future of Faith-based Health Care

Have you dealt with any of these issues? Please consider writing an article for us. We sincerely want to hear from you! And, as always, if you haven't already done so, we hope you will subscribe online to *Caring Connections*. Remember, a subscription is free! By subscribing, you are assured that you will receive prompt notification when each issue of the journal appears on the *Caring Connections* website. This also helps the editors and the editorial board to get a sense of how much interest is being generated by each issue. We are delighted that the number of those who check in is increasing with each new issue. Please visit *www.lutheranservices.org/newsletters#cc* and click on "Click here to subscribe to the *Caring Connections Journal*." to receive automatic notification of new issues.

Editorial

Lee Joesten

THIS ISSUE OF *CARING CONNECTIONS* REVISITS A TOPIC that it addressed back in 2012. However, the emotional and spiritual pain associated with suicide continues to challenge the church at large and all individuals involved in ministry, whether in institutional or parish settings. The complexities of suicide are numerous.

For starters, suicide is fraught with ambivalence. The life force is powerful. Note the tenacity with which a premature infant will cling to an adult finger even as underdeveloped organs struggle to survive with the support of medications and machines. At the other end of life's spectrum adult hearts can stubbornly keep beating long after other organs have failed and consciousness has disappeared. The thought of suicide represents a counterforce to that inbuilt urge to live and survive against all odds. This tension reflects the proverbial irresistible force meeting an immovable object.

Invariably pain is behind the impulse to "end it all," whether physical, emotional or spiritual. Admittedly some pain is beneficial because it warns of threat. Paul Brand, a physician that spent much of his life working with people inflicted with leprosy in India, makes this overlooked observation in his book *Pain: the Gift Nobody Wants*. Lepers suffer the loss of flesh and even limbs because they cannot feel pain.

However, pain that persists beyond the point of meaningful instruction begins to erode the will to live. One of the things many cancer patients fear most is not death, but the way in which death will occur. They fear the pain of dying more than death itself. Hospice programs fan the flame of flickering life with the assurance that distressing symptoms, such as pain, will be kept under control. In spite of that assurance, some people persist in turning to suicide or assisted suicide to fend off the threat of pain.

Adding to the list of complexities is that suicide appears to repudiate God's creative intention, resulting in a spiritual quandary. If God is for us, why do we so often feel abandoned by God and alone in our misery? We hear the statement that "all life is from God." At the same time, we hear Jesus say, "No one takes my life from me. I give it freely." He seems to say with his words and with his sacrificial life that some things are worse than death and that sometimes death is worth it. How do we resolve these conflicting messages?

Yet another complexity is that suicide is not always intentional. It may be the unintended consequence of life style choices. To their own peril many people persist in behavior known to be detrimental to their health. Some deaths due to an overdose of drugs are accidental, not intended. When people under the influence of alcohol get behind the wheel of their car, they're not thinking about ending their lives. Death in

the line of duty by military personnel and law enforcement officers is a price they are willing to pay in order to keep others safe, including you and me.

One more complexity worth mentioning is that the pain that motivates someone who dies by suicide doesn't end with the death. It merely transfers to those who survive the death. Survivors are left to struggle with their emotional pain of guilt, anger and feelings of failure. They are left to question their loved ones' whereabouts and whether they will see them again after their own deaths.

No single issue of *Caring Connections* or combination of issues will fully resolve all of these complexities. But we keep trying. The church continues to search for ways to bring the healing power of Jesus Christ to bear on those who are at risk of suicide and on those who must deal with the aftermath of suicide.

I'm grateful to the following contributors to this first issue of *Caring Connections* for 2019.

- **Fred Niedner** creates a theological context for our reflection on suicide. Drawing from his own pastoral experience he applies Biblical insights and basic church teachings to help us formulate a message of courage and hope to those affected by a death by suicide.
- **Analeise Parchen** shares practical ways of talking about suicide with children. Her guidance is gleaned from years of experience as a bereavement counselor connected to a hospice program.
- **Dan Carlson** spent many years as a police officer and a chief of police of a metropolitan police department. He now has a ministry to first responders. He challenges all of us to reach out preemptively to police and first responders recognizing how vulnerable they are to suicide themselves.
- **Lorinda Schwarz** reminds us that suicide within an institution, in her case a correctional facility, poses unique challenges for administration officials, staff and inmates (or residents) within that institution.
- **Staff of The Samaritan Counseling Center in Tonowanda, New York** invite us into a conversation about how suicide can cross generational lines. They discuss amongst themselves their exposure to suicide within their own families of origin and in their professional lives as therapists.
- **Dave McCurdy**, former *Caring Connections* editor and specialist in medical ethics, thoughtfully explores the cultural phenomenon of physician assisted suicide. Once promoted mainly by medical professionals deemed to be radical, assisted suicide is gaining traction as a culturally acceptable alternative to natural death under certain circumstances thereby posing unique challenges to spiritual care providers.
- **Diane Greve,** my co-editor of *Caring Connections*, shares a brief review of a book she found to be a helpful resource for congregations that strive to reach

out to those contemplating suicide and those putting their lives back together following a loved one's suicide.

I leave you with three other resources with a wealth of information to explore on your own.

- *elca.org/Faith/Faith-and-Society/Social-Messages/Suicide-Prevention* This ELCA website includes a list of myths about suicide, a suicide prevention helpcard and a list of National Suicide Prevention Organizations.
- *lcms.org/workerwellness* This will take you to a page with a wellness wheel and a link to resources for emotional well-being. The first line will give a list of risk factors for suicide, tools for helping someone and a number for the National Suicide Prevention Lifeline.
- The February 27, 2019 issue of *Christian Century* has an article by Samuel Wells titled, "Liturgy at the edge of life." He speaks of his church's service for those affected by suicide.

May the Lord of life richly bless your ministries with compassion, courage and joy.

Buried with Christ—Gospel in the Aftermath of Suicide

Frederick Niedner

A FEW MONTHS BEFORE HE DIED, my grandfather told me he once preached a sermon that haunted him for the rest of his life. While newly ordained at the dawn of the 20th century and still learning the members' names in his rural Kansas parish, a young woman of the congregation died in a horse and buggy accident as she returned home from a Saturday evening dance. The elders of the church solemnly informed their young pastor that this woman's fate must serve as a lesson for the community. They insisted he preach at the funeral that God had struck down the woman for the sin of dancing and that her soul was surely in hell. He did as instructed, but he tearfully confessed that he didn't believe what he said even as he preached those damning words. Now, in his old age, he would give anything if he could find the woman's devastated family members and beg their forgiveness for failing them and compounding their grief when he should have preached the healing gospel.

I wonder sometimes how many preachers have gone to their graves with similar regrets, and how many families have been denied or robbed of comfort, thanks to prevailing notions and practices surrounding sins deemed unforgivable. We haven't burned heretics for a several centuries, and we've come to treat dancing like a quaint, harmless pastime. However, many today still struggle with taboos and traditions that leave them uncertain over how to minister faithfully to those who grieve in the aftermath of suicide.

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Early in my own ministry, while serving as both a college teacher and member of the pastoral staff that served students, one of our first-year students took her own life. Her pastor and home congregation in another state conducted her funeral and saw to her burial, but our school always held memorial services for students who died during an academic year—something that seemed to happen at least once a year, mostly due to accidents of various sorts, and always left the campus in shock. This time, as we planned the memorial service for the young suicide, the senior pastor in charge of the service told the rest of us he planned to preach that by ending her own life this young woman had also forfeited salvation and would spend eternity in hell. He must say this, he explained, lest other students get the idea that suicide is an acceptable way to solve their problems.

I was stunned, but not totally surprised. I knew the tradition. The cemetery on the edge of the small Midwestern town where I spent my youth had a fenced off

corner where families could bury unbaptized infants and suicides. Neither received "Christian burial." My pastor father, who has long since joined those fallen asleep, ministered on several occasions to the families of congregants who had taken their own lives. I know he went with them to the cemetery, albeit from the local funeral home, not from the church, but I don't know what he said there. Nor can I ask him now whether his public words and personal beliefs agreed as he accompanied and spoke to those families.

Thankfully, to my mind anyway, the memorial service for our young suicide did not include a sermon that consigned her to hell. Instead, the senior pastor heeded pleas from the staff and commended the deceased, along with all the rest of us, into God's mercy. I found relief as well as comfort in those words, and I needed both. The young woman had been my advisee, and I had tried, but failed, to prevent her suicide. Three weeks into her first college semester, she had gone home for the weekend and learned that her father, whom she idolized, was leaving her mother to take up with a young employee. She returned to campus devastated, disoriented, and depressed.

Two or three times she said, "This is so painful. I wish I could escape it all and go to be with Jesus." Much as I cherish and proclaim the prospect of being with Jesus, those words sent a chill through me.

A few days later she came to my office intending to drop a course or two in hopes that a lighter load might help her cope. She was visibly depressed and showed little affect as she told me her story. Two or three times she said, "This is so painful. I wish I could escape it all and go to be with Jesus." Much as I cherish and proclaim the prospect of being with Jesus, those words sent a chill through me. With the young woman still in my office, I arranged an appointment for her in the counseling center that afternoon and engaged two students from her residence hall to pick her up from my office and remain with her until they could escort her to the counseling appointment. Soon after leaving my office, however, she somehow managed to elude the two friends. She collected a two-liter soft drink and medications of various kinds from her own room and two more nearby, walked to a farm field a mile from campus, and consumed all the pills.

The farmer who owned the field found her body ten days later. Throughout those ten days, hundreds of students and staff volunteers searched for her, or for her body, but none so restlessly as did I and the two students from whom she had slipped away. Had the campus pastor consigned the young suicide to hell, he would have dispatched the three of us, along with her parents and goodness knows what other family members, to perdition along with her. In a sense, we had already sunk there. In my experience, every suicide leaves behind a community swallowed up in remorse, guilt, second-guessing, and a deep sense of failure, not to mention anger, sorrow, depression, and all the other parts of grief, including an overwhelming desire for a do-over, just this once. These, too, are a huge piece of the context whenever one

is charged with counseling or preaching in the aftermath of suicide. The deceased party's pain has finally ended. Everyone else's is just beginning.

Thirty years later, I assisted with the liturgy as a colleague on the pastoral staff presided at a glorious Easter Sunday Eucharist. She beamed with joy, or seemed to, as she offered us the body and blood of our risen Lord. The very next day, a deep darkness we later learned had pursued her relentlessly for most of her life consumed her. She left a note before she ended her life, but the law says only her family could see it. Consequently the rest of us could only guess at her last thoughts. Once more, the community entered that wordless void in which the bewildered wonder what they did or didn't do or say, and what they might have done differently. A student leader among those active in campus ministry asked, "To what do we cling when the person who helped the rest of us hang on lets go?"

That question draws us toward the things that most need saying in such a time. We cling to the promise of our baptism, the promise made to us when we were crucified with Christ by baptism into his death and raised to new life with him and in him, as a member of his body, the only body he has right now, the body of Christ in the world. In our baptism, Christ himself, in the flesh and blood of the body of Christ, promises us that as members of this body, nothing can separate us from the love of God in Christ Jesus. Nothing in life or death, nothing we could ever do, nothing that could be done to us, can separate us. We might lose our grip when attempting to hang on, and as we confess with Luther in his explanation of the creed's Third Article, by our own strength we cannot even keep on believing the promise, but the Holy Spirit and the body of Christ never let go. Moreover, in the baptismal creed we confess that our Lord, Jesus Christ "descended into hell." That is, he went all the way to deepest, darkest place where God is not, so that should we ever land there somehow, he would be there to meet us, welcome us, and say to us what he says to everyone everywhere, "Come with me." Or as Luther loved to say and often repeated, that Christ descended to hell means that no matter where I might sink, or in whatever God-forsakenness I might end up, even there he is Lord for me.

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Our forebears seem to have thought either that suicides were condemned because their last act was a sin for which they had no time to repent and seek forgiveness, or that they had embraced despair, spurned God's help, and thereby committed the unforgivable "sin against the Holy Spirit." By that logic, everyone who dies suddenly after some sinful thought, word or deed, is damned. That is bad theology and a sure recipe for severe anxiety. A central article of Lutheran confessional theology, the Apology of the Augsburg Confession Article IV (on justification), says that we preach and teach genuine gospel when we honor the death of Christ as the one and only thing

necessary and sufficient for our salvation, and when we proclaim that in such a way that it comforts and consoles devout hearts.[1] If we teach or preach that someone's place with God depends not only on Christ's atoning death, but also on a worthy last thought before we die, we dishonor the death of Christ as insufficient, and we deny the comfort the gospel should and would give to the brokenhearted. Moreover, the simplest way to blaspheme the Holy Spirit is to bet against the Spirit's faithfulness. If the Spirit pledges, "I can find and call you back no matter what happens or what you do," all you need say is, "I'll bet you can't." To deny the Spirit's faithful grip on someone because his or her last act was self-destruction is a bet against God's Spirit and God's love, and it renders the denier as much a candidate for the ultimate blasphemy as one who gives up on hope and life.

To deny the Spirit's faithful grip on someone because his or her last act was self-destruction is a bet against God's Spirit and God's love, and it renders the denier as much a candidate for the ultimate blasphemy as one who gives up on hope and life.

Near the beginning of the 2003 Thrivent-produced "Luther" film, the young reformer, still a monk, interrupts the burial of a troubled boy who had hung himself and was now being denied the blessing of a Christian funeral. Luther defiantly digs the grave himself and then conducts a Christian rite of burial. No biography of Luther tells of such a moment because it never happened. The filmmakers created the scene based on something reported in Luther's so-called "table talks." Once, when discussing suicide in an informal setting, Luther said, "I don't share the opinion that suicides are certainly to be damned. My reason is that they do not wish to kill themselves but are overcome by the power of the devil. They are like a man who is murdered in the woods by a robber."[2] In the film scene, Luther speaks that last line as he buries the boy, adds the conviction that God is above all else merciful, then lays his own pectoral cross on the boy's body and pronounces absolution. This funeral "sermon" is as much visual as aural. The boy is buried with Christ—with the crucified Christ—as are we all. That is and remains the ultimate truth concerning us no matter what becomes of us.

Whenever we preach, we do some version of what Luther did in that film scene. We connect our own lives and the lives of all those present to the life of Christ the crucified. With our words we seek to show how despite everything and in the midst of every circumstance of life and death, Christ's story has become our story, and our story has become his. He took on himself our death. We now have and live his life. We do the same at funerals, only then we also offer up in thanksgiving the life God has given us in the person of the deceased, and we hand that one back to God in thanksgiving. This last thing humankind has always done by telling stories that help us remember and name the gift we gratefully received and now hand back. Moreover,

1 *The Book of Concord,* edited by Robert Kolb and Timothy Wengert. Minneapolis: Fortress Press, 2000, p. 120–121.

2 *Luther's Works*, American Edition, vol. 54. Ed. and trans. Theodore G. Tappert, Philadelphia: Fortress Press, 1967, p. 29.

we tell the person's story in such a way that it becomes cruciform. That we do by discerning and describing the moments when betrayal, accusations, taunts, nails, darkness, and God-forsakenness entered and seized for a time the life of the one we lay to rest. Then we remind each other that this all began in baptism, this dying and rising, dying and rising, dying and rising.

The formula remains the same when the story includes suicide. We need not try to hide the facts of a suicide. We likely couldn't even if we tried. That said, we also don't look at a suicide's life or tell his or her story from the lens of the story's tragic, penultimate moments any more than we would do that with a cancer victim or someone murdered by a robber in the woods. We look through the lens of baptism, and we lay this one to rest with the crucified Christ who knew the darkness as well as he or she did, and probably better. They will rest now together, Christ and the deceased, their lives hidden together in God. No matter how much of eternity it takes, God will have this one back, along with Christ, in God's eternal, merciful embrace.

Frederick Niedner is a Senior Research Professor in Theology at Valparaiso University, where he taught primarily biblical courses for 40 years. These days he leads retreats and workshops on biblical topics and writes for numerous publications that support the ministry of preaching.

How to Care for the Youngest Grievers Affected by Suicide

Analeise Parchen

SUICIDE IS A PROFOUND MYSTERY, and Lutherans are significantly positioned to respond to death by suicide from within our theological and spiritual integrity. We stand in the awkward place between the divine and the human, acknowledging unconditional love and human brokenness. It is a function of Grace, a context and way of being from which we live.

I write as a bereavement counselor, having served children and families as they've faced a death of a significant family member. This clinical experience ranges from individual and family therapy to co-facilitating a family support group and bereavement curriculum called Good Mourning Programs for Children and Families that is affiliated with Rainbow Hospice and Palliative Care located in Mount Prospect, IL. In those capacities I've encountered death by suicide in its multiple iterations and complexities. Consider this article a primer on being with and conversing with children who have experienced the death of a family member to suicide. "Primer" may be a generous description, but I hope to capture some helpful constructs, language and behaviors if you are called to care for children and families impacted by suicide. If you do not necessarily interact with children, no fear, you will see quickly that much of what we need as children crosses over to adults when we encounter something this large.

Much of what we need as children crosses over to adults when we encounter something this large.

First things first:

The first important work in addressing a suicide is to **own your reaction**. If the person who died is someone you loved or knew, you are likely feeling upset or confused yourself. This can cause a strong helplessness. It can take your breath away in the sucker punch that it is. It is heart-breaking. Take the time to breathe deep and dig deep to match this moment.

Next, **check in** on other reactions. Humans have a natural fascination with the macabre, with violence. We slow down for car accidents. We watch murder documentaries. I believe this has to do with our own desire to control and/or understand ourselves, to come to terms with human darkness, to distance ourselves from the darkness in others or ourselves. Be compassionate with this phenomenon inside of yourself. If you can find your way into non-judgment with your own reactions to these extremes, you will be significantly more valuable to others in the midst of their own reactions.

Come **armed** with your own assurance that we are all loved more than we can imagine by a God that is the beginning, the end and so much more. I choose the

word armed because suicide is often perceived as assaultive. Intrusive. Scary. Be armed and equipped with our own spiritual commitment to a Love that surpasses all understanding. Little people (and big people) need to create a **workable narrative** about their person's life and death, one that is not cheap, controlling or dishonest. Instead of attempting to "understand" death by suicide, ("Why did this happen? Who is at fault?"), Lutherans can stand in the tension between NOT controlling for understanding and LIVING into a workable understanding. We respect mystery. Do this for yourself, and you potentially can help someone very close and little do this for themselves.

Next things next: Story-Making & Narrative Building

This workable narrative is the beginning of healing and is unique to each person involved in the death. In being with a child or teen work diligently to keep it simple. Create and look for opportunities for connection, empathy, quiet and honesty in the smallest of ways. These build trust. Suicide is disorienting. Being trustworthy in small ways allows for people to connect during this particular stress.

Additionally, build trust in the truth. In the family support program mentioned above, we are often coaching and educating parents to support and protect children with the truth as they request it. Not to be trite, but truth sets us free. It keeps a conversation moving forward between families as they live through grief and bereavement. We want our children to have freedom in this hard time to rely on their surviving family members. Families must learn to share "the hard stuff," by not shutting down in an attempt to prevent others from feeling bad or keeping themselves from feeling bad.

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Research suggests incorporating the following elements into a story (or narrative) of the death:

- The story makes sense to the person at his or her own level of understanding. This has been described to me by the brightest in my field as providing a frame around death so that a child (or adult) can work with the transformative nature of grief. This story also becomes a frame for suicide itself, as it is not the last time a child will encounter death in this manner.
- The narrative can assist in a child or teen's personal impulses or suicidal thoughts. Scary as this is, when death by suicide happens close, it is common to consider causing one's own death. As you partner with a child or family in the midst of an important person's suicide, you can be a touchstone for compassion and clarity in the moments that follow.
- The story sticks with the facts. It is honest. Children may run into this story or versions of it throughout their lifetime. Staying honest about what occurred in

a method that a child can integrate encourages stability in the face of personal questioning or public scrutiny.

- The story does not provide more detail than requested or necessary. More details can be added when needed. This provides an anchor of understanding that can be repeated and expanded as more information continues to be incorporated at different ages. Children will be recreating this story as they mature, but to be sure, this early narrative is fundamental and provides powerful touchstones over time.
- The narrative allows for loving the person who died. In fact it can be a connector that facilitates loving the person beyond their death. It is a function of bereavement in general to create a connection and another love with a person upon death. In suicide there is a possibility of empathy for another's suffering that can allow a child to stay connected and loving despite the circumstances of the death. "Your Dad's brain was so confused by his illness that he didn't remember that feelings change and can get better. This may be hard to understand about him, but we can feel a lot for the hurt that his illness caused."

In suicide there is a possibility of empathy for another's suffering that can allow a child to stay connected and loving despite the circumstances of the death.

- The story affirms that there are people available who love and want to take care of the child or teen. Specifically there are close adults that are safe and available and are not impacted by depression or mental illness. "I am sad but do not have a sickness in my brain that has me confused in my sadness. I am going to miss your mom, but I am here to be with you." The demand to know that we are going to be OK regardless of what is occurring is a human need. Children and teens affirm this demand in the short-term focus they can have. Grief gets worked out and life gets lived when we know that we'll still have our typical waffles in the morning and that things that make life work will continue even as mourning occurs.
- The narrative does not blame anyone, be it the person that died or others in his/her life. Period. Illness is illness is illness. We accept death by other circumstances. We acknowledge our inability to stop car accidents, and we know sometimes cancer kills. Blaming in those circumstances does not hold up or make sense. The same applies here.
- The story does not sensationalize the death, regardless of how public the event, particularly if the death makes it into a more public sharing. In the world of google, details of this death might be available regardless of veracity. In the world of a judgmental humanity there is often speculation about the why and how suicide occurs. Teens in particular are vulnerable to this kind of curiosity.

Helping a family member stay focused on what occurred vs. what people might say about what occurred is very helpful in managing the impact of death by suicide.

- It is hard to take in some of the cruelty facilitated by the internet, but I have had child after child speak to the mean-ness that occurs. In the nightmare of suicide helping children and teens cope with the scrutiny and short-term fame and/or shame from this event is imperative. Kids live for the reactions of their peers and are fearful of anything that can place them outside the group or makes them too weird for the group. This event can throw unwanted and overwhelming attention their way. On the flip side there is the guilty pleasure of the attention this kind of event can create for a teen. Popularity (and support) in these events are short-lived and, in the end, not typically sustaining, making for a wide range of confusing feelings. Just be prepared for this.
- Often when a death occurs due to suicide, the person who died was complicated or difficult to be with in life. A workable narrative builds room for this kind of difficulty. Invite children into understanding that those difficulties were the result of a brain in trouble and that their own reactions to this trouble make sense given the illness their family member was facing. It is OK to have loved the person and hated what they did while sick. The story of their life and death has room for both truths. This balances the experience.

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- Any narrative worth its weight will have space for good memories. Encourage remembering the positives and holding onto them despite the pain inside. A child's ability to hold onto what is good is a very large indicator of their own healing, and everything we can do to foster that is in service to the good. People are often afraid to ask about the person who died by suicide. However, being open to sharing those moments and memories is curative.
- This narrative of the death can provide the framework for eternal life and knowing that Love is all that matters, even in the worst of times, and that God is available. Listen with your heart and stay heart-centered in the midst of this conversation. It is tricky, because well-meaning people want to ameliorate pain and can become trite with speculations about heaven which can cause harm and distance from adults that does not serve anyone. Children and teens have often shared their frustrations with this kind of conversation. Knowing that your person is "an angel watching over us" can trouble kids. "I want them with me now," or "Now my person knows all the bad stuff I do 'cause they're watching me all the time," or "Where was their angel when they needed one?"

- Sometimes those well-meaning, ineffective admonitions provide something to fight against. At that age it often works to come back into your own personal center of gravity by being angry with the things people say. Do not panic that a child or teen is unhappy with what strikes them as pithy. In fact, think it out loud for them. It can be an opportunity for them to find their own compass around what it means to be loved in hard times or to confront the mystery of Heaven. They can learn that this death is not the end; that the God, where Love comes from, is not someone we see but is a reality all the same.

After a death by suicide you might find yourself in a very deep theological conversation about the existence of Heaven, where Heaven might be, and most importantly, if we will get to see our loved ones again in Heaven.

A word about Heaven: Children hear about Heaven from a variety of sources, and after a death by suicide you might find yourself in a very deep theological conversation about the existence of Heaven, where Heaven might be, and most importantly, if we will get to see our loved ones again in Heaven. Stay honest. We don't know where Heaven is. We feel Heaven. We feel Heaven and feel that God is loving our people no matter what. Children know Love is real, and that their feelings are real even though they are invisible. We can see the impact of a feeling in the look on someone's face or feel a feeling in our own bodies (warmth in a hug, hearts race when we are scared, etc.).

Feelings teach us about our preferences, and certainly our preference regarding death by suicide is that it did not occur and that we could still be with our important people. Being angry or sad or whatever we feel is good information about this death, but they do not cancel out loving a person. In the same way, we can feel our way into knowing heaven as a reality and stay focused on loving your important person, even if we get really mad at them for dying. Their illness caused their death. Love fuels life.

As Lutherans we are people of the Word. We have been promised eternal life and grow a faith rooted in Word. Making that faith accessible for young people is an art. I use feeling as a bridge to faith because it is familiar, invisible, and accessible in the face of stressful times such as bereavement.

A Word about Hell: No joke, our kids will hear along the way that their important person is in Hell because of this method of death. This kind of story is a Hell in itself, and frankly I could indulge a rant here about this kind of cruelty. Suffice it to say that people of faith can be a powerful force against that ignorance. Reminding families that God is larger than any illness or any one mistake and does not abandon anyone at any time is our privilege to share.

The next things after that: What to say, How to Listen from Grace?

Conversations, specifically conversations with children and teens, are driven by very careful and prayerful listening. Continuously ask yourself what exactly is the information that is requested by kids or necessary for kids as we deal with a death by suicide. Below are some points of reference for these conversations.

- "Your father died," instead of "Your father committed suicide" or "Your father killed himself."
- How did Dad die? "He stopped breathing," instead of "He hung himself."
- How did Mom die? "She made it so that her heart stopped beating," not that she "took a lot of pills" or "cut her wrists."
- How did she stop her heart from beating? "She cut her arm so that her body did not have enough blood to stay alive."
- Why did Mom die? "She had a sickness in her brain that made her so sad that she thought she'd never be happy again. A brain with this kind of sickness does not know that what you feel changes. Sometimes you are happy, then sad, then mad, then hungry, then happy again. It goes like that for people who do not have this kind of sickness. The sickness changes the way people think."

Whatever the particulars the moment death occurred, that was not the cause of death. There was a method of death, but the cause of death was the troubled thinking based in a brain that was not working at the time.

- Am I sick like that? Are you going to get sick like that? "No, you and I are not sick like that. I am very sad, but I am OK and ready and able to take care of you. Whatever happens, I will take care of you."
- Focus on the illness, not the mechanics of the death. This bears repeating. Whatever the particulars the moment death occurred, that was not the cause of death. There was a method of death, but the cause of death was the troubled thinking based in a brain that was not working at the time. It was not what you did, not what I did, not what we did or did not do. Blaming anything or anyone is a slippery slope that makes forgiveness difficult.

  A Word About Forgiveness: Forgiving in suicide is tricky. We forgive the world that has the possibility of cancer. So too we can forgive the world the possibility of crippling mental illness. We work into forgiveness for things that cause death or illness on the planet. Think of things related to lifestyle and choices, such as smoking or driving without a seat belt, etc. We can create a workable forgiveness for persons in their choices as bereavement progresses. There is no rush for this, just the possibility. You help set the stage.

Final thoughts…

Grace is a context from which to live where God loves in the middle of death by suicide. Lutherans acknowledge free will and a God that loves so much that we are not controlled. We are invited to love. Get radical. Take on that death by suicide as a radical opportunity to love, to match the circumstance with a love that is **stronger** and **larger** than anything humanity dishes out. It is a worthy fight, be it in quiet or big volume, as we stand together in our humanity and in our divinity. In this people can find their way into a workable understanding and healing following suicide. Often our children lead us in this effort. Peace to you in your efforts for yourself and others!

Analeise Parchen is a licensed clinical social worker with thirty years of experience in bereavement and trauma. She is currently practicing family and individual therapy in the Northwest Side of Chicago in a private practice as well as volunteering in bereavement with Rainbow Hospice. The Lutheran liturgy was a constant for her through many moves as the daughter of a naval officer. She attended Wittenberg University and credits the Lutheran Volunteer Corp for providing her the opportunity to consider social work following college.

Suicide. . . 36 Words of Care

Dan Carlson

THERE IS A LOT OF ATTENTION GIVEN to the issue of suicide these days. So, when I was asked if I'd write a short article on suicide for *Caring Connections*, I hesitated. I am not an expert on the subject. Nor am I a professional writer. Even though I have attended some classes on suicide awareness and done a bit of informal writing online and in print, I felt under qualified to address such a critical and personal subject.

But I do have a unique perspective on suicide and a considerable amount of first- and second-hand experience dealing with its aftermath. For more than a dozen years, I have been a full-time chaplain for public safety professionals and emergency first responders. Prior to that, I was a police officer for 25 years, retiring as a police chief of a large suburban department on the west side of Minneapolis. I have seen a significant amount of death, including suicides. However, my experiences are quite limited when compared to the police, fire and EMS responders who spend their entire careers working the streets. In my work as a chaplain to professionals who respond to tragic deaths, I believe I have learned something of value to share on the subject.

It is generally accepted that there is a much greater chance that police officers will die by suicide than by criminal homicide in the line of duty. Due to inaccuracies in how suicides are documented, some argue that the actual number of suicide deaths of police officers is four to five times greater than homicide deaths. It is also my experience that suicide in the fire service and EMS professions occurs at an alarming rate. Our trained emergency responders, as well as their families, are not immune to the suicide challenges that the general population experiences.

It is generally accepted that there is a much greater chance that police officers will die by suicide than by criminal homicide in the line of duty.

Knowing that suicide is a significant problem in society, as well as in our individual contexts, how should we respond? It is critical that health care experts and professionals continue to do the research, gather data, identify treatments, build awareness programs and develop educational resources that can be used for intervention if people have already made the decision to die. My personal response to the issue of suicide, as a chaplain who provides spiritual care and support in times of calm as well in times of crisis, is to look at ways to intervene in the time of calm before a crisis occurs.

I learned early on as a chaplain and care provider for cops, firefighters and medics, that these wonderful care providers are actually horrible care recipients. They don't welcome care from someone they don't know and trust. And if they don't trust the care provider, they won't participate in the care. My strategy, though

very simple in application, has taken me years to understand and actually put into practice. My faith community of public servants isn't easy to *care for*, but I can easily *care about* them, even if they won't engage in my care services. So, I came up with my "36 Words of Care" to help me apply my strategy on a daily basis in virtually every situation of care I engage.

- *"As professional care providers, before we can truly care **for** someone, we must start with caring **about** them. We need to gain an understanding of who they are… what they do… and why they do it…"*

This strategy can be very time consuming and, in some cases, may take years for trust to develop. In crisis interventions the process is accelerated, but learning *about* the person in crisis is a critical step to take before *caring for* them can occur. Once a relationship of non-intrusive *caring about* is established, it amazes me how easily *caring for* can happen. When we have deliberately and intentionally gained an understanding of who they are, what they do and why they do it, the *caring for* is much more effective and enjoyable for all involved!

Pastor Dan Carlson serves as a deployed missions pastor at Mount Calvary Lutheran Church in Excelsior MN. He is president and founder of Public Safety Ministries, Inc. where he provides chaplain services to police and fire departments throughout Minnesota. He is also a retired Police Chief with the Eden Prairie, MN Police Department.

Suicide Inside the Institution — What Happens Next?

Lorinda Schwarz

I HAVE WORKED AS A CHAPLAIN at Eastern Oregon Correctional Institution (EOCI) for 25 years. EOCI is a male medium, 1700 bed facility located in Pendleton Oregon. Such a facility can house men with all lengths of sentences, including lifers (usually having at least 2 years or more left on their sentence) and others with various behavioral or mental health problems and sentenced for any crime imaginable. EOCI is a remodeled mental health facility that was built in the mid-1800s. It is four stories high and has outside staircases leading to the entrances of all the upper story housing units. These staircases initially were open air outdoor staircases. Consequently EOCI experienced more than the usual number of suicides an institution of its size might expect in the 1990s. The high number of suicides among the inmates incarcerated there led staff to have certain expectations following each suicide. Over the years I found that these expectations were not unique to EOCI but were standard for similar institutions across the state following suicides. For that reason I suspect that this may be true for any institutional setting where suicide is experienced. While exact statistics are not compiled for suicides among individuals living in institutions, it is generally accepted that within institutions the suicide rate is higher than the rate for the general population.

Eastern Oregon Correctional Institution

I would like to explain the nature of the suicides that took place in the 1990s at EOCI and then address the institutional expectations that were created. The first time an inmate climbed to the fourth floor landing of the stair case and jumped off head first, staff was shocked. It was some time before another inmate copied the same action. Eventually the largest number of suicides completed in a single year performed in this manner was seven. Six of these were successful. In the other the individual climbed to the third floor landing and jumped, incurring a massive brain injury but did not die. After this last attempted suicide the state caged in all of the outdoor stairwells at EOCI.

Since the method of suicide was readily available at EOCI during that time, one expectation that arose was that one successful suicide by that method increased the likelihood that others would follow. In just three to four short years EOCI went from having a single suicide in one year to having the seven. The mental health specialists

requested that inmates who had suicidal ideation be placed on lower level housing units. Staff tried to acquaint themselves with these inmates in order to be better able to recognize them and send staff to stop them if they saw them beginning to ascend any of the staircases. No suicide "pacts" existed. It was simply that one successful suicide led others to consider this same act. It was as though the success of one individual gave others the courage to follow through, especially if the method of suicide was successful and seemingly fool-proof.

A heightened air of tension followed each suicide as staff waited for the next one that might be attempted. The expectation was that another would come.

Immediately following a suicide, as is true for any incident of magnitude within a correctional institution, the facility would be in lock-down. Lock-down mandated that all inmates return to their bunks and that a count be done to ensure that the facility knew for certain who the inmate was who had committed suicide. Then the journey began to return the facility to normal operations. Most of the individuals choosing to do this would not take identification with them. Consequently it was not always immediately apparent who the victim was.

Often after a suicide (successful or attempted) I would meet with individuals questioning how God views this action and if there may be eternal judgment involved from God for this act.

Suicides have a huge impact on those around when the event occurs, including those who knew the individual, those who witness the event, those who administer first aid and those who wait for paramedics and police to arrive. The list goes on to include those dealing with the mental and spiritual impacts of such an event. Often after a suicide (successful or attempted) I would meet with individuals questioning how God views this action and if there may be eternal judgment involved from God for this act. The response has to be tempered against the unknown. Are the individuals asking due to their own consideration of suicide and hoping for absolution if they are, or are they struggling with an image of God as judge and how this affects their own relationship with God. These questions often bombard the chaplain in the immediate aftermath of the event, making it hard to sort out the reasoning for the questions and making it difficult to give a well thought out response. It is important for chaplains to think about these kinds of questions in advance of any such event. There are also usually several individuals dealing with their own guilt at not seeing symptoms or signs, not reporting some small thing that seemed insignificant at the time, or not "being there for the individual." The "if onlys" can lead people down long, lonely roads that isolate, blame, convict and depress individuals in their own minds. Talking this out with an uninvolved third party, for instance a chaplain, can help re-establish some sense of normalcy and a more balanced view of the incident.

The tension can increase within the institution with everyone waiting, hoping for the best but expecting the worst. Watching for signs and signals in anyone else who

may consider suicide creates increased stress and overall increases the moodiness of the institutional environment. Almost any unusual event creates the need for staff to work overtime. The overtime experience is a result of the institution trying to deal with the effects of the event upon other incarcerated individuals and staff members directly involved with it. Suicide is no exception.

Staff who have had a family member commit suicide are particularly vulnerable to re-occurring trauma that might be triggered. They may find themselves discovering a suicide that has vast similarities to that of their family member's suicide. This may in turn create more absences and time off again increasing the need to utilize overtime.

Chaplains can expect to be called in immediately to help deal with the emotional trauma and the spiritual dimensions created when a suicide is committed. After a recent suicide on our Mental Health housing unit I was called to the institution to help deal with individuals who were friends of the person. They were experiencing the numbness that often accompanies sudden loss. They wondered if they were OK, since they were not feeling "anything" in their estimation but believed they should be "feeling everything." Other individuals were also present who had not really known the person, but lived on the same unit and saw the person on the floor after the suicide. Some were deeply emotionally affected by this trauma in their "home" while others asked them what the heck was wrong since they didn't even know the person. These responses point to the wide range of anger that can appear for various reasons. Some are angry because their routine is disrupted. Some are angry because the individual didn't think enough of others before committing suicide. Some are angry at the ones who are angry, especially if they think the other's anger is from callousness or self pity. Still others are angry that staff didn't see it coming and didn't do enough. Some are sad or experience symptoms stemming from their own conditions, such as PTSD, anxiety disorder, depression, etc. There begins to be a "play" of emotions with one individual's response contributing to another's. One person's triggered PTSD can trigger anxiety or anger in another. Questions, like the ones mentioned above and others begin to surface, sometimes demanding an answer.

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The institution's management believes its spiritual care staff is some of the best individuals to address the trauma created in both staff and inmates. They look toward staff that they believe have the experience and training to deal with such emotional issues. Many chaplains have taken critical Incident training, or Mental Health First Aid, or training to deal with traumas. I encourage all chaplains to get such training. Institutional management tends to see well-trained chaplains as having better boundaries and resources to deal with emotional and mental trauma. They

also, by nature of their job description, believe that chaplains know more about the spiritual realm and are better equipped to deal with spiritual issues. My institutional administrators have told me that I am the spiritual expert within the institution and, along with mental health staff, one of the best trained individuals for dealing with trauma. Other staff members often indicate how inadequate they feel when it comes to dealing with these sorts of issues. That is one primary reason I think it is important for chaplains to be present and to appear self-assured whether they are feeling that way at the moment or not. Along with mental health staff we are expected to be present on the housing units to be supportive to those having rough emotional times. The need and desire to see mental health providers/clinicians/counselors may rise well beyond the normally requested levels, making it necessary for staff to prioritize needs and causing longer waiting periods to happen for some.

A suicide within an institution creates the need to call police in, which means the area must be cleared and maintained as a crime scene until they declare it a suicide. This creates added tension and can disrupt the sleep and work patterns of those who reside there. So again the mood of the institution is heightened, everyone being more on edge. In a large institution all of these reasons for increased tension do not easily subside and may last for several weeks, even months. Staff as well as those incarcerated may deal with this tension through what is commonly known as "gallows humor." This can again increase the impact of emotions many may be dealing with due to the baggage they may be carrying into the situation.

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So, staff become tense and stressed working long hours, watching for signs of other potentially suicidal individuals, and wondering if they missed something along the way that may have helped prevent the suicide. Other incarcerated individuals also wonder what they may have missed. They may become guarded and tense in dealing with all the emotions and strain of what is happening around them. Eventually, if another suicide is not completed, the institution begins to relax and return to normalcy. The organization looks at what can be done differently to try to protect those who are vulnerable in this way. Inservice classes are designed to help staff better spot warning signs and signals and better deal with emotions if the inevitable event (suicide attempt or suicide) occurs again. Incarcerated individuals are offered grief recovery classes and mental health coping strategies. Everyone relaxes, living with the ever-present knowledge that it is only a matter of time before the entire scenario can repeat itself and hoping that those who live and work in the institution can come to cope with the experience in a little better way.

It seems to be true then that suicides within a correctional setting repeat themselves. Staff and inmates (or other residents) go into a heightened state of

emotions with subsequent tension being a pattern that readily manifests itself. Staff overtime and related concerns increase due to that heightened state. Suicide attempts increase with copycat scenarios utilizing similar modes or methods as was used in the successful suicide. These patterns take weeks to months before the institution returns to a normalized state depending on the number of subsequent suicide attempts, if the tension leads to other incidents within the institution, if staff overtime can be easily rectified, and the level of coping skills possessed by all affected and involved.

Regardless of the type of institution in which a chaplain works a staff or resident suicide brings with it an overwhelming flood of emotion and tension for that institution. Debriefing skills and critical incident support must be utilized to help return things to a normalized state and for healing to begin. As people are overwrought with emotion and dealing with all sorts of triggers in their lives sometimes the best a person can do is to be present with the individual. There are no words that can take away the pain or torment. Often words are not even heard or are only received as simple platitudes or advice the person cannot embrace at the moment. Simply being with a person can be powerful. I was once told years later that an individual remembered how helpful I had been in a time of crisis. When I asked what I said that was so helpful, the person looked at me and said, "It wasn't what you said that helped. You simply sat and cried with me. It was a powerful thing for me." In those holy moments of tears and silence there are often no words that will help. At those times the chaplain must remember that a ministry of presence can be a lifeline of hope and be the greatest gift they can give to their institution and those who live and work there.

Lorinda Schwarz is a Deaconess in the LCMS serving as an Endorsed Chaplain at Eastern Oregon Correctional Institution (EOCI) in Pendleton, Oregon. EOCI is a male medium custody 1700 bed state prison facility. She began her career with the Oregon Department of Corrections (ODOC) in the fall of 1993. She has served at two Oregon facilities ministering with incarcerated men and women. Prior to this ministry she was involved in ministry to those with developmental disabilities. She is a graduate of Concordia College, Portland, Oregon and Valparaiso University, Valparaiso, Indiana.

Suicide from a Family Systems Perspective

Samaritan Counseling Center staff in North Tonawanda, New York

This article is comprised of excerpts from an edited transcript of a conversation between members of the Samaritan Counseling Center staff on January 15, 2019. In attendance were Rev. David Wurster, PhD, (Diplomate Emeritus, AAPC), Rev. Irwin (Erv) Brese, D.Min., Rev. Robert (Bob) Spillman, M. Div. (ACPE Supervisor), Ms. Lori Jagow, BA, (Methodist lay minister), Rev. Jan Hubbard, LMSW, Ms. Theresa Walker, M. Theo., M. Div., Ms. Tina Harding, BA, (Methodist lay minister). This group includes pastors, pastoral counselors, educational coaches, social workers and teachers of theology. All have had significant experience in ministry. They represent Lutheran, Roman Catholic, Methodist and Wesleyan traditions.

In order to keep a measure of confidentiality names in some sections are replaced by the following: PC-W= pastoral counselor woman; PC-M=pastoral counselor man.

Dave briefed the group on the process they would follow. The following points have been known in the group over time.

1. *The theory the group uses is natural family systems (Murray Bowen) in which all of life is relational, including suicide.*
2. *Group hypothesis: higher self differentiation/identity lowers death risk; lower self differentiation/identity raises death risk*
3. *Group members have experienced suicide, either personally in their own family system or professionally.*

Dave's Story and Starting Point

A 16yr old girl attempted suicide. There were empathic positive bonding therapy sessions prior to this attempt. EMT took her to the hospital where she was admitted. A meeting was conducted with hospital staff, parents, grandmother, boyfriend, pastor and social worker. Dave, a chaplain supervisor of volunteer community clergy chaplains group, was invited to join in. At some point, Dave asked the girl, "Is there anybody you can think of who would like to see you dead?" "Yes, my mother!" she shouted. "She never wanted me anyway!" At that point her mother 'hit the ceiling' and confessed, "My mother never wanted me either!" Now grandma is 'whirling' around the room and that really broke the whole thing open. We ended the session and I went on my way. Two weeks later I saw the pastor who was present and asked how the situation was doing. He said, "Oh, the 16-year-old is doing well; now Grandma

At some point, Dave asked the girl, "Is there anybody you can think of who would like to see you dead?" "Yes, my mother!" she shouted. "She never wanted me anyway!"

is depressed." I said, "Well at least the depression is in the right place for now. So, Grandma can get counseling."

Dave's assessment: looking at it from family systems and broadening it out a bit, we can discover the strengths in the family. It changes the whole tone. It starts us with a sense that suicide is a relational thing and not just an individual choice.

PC-M Tells His Story (from his role as pastor and clinical counselor at The Samaritan Center).

A parishioner came into my office looking very distraught and reported that one of her sons was killed. He got out of his vehicle which was having trouble and a policeman pulled over to help. A semi truck side swiped them, killing them both. She got a big compensation check which she hated because she wanted her son back. He was buried near the parish and his mother went daily with flowers. Six months later she came to my office and stated, "I'm here to talk about my son because everybody I talk to says I should be over it by now. It's been 6 months." I discerned that she was half saying, "I don't know what else to do. Maybe I should just join my son." The long and short of it is that she came by regularly to talk and unravel a whole bunch of stuff in her life. It went back to when she was 6 years old and living in Germany where her father was an SS officer. Her mother primarily raised her because her father was very tyrannical, and her mother didn't know what to do. When she was 6 years old, her mother jumped out of a second story window and killed herself. She went to live with her aunt and uncle on a farm where she endured sexual abuse from her uncle. Her aunt helped her uncle. She also developed a fear of dogs and cats which she used to masturbate; confessing some real heavy stuff. After a while she began to calm down, unravel and ended up giving the money to a charity. She worried about me retiring from the church, but I continued to counsel with her here at the Samaritan Center. As she began to get it together she came less, but she never neglected to give me gifts on Christmas and my birthday. The woman's second son also had a son. The woman took close care of this boy. She took her grandson to church which had always been a place of refuge for her. She later stated, "It was only God who got me through this all." She can now tell her story. She said, "When I think about my life, I would have joined my mother a long time ago if it wasn't for talking to 'this guy' (referring to PC-M). " Even though he said things that were unkind, sometimes they were very helpful." She still refers people to me.

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Dave: Some of the things you said to her were probably boundary statements which can be very painful.

PC-M: Oh Yeah!

Bob: What did you learn about suicide in that experience?

PC-M: It's a long generational thing. If there is one back in history, and if life gets difficult, one way to deal with it is to join history. She wouldn't kill herself now, but she was close to it then. Talking about it was much better than doing it in the long run. That's all part of the family system. I wouldn't be surprised if her remaining son and daughter, who are going through some tough times, are thinking about their mother's story and drawing strength from her courage.

Dave: Suicide is not only relational, but it echoes through the generations.

PC-M: Yes, that's what I was trying to get across. Not just the generation closest to you.

Bob: It seems to be helpful for people who are going through difficult times and those close to them to be able to think, experience and express thoughts and feelings to each other about those difficulties. I think we lose sight of that. There is evidence that this woman who came to see you 'grew' in the midst of a pretty messed up family with a low level of maturity. Is that accurate?

PC-M: Sure. Because of what she said "If it wasn't for 'this guy' I'd have been dead."

Dave: She also said "It was only God who got me through all of this." Of course, you (PC-M) represent God.

PC-M: Oh Yeah.

Dave: As 12 Step recovery programs recognize, if she wasn't able to see beyond herself she would have been dead. There was always a beyond.

PC-W Personal Story

When I was 18, my mother remarried a man with three teenage children at the time. One of them, the eldest son, struggled with learning disabilities and his sexuality. He was ruthlessly teased at school. Their mother left the family for another man many years earlier. My mother was his third marriage; a blended family with 5 children in all. This eldest son committed suicide in 2012. He, by that time, had 'come out of the closet' and had been in a homosexual relationship. He left a suicide note which said 'so and so' killed him, blaming the suicide on his partner. He had gotten into drugs and deliberately overdosed. Looking at the family there is cut off everywhere. Shortly before his death, his sister Tammy, the middle child, took him in her home because he was homeless, living on the streets, destitute, in and out of jail. She was on a mission to save this poor soul, her brother. While he

One of them, the eldest son, struggled with learning disabilities and his sexuality. He was ruthlessly teased at school. Their mother left the family for another man many years earlier.

had some basic needs met, his problems progressed. David, his youngest brother, had joined the service and moved to Germany, never to look back. He attended the funeral, but that's about it. The cut off is even worse now between the step family members.

Dave: Theologically how are you framing this for yourself and for your own faith journey? You are good at this.

PC-W: Well, I'm not really sure. I can say, my struggle in all of this is in watching the rest of the family continue enabling behavior. I can see that this enabling is contributing to the problem to begin with. So when I have discussions with my mother, it's tough because I can see how the same patterns that contribute to the problem continue, and I get anxious over that. My struggle is seeing the generational stuff continuing and trying to separate myself so I don't get worked up over it.

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Bob: Fascinating. It seems there are two extremes. Either people try to rush in and fix it or cut themselves off from it. For example Tammy tried to save her brother (fusion) while David distanced himself from the family (cut off). Is there a more mature way to be involved? Can one become a resource in the midst of what is beyond one's control? That's what I hear.

PC-W: That's what I am trying to work out, without going in either direction. It takes a lot of work for me to remain present. I think that my step father appreciates that because now his remaining son and daughter are pretty much cut off. My goal is to try and stay in touch without cutting off or enabling (fusion). I am learning from it. But it is a struggle.

Jan: So you represent trying to be a healthy self in the midst of this anxious system, where the 'hot topic' is suicide. Different people in the system have done harm to self out of the high anxiety within the system. Everyone is glued to the idea that this suicide is the identified issue. Yet the more they focus on suicide the higher their anxiety goes. Your ability to step back and say, "OK, I'm in this too, and I got this high anxiety too, but I can be different with it." I think that is being a healing presence because you're being honest. You're able to say that this is a huge struggle for you too, but you're not going to cut yourself off. That's hard work You're trying to stay connected to the people that are important to you in a way that is honest about what is going on and what it's doing to you. You're saying, "I see this, but…." And that is where God comes in.

PC-W: That's right.

Jan: God is present. God is with us. There is a power greater than our anxiety here. It's as if you're saying, "I don't know what you all are going to do, but I am going to recognize God in this."

PC-M Story

This is a good time to segue into my own family. The only part I can control is asking what's my part or how do I play a role. In March of 2000 I got a call from my brother-in-law who stated that my sister took her life. I got up out of the chair and told my wife, "She did it." My response at that point I think indicated that I was the distant one. I was in Buffalo, and the rest of the family was in the Philadelphia area. I didn't realize she was going down with her mental illness and had some hospitalization. We all focused on her and her problem and couldn't see we were all players in this. There were a lot of changes in her life that I can't get into. Within the course of those changes in the family she went downhill. I realize more now that this was a pattern that was long time coming. Her response to stress was to absorb it and get helpless. She was our oldest sibling who always gave advice to others but couldn't make a decision about anything. It went downhill. Everybody was heavily involved in trying to fix her, but I was on the edge. I thought I was in a more mature position. Like hell I was. I was as much a part of it but on the outside of it. I remember the funeral visitation. My brother-in-law asked me to say a prayer, but I was reluctant because I didn't really want to play the role of pastor. I did it anyway. The family did survive. My brother-in-law remarried and they are still in the family. I've seen problems of my sisters going back up the generations and back down though not as severe as suicide but with mental illness.

Everybody was heavily involved in trying to fix her, but I was on the edge. I thought I was in a more mature position. Like hell I was.

Erv: See, that's the label society gives as the reason why people do this or that, including suicide.

PC-M: I totally agree Erv, but that's not sufficient. It's a family process. I'm going to go to my sister's grave and say, "Ya know, you took on a lot of stress in this family. I don't know that I'd say, "Thank you for saving my life, but the same pattern's there. I think she absorbed more and didn't handle it well."

Tina: So when did you realize your part in it?

PC-M: I always thought I was pretty present. Because that's what I do for a living.

Tina: Right. So when did you recognize that you weren't?

PC-M: Well more recently. Going to the Bowen Center has helped. I was talking about anxiety and stuff, and the leader mentioned emotional cut off in the family. I realized what little contact I have with the people that should be important.

I mean I do with my immediate family, but none of the extended family was at the funeral.

Erv: You know that we're all different. I could see all of the 'cut offs' that were in my life when I did the family genealogy.

PC-M: Exactly.

Erv: Makes connections, and other family members eat it up.

Tina: Yes. Well it ties into identity. The more I understand my family, the more I understand myself. Then perhaps I can be more of a self.

Jan: It's like a two step process because first you have to see it. That itself is so difficult. Because as we are talking here I can see that it's more than just about suicide. It's other things as well. Like how we get hooked into relational patterns, even long distant, that we play out over and over and don't even realize it. That's the power of this kind of a conversation. When we hear other peoples' stories, we recognize ourselves in them.

That's the power of this kind of a conversation. When we hear other peoples' stories, we recognize ourselves in them.

Lori: We think of suicide as someone trying to escape pain. For example, there's a well-known person who was born with no arms or legs. He talked about the time he wanted to commit suicide. He was in the bathtub when he was ten years old. The water was running, and he had a tough time turning it off. He thought of not yelling for help and just drown. He said the thing that stopped him was the pain he thought it would cause his parents if he did that. Even though he was in a lot of pain and wanted to die, what stopped him was the pain it would cause to others.

Dave: Theologically, the power of the automatic response is there, but there is something about the central message of grace that is scary as hell. It's comforting, but it's also very frightening. I mean we are scared to death of it sometimes.

Lori: Because **we** have to change.

Dave: The way we get there is to acknowledge the helplessness.

Lori: Yes, the Powerlessness.

Bob: That's the scariest thing.

Lori: It's the worst. Death to self.

Dave: Death to self. OK. There's the theme. To die to self is scary as all get out.

Lori: When I stopped the rescue mission (in her life) I had to die to myself. It might mean I am married to you, and you provide for me, and I might not be

provided for anymore; but I have to die to that. It might mean you might hate me; but I have to die to that.

Dave: But to be really alive and to be a strong living human being is also scary sometimes.

Tina: A poem from a despairing individual reads:

Truth Is
You don't know how I cry
You think I'm just fine
You don't know how I cry
Because I tell you I'm fine
But really I'm lying
What lies do you believe?
I tell myself all I need is me
But it's not reality
Truth Is
I need you

Tina: And that can be scary

Dave: People avoid marriage these days and just want to live together because they might have to 'die' around all those new people.

Erv: To illustrate Bob and Jan's point, a guy came to me and said, "I can't get out of this problem." I asked, " What's the problem?" He is a distinguished professor, successful and established. He said, "Whenever we have a family reunion, and I go home, I'm like twelve years old again."

Dave: Recognizing it is the first step.

Bob: The paradox is that it's in that moment that one can begin be a more responsible self; to change into a more centered self. You can't do it without feeling that awareness first. That's where grace is fearful. Realizing I can't fix this, but I can regulate the self which asks, "What are my responsibilities in the moment when I'm not in control?" That's what people run away from. I ran away from it.

Being afraid of grace. That's why some people don't go home. They are afraid to feel twelve years old again.

Erv: Being afraid of grace. That's why some people don't go home. They are afraid to feel twelve years old again. I can solidify my life here without those people, but they never do.

Tina: Like what the poem says. I actually recognize that in reality I need you. I am not able to cut off from you

Bob: Another way to say that is if our job is to become a self, we can't do that apart from relationships.

Erv: Right

Tina: And that can be frightening.

Jan: I just think it's such an interesting thing theologically. It is such a vicious cycle. Relationships do us in, but relationships also can save us. But where is God?

It is such a vicious cycle. Relationships do us in, but relationships also can save us. But where is God?

Bob: It's how one functions in that.

Lori: Right.

Bob: There are all kinds of words such as boundaries or sense of maturity, but people want the easy way out.

Tina: How much power am I giving away?

PC-M: Some people say suicide is taking the easy way out, but others say it's the hardest thing. My little sister wonders how one can even think like that while my older sister did it. I am somewhere in the middle. Not that it's a better way of thinking, but I can understand how someone can get there.

Erv: Maybe it's because you're the middle child.

Dave: Jan reminded me what C. S. Lewis said in the Screwtape Letters. Talking about marriage the devil says that his task is to get persons to marry someone who takes them down, not up.

Erv: Shoots their fantasy of marriage to hell.

Jan: From a family systems perspective that is when we marry someone that we can lose ourselves in and fail to become a self. I think we do that until we wake up and say, "I don't want to do this anymore." That's usually when people go to marriage counseling.

Dave: And when they talk about assisted suicide, realizing **all** suicide is assisted.

Bob: Emotional System!

Jan: So if in relationships we are always trying to fix something/someone, then it's going to keep the anxiety going. Thus the purpose of coming down with a substance abuse problem or suicide or something else, avoids the real problem.

Dave: Pain Avoidance.

Lori: Pain Avoidance.

Bob: Right. It looks noble. We want to help you, but really we are avoiding. We're so uptight that you need to change so I feel better.

Dave: Our obsession to fix problems will probably correlate with our inability to really forgive. If I am obsessed with fixing then I'm probably not very good at forgiving.

Bob: Add on to that for a minute.

Tina: Deeper into forgiveness.

Dave: To me that means I don't need Jesus Christ much at all.

Jan: Because I am in control, and I'm going to fix this!

Our obsession to fix problems will probably correlate with our inability to really forgive. If I am obsessed with fixing then I'm probably not very good at forgiving.

Dave: Ah. Right!

Bob: That's a part of it.

PC-W: Yes, and the reverse is also true. Because when I was married to an alcoholic and while I was in the rescue mission, there was no forgiveness. But once I surrendered, and was moving toward a relationship with God, I experienced this. When I reached the time to forgive, I realized that there was really nothing to forgive. There was nothing to forgive because he wasn't doing this to me. I was pursuing this relationship because of my need to fix. There's nothing to hate. I was no longer angry at him for being an alcoholic.

Tina: For me, I stayed angry at myself. It was harder for me to forgive myself.

Lori: I was able to forgive myself because I saw that not only was he driven in his compulsion to drink, but I was also trying to fulfill a need so there was nothing to forgive.

Bob: Pardon the theory language, but it's as if you were saying, "I'm so angry that I married someone on the same level of differentiation that I am on. I'm as much a problem as he is."

PC-W: When I got stuck at my father's house from whom I was estranged during that time, I realized this man doesn't owe me anything because I saw that he didn't have anything to give. Therefore, I can forgive.

PC-W: I could have jumped in at the beginning because I did attempt suicide on March 8, 1965. I can remember the day. I was sixteen years old. It revolved around an incident of abuse from my father. Fortunately I only got very sick. That is how I learned to disassociate. I could leave my body. I could leave the room. I could just vanish. This has been helpful in dealing with clients because I understand it, and I know when people are doing it. But that is how I survived. I looked for other relationships, but I gave up on God. I married someone where I could lose myself. At some point I was talking to my father's sister, my aunt. I cut off from my parents when my mother didn't know yet about my father's

abuse. But I told my aunt. It was only coming back in touch with my relationship with God that helped me survive. I knew I had the capacity to grow beyond my circumstances. I educated myself after my divorce and began to heal. I remarried and continued to change and heal. Eventually I told my mother. Her reaction was surprise. She wondered how this could happen. She wondered where the hell she had been. But she never doubted me. He was abusive, and she spent the rest of their lives making sure he never touched any of my kids. She became more in control and became more of a self. I was the one who sat with my father at his death bed coming up on 20 years now. My father said to me, "I see now that you have raised your children with love. I could never do that." He asked for my forgiveness, and I gave it to him. He died two weeks later. I was then able to do all of the things I have done since then: Masters degree, raising children, assisting my husband during his death and now my mother on her deathbed. I see how it all relates back to my wanting to commit suicide because I felt there was no way out.

Jan: What is saving you, if I am understanding correctly, is your courage, acknowledging the pain and your mother's support? Is that correct?

PC-W: Her believing me was a huge piece.

Bob: How did your father respond to your mother's growth?

PC-W: She began to control him rather than him controlling her. She became the protector, and I always thought I was protecting her. And I was. He was very intimidating and the potential for real deadly violence was there. Thank you. I needed to get that out.

Dave: Thank you all. Maybe this is a good place to close. Good day!

Challenges of Physician-Assisted Suicide

David McCurdy

Introduction

Physician-assisted or practitioner-assisted suicide (PAS) poses distinctive challenges for healthcare chaplains and others in specialized ministry. PAS is typically sought by patients facing terminal illness or a progressive, incurable condition that inflicts or threatens to inflict substantial suffering. Usually patients ask the physician to prescribe medication that they can take if and when they choose to end their life. An increasing number of specialized ministers serve in areas where PAS has been legalized and a regulated protocol for its practice exists or is being developed. In Oregon, PAS has been legal, and practiced, for over 20 years. Legalization in other jurisdictions has followed, largely in the last five years.[1]

While PAS is currently legal in eight U.S. jurisdictions, nowhere in this country is active euthanasia—the direct administration of a lethal substance to a patient by a second party to end pain and suffering—permitted. In a perhaps surprising way, PAS has become a broader North American reality. In Canada, both medically assisted suicide and voluntary active euthanasia were decriminalized in 2015. A federal statute allowing "medical assistance in dying," or "MAID," now governs the use of both PAS and euthanasia under specified conditions. Importantly, MAID may be administered by either a physician or a nurse practitioner.[2]

This article will primarily address ethical, theological, and pastoral dimensions of PAS. It will draw primarily on resources from the law, medical ethics, Lutheran church bodies in the U.S. and Canada, and pastoral care literature. Attention to experience and reflection in both Canada and the United States may help sort out the questions raised by PAS and its possible association with euthanasia. Attention to these questions may be more urgent in a time when the opioid crisis has led to more stringent controls on certain pain medications. Some suffering patients may now be deprived of their only source of effective pain relief.[3] Will some of them seek PAS because their better option became inaccessible?

Attention to experience and reflection in both Canada and the United States may help sort out the questions raised by PAS and its possible association with euthanasia.

1 For more information, see the Death with Dignity website: *https://www.deathwithdignity.org/learn/access/.*

2 Statutes of Canada 2016, Chapter 3, "An Act to amend the Criminal Code and to make related amendments to other acts (medical assistance in dying)," First Session, Forty-second Parliament, 64-65 Elizabeth II, 2015–2016; see also Medical assistance in dying—canada.ca.

3 Marcia Angell, "Opioid Nation," *New York Review of Books*, December 6, 2018, pp. 56–58.

The U.S. Legal Context and Some Consequences

While legal considerations do not determine ethical judgments, they do reflect and influence the ethical climate. U.S. laws on PAS also reflect political realities, beginning with their terminology. The Oregon statute, for example, called the Death with Dignity Act, does not refer to "physician-assisted suicide." Terms like "physician aid in dying" (PAD) or "medically assisted dying" are widespread, though media stories still refer most often to physician-assisted suicide.

The preference for more neutral language may not be mere euphemism or obfuscation. Not only PAS proponents but others note the stigma associated with suicide generally, and believe the term unfairly taints aid in dying and those who seek it. Isn't ending one's life in order to avoid the prolonged suffering of an ineluctable illness different from "suicide" under other circumstances? This claim is disputed but merits consideration.

Isn't ending one's life in order to avoid the prolonged suffering of an ineluctable illness different from "suicide" under other circumstances? This claim is disputed but merits consideration.

Statutes permitting PAS typically establish safeguards and mandate regulations to minimize the chance of abuse by ensuring that only patients with terminal conditions involving substantial pain or suffering receive lethal prescriptions; that physically and psychologically vulnerable patients are protected from coercion; that underlying psychological issues and decisional incapacity do not compromise patients' judgment; and that a request for PAS truly reflects a consistent and enduring desire of the patient. A second opinion on the patient's medical condition and prognosis is normally required. PAS laws usually require that each request for PAS and each instance of PAS be reported, and that data be compiled and publicly reported.[4]

State or federal regulation of professional conduct and prescribing practices, restrictive policies of employing organizations, and professionals' native caution about litigation often prevent physicians and hospice or palliative care staff members from being present when lethal medication is ingested. Oregon statistics have suggested that perhaps 5% of cases—about 1 in 20—of attempted PAS led to complications, such as vomiting and occasionally a prolonged dying process.[5] Arguably the presence of healthcare professionals might lessen such possibilities.

Bioethical Considerations

Basic ethical arguments for and against legalizing PAS will be familiar to many readers. Permitting PAS would respect patients' autonomy, enhance compassionate care for suffering patients, and address shortfalls in pain management or palliation.

4 See the Death with Dignity website (n. 1) for current descriptions of each jurisdiction's law and implementation process.

5 Task Force on the UCC Resolution on Physician Aid in Dying, "Report and Recommendations," unpublished report, Advocate Health Care, 17 January 2011 (revised June 2011), citing Katrina Hedberg et al., "The 10-Year Experience of Oregon's Death with Dignity Act: 1998–2007," Journal of Clinical Ethics 20, no. 2 (Summer 2009): 124–132.

Ready access to means of peaceful death would ease anxiety and actually result in longer lives; PAS would forestall resort to more violent means of death; and procedural safeguards would prevent abuses.[6]

Opponents claim that allowing PAS would violate the sanctity of life, and would ignore the fact that suffering can almost always be significantly relieved. Requests for PAS can never be truly "autonomous"; safeguards could never eliminate the potential for abuse; and allowing PAS even for narrow reasons would inevitably be followed by broader justifications of eligibility (a "slippery slope"). Moreover, the healing role of medicine would be jeopardized and trust in physicians and other professionals undermined.[7]

Underlying the PAS debate is a larger issue at the heart of medicine itself. If medicine is committed both to beneficence (benefiting patients and protecting them from harm) and to nonmaleficence (not inflicting harm on patients), does not helping patients hasten their deaths violate both principles by prescribing or providing them means to kill (= harm) themselves? Proponents of legalized PAS contend that the true "harm" is inflicted by a medicine that denies patients the means to meet their real needs and condemns them to greater suffering and prolonged dying. PAS or even euthanasia is beneficent by contrast.[8] The arguments in this disagreement are complex and cannot be pursued here.

If medicine is committed both to beneficence (benefiting patients and protecting them from harm) and to nonmaleficence (not inflicting harm on patients), does not helping patients hasten their deaths violate both principles by prescribing or providing them means to kill (= harm) themselves?

There are other important bioethical issues in the PAS debate that also cannot be considered here.[9] I will, however, highlight two points, often overlooked, that emerged in a vigorous debate about PAS in the 1990s medical literature. One author, opposing PAS, notes that both PAS and euthanasia eliminate suffering by eliminating the sufferer. In fact, medicine becomes the agent of a form of death that is actually a "violent remedy in the name of beneficence." The virtue or motive of compassion is not enough to justify an act that violates the core medical principle of "do no harm."[10]

Other authors, supporting PAS and/or euthanasia, point out that modern medicine's very success, plus physicians' tendency to use its technology so long as it offers *any* hope, can "set up" patients for a more difficult dying process at the end of treatment than the faster death that would have ensued without the technological

6 See Thomas A. Shannon and Nicholas J. Kockler, *An Introduction to Bioethics*, 4th ed., rev. and updated (Mahwah, N. J.: Paulist Press, 2009), pp. 188–190; Bernard Lo, *Resolving Ethical Dilemmas: A Guide for Clinicians*, 5th ed. (Philadelphia: Lippincott Williams & Wilkins, 2013), pp. 150–151.

7 Shannon and Kockler, pp. 190–191; Lo, pp. 151–152.

8 The tension is reflected in the title of a book, *Beneficent Euthanasia*, edited by Marvin Kohl (1975).

9 Interested readers may consult Shannon and Kockler or Lo (n. 7) for discussions of other pertinent issues.

10 Edmund Pellegrino, "Doctors Must Not Kill," *Journal of Clinical Ethics* 3, no. 2 (Summer 1992): 95–102; idem., "Compassion Needs Reason Too," *JAMA* 270, no. 7 (18 August 1993): 874–875.

intervention. Especially if PAS is not available, medicine itself is then responsible—the culprit—for the patient's plight.[11] Neither of these arguments decides the question of PAS; both belong in any serious discussion.

North American Lutheran Perspectives

The United States: The pivotal position statements of both the Evangelical Lutheran Church in American (ELCA) and The Lutheran Church—Missouri Synod (LCMS) were issued in the early 1990s. Both oppose PAS. "End-of-Life Decisions," a 1992 ELCA social message, addresses several issues, including "physician-assisted death." Most language in that section seems to refer to active euthanasia, but clearly PAS is meant as well. Physician-assisted death is opposed as "contrary to our Christian conscience."[12]

"Christian Care at Life's End," a 1993 statement by the LCMS Commission on Theology and Church Relations, condemns "euthanasia," or "mercy killing" in the form of "suicide and/or murder" (PAS and active euthanasia). Both "are contrary to God's law." Further, the claim that "compassion" drives PAS is false; PAS "distorts" compassion. Nor can we aim to kill and claim it is "care."[13] A 1995 synodical convention resolution, reaffirmed in 1998, deems "the attempt to legalize" PAS "an affront to the Lord."[14]

Comments on PAS by Lutheran ethicists both support and challenge these perspectives.

Comments on PAS by Lutheran ethicists both support and challenge these perspectives. Mark Brocker affirms a "strong Christian presumption to preserve and protect life created in the image of God" that is reflected in the ELCA message, but proposes that Bonhoeffer's "concept of an extraordinary situation of ultimate necessities" might impel rare assistance in suicide. Such an extraordinary course of action should never become the "standard of care."[15] Daniel Lee opposes PAS, yet believes that opponents have no "business using the coercive power of the state to prevent those who disagree … from doing what they believe is right" when no third party is harmed.[16]

Gilbert Meilaender holds that there is neither a "right to die with dignity" nor a "right to life," because life is not "mine" but is lived in community. Legalized euthanasia, and by extension PAS, involves the medical professional and society in "an act of abandonment." Meilaender rejects the claim that assisted suicide or

11 Howard Brody, "Assisted Death—A Compassionate Response to a Medical Failure," *New England Journal of Medicine* 327, no. 19 (5 November 1992):1384–1388; Guy I. Benrubi, "Euthanasia—The Need for Procedural Safeguards," *New England Journal of Medicine* 326, no. 3 (16 January 1992): 197–199.

12 Church Council, Evangelical Lutheran Church in America, *A Message on End-of-Life Decisions*, social message, 1992.

13 Commission on Theology and Church Relations, The Lutheran Church—Missouri Synod, *Christian Care at Life's End*, 1993.

14 "To Speak Out against Legalization of Assisted Suicide," Resolution 6-02, Synodical convention, The Lutheran Church—Missouri Synod, 1995.

15 Mark S. Brocker, "Let God Be the Judge: Who Will Throw the First Stone?" *Journal of Lutheran Ethics* 2, no. 8 (August 2013), accessed at *https://www.elca.org/JLE/Articles/930*.

16 Daniel E. Lee, "Physician-Assisted Suicide: A Conservative Critique of Intervention," *Hastings Center Report* 33, no. 1 (January–February 2003): 17–19.

euthanasia can be justified as "compassionate relief of suffering." Compassion does not eliminate the sufferer. The guiding principle of "Christian compassion" must not be "minimize suffering," but "maximize care."[17]

Canada: In Canada, "medical assistance in dying," or "MAID"—either PAS or active euthanasia—is now permitted and may be practiced throughout the country. After the 2015 Supreme Court decision decriminalizing PAS and euthanasia, the Lutheran Church—Canada (LCC) signed a multi-denominational declaration asserting the moral wrongness of PAS and euthanasia and urging the government to protect life and human dignity as it developed implementing legislation. The LCC president reaffirmed "the commandment not to commit murder" since humans have "the image of God upon them" and God's "breath of life within them."[18]

The Evangelical Lutheran Church in Canada (ELCIC) revisited a 1997 statement opposing PAS and, more broadly, is developing a church-wide response to the fact that legalized MAID will be "an option for the foreseeable future." A proposed resolution framing this response does not directly oppose or endorse MAID. It is above all a "call to faithfully journey with" the dying, including those who may seek MAID. Perhaps following the law, it does affirm "a right to assistance in dying" that includes MAID as one option. It commends trusting those who must make difficult medical decisions, recognizing that people will disagree. Such trust entails support for decisions of healthcare professionals who opt out of MAID, though they should refer patients to other providers.[19]

The Canadian experience signals that broad legalization of PAS, for which U. S. demand is growing, can challenge or alter pastoral practice, perhaps rapidly.

Implications for Chaplains and Others Offering Pastoral Care

Some U.S. chaplains and others who offer pastoral care have had first-hand encounters with PAS where it is legal. The Canadian experience signals that broad legalization of PAS, for which U. S. demand is growing, can challenge or alter pastoral practice, perhaps rapidly. How may, or how should, chaplains and others respond?

Some guidance from CASC (Canadian Association for Spiritual Care) resources is instructive. A "guidelines" document notes the fundamental need for chaplains to balance "freedom of conscience" (their own) with professional responsibilities to those they serve. Chaplains and "psycho-spiritual therapists" may opt out of participation in the MAID process, including conversations with patients considering MAID, or may choose to engage with patients considering or awaiting MAID. Either way, their response to the patient begins with "honoring" the Canadian patient's

17 Gilbert Meilaender, *Bioethics: A Primer for Christians*, 3rd ed. (Grand Rapids: Eerdmans, 2013), pp. 60, 64–65.

18 "LCC Joins Catholics, Evangelicals, and Others in Declaration on Euthanasia," *The Canadian Lutheran*, September–October 2015, p. 15.

19 "The Call to Faithfully Journey with Those Who Are Dying: An ELCIC Resolution," Proposed Resolution, Task Force on Decisions at the End of Life, Appendix D, Minutes of the National Church Council Meeting, Evangelical Lutheran Church in Canada, September 6–8, 2018. Accessed at *http://elcic.ca/National-Church-Council/National-Church-Council-Minutes.cfm*.

right to choose MAID. The patient's choice merits a "compassionate" and respectful response. Chaplains and therapists with conscientious objections should still arrange for continuity of spiritual care. Crucially, any engagement or discernment is grounded in continuing inner work of self-awareness. "Know thyself" (my term) is the hallmark of spiritual care here: tracking one's own feelings, attitudes, reactions, and limits at every turn in the relationship.[20]

Crucially, any engagement or discernment is grounded in continuing inner work of self-awareness.

The CASC guidance helpfully addresses the question of confidentiality in this delicate matter. Chaplains should steer between sharing "sufficient" information to adequately inform "team members" on this issue and respecting client privacy. However, the guidelines state firmly that chaplain conversations about MAID "must remain confidential" until the patient/client formally initiates a MAID process involving a physician or nurse practitioner.[21] The rule of absolute confidentiality at the outset may challenge U.S. charting practices or assumptions but is worth considering seriously, given the gravity and deeply personal nature of any conversation about having one's own death facilitated.

A second CASC resource calls on chaplains to respect patient/client autonomy and to be "sensitive to power imbalances" and the dynamics of conscientious objection in the MAID situation. The reference to "power imbalances" seems to mean not only a potential for subtle coercion of the patient/client but also possible pressure on professionals to participate in MAID even if they have objections.[22] Similar issues are certain to arise in U.S. contexts as well (and have surely arisen already).

A 2005 survey of fifty Oregon hospice chaplains regarding PAS may remain relevant today. The chaplains were about equally divided between proponents and opponents of PAS. They saw their primary roles as helping patients explore the "role of faith/spirituality/God" and explore their "reasons" in choosing PAS, and discussing family members' concerns about PAS. These chaplains felt that feared loss of dignity, a desire to control the circumstances of dying, and the reality of pain and/or fear of greater pain, were leading factors in choosing PAS. Depression was *not* considered a substantial factor in patient decisions.[23]

A particularly important point for ethical practice may be that few chaplains felt their conversations somehow influenced the patient's choice. Some remarked that patients making this choice were already firm in their resolve when the

20 Canadian Association for Spiritual Care, *Guidelines for Spiritual Care Providers and Psycho-Spiritual Therapists in Responding to Inquiries Regarding Medical Assistance in Dying (MAID)*, December 2016. Accessed at *http://spiritualcare.ca/ethics_home/maid-information-ethics/.*

21 Ibid.

22 Canadian Association for Spiritual Care, *Responding to Clients Considering or Requesting Medical Assistance in Dying (MAID)*, December 2016. Accessed at *http://spiritualcare.ca/ethics_home/maid-information-ethics/.*

23 Bryant Carlson et al., "Oregon Hospice Chaplains' Experiences with Patients Requesting Physician-Assisted Suicide," *Journal of Palliative Medicine* 8, no. 6 (2005): 1160–1166.

chaplain visited. In particular, chaplains felt that *opposing* the decision for PAS had or would have little effect on the decision.[24] Oregon chaplains also reported that "nonjudgmental presence" seemed most helpful for the pastoral relationship in PAS situations.[25]

These chaplains' impressions may be unique to the Oregon context. But their reports also suggest that the old CPE adage, "Don't go into the patient's room with an agenda," applies when PAS is an option. A chaplain's desire to persuade, or dissuade, should be recognized for what it is, then probably set aside. Receptive presence (my term) is ethically and pastorally sound practice; it does not impose the chaplain's values and is more likely to be experienced as helpful.[26]

Conclusion

It was not the goal of this discussion to resolve the question of the ethical permissibility of physician-assisted suicide, and clearly it has not done so! Nevertheless, surveying an ethical and religious landscape may help chaplains and others in specialized ministry see a bigger picture and probe more deeply into the issues and their own role. The chaplaincy or pastoral care literature on PAS and experience with it is still surprisingly sparse, at least given the sources I have found. Perhaps experience in Canada will enrich U.S. understanding, even as growing U.S. experience should produce additional research and informative anecdotal accounts.

A danger of adopting PAS and its protocols is the increased routinization of death and a tendency to become hardened to what we are really doing when clinicians participate in inducing the death of a patient.[27] We should never lose our sense of awe and apprehension at the prospect nor, I think, some sense of disquiet when death is made to happen in this way. Nor should we lose sight of the potential impacts that PAS will have on healthcare professionals and their needs for support, whether or not they choose to participate in PAS.

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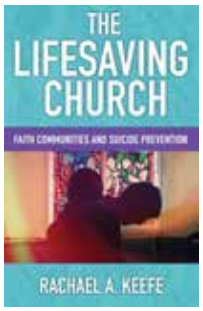
24 Ibid., pp. 1160, 1164.

25 Ibid., pp. 1160, 1165.

26 In contrast, a chaplain's account of a hospice relationship in which the care team apparently persisted in efforts to dissuade the patient from carrying out PAS may suggest the pitfalls of such an approach. See the case in Vicki Farley, "The Chaplain's Role When Aid in Dying Is Legal," *Health Progress*, January-February 2014, pp. 11–13. It should be noted that the outcome in the case is clouded by other factors, notably the apparent failure of PAS medication to work as expected.

27 One is reminded of Brock's caution against PAS becoming a "standard of care" (see n. 15), yet the establishment of a protocol can tend in that direction.



Book Review:
The Lifesaving Church: Faith Communities and Suicide Prevention
by Rachel A. Keefe. Chalice Press, 2018.

Reviewed by Diane Greve

RACHAEL A. KEEFE IS THE PASTOR of Living Table United Church of Christ (UCC) in the Twin Cities. She is a former pastoral counselor and clinical chaplain. As a teenager, she lived with depression and attempted suicide. Through the compassion and companionship of her pastor, she was able to find hope and a path to life. He visited her in the emergency room. She did not experience judgement from him. "He was the first person who embodied Christ's love for me. He did not want anything from me except, perhaps that I not die… There was no condition on his showing up. I needed that more than he probably knew, certainly more than I knew." p. 5.

Her book tells her own story and offers numerous resources for chaplains, counselors and parish leaders to help prevent suicide and to serve the bereaved and struggling families in the wake of a death by suicide. Speaking openly about mental health disorders in the congregational setting can be awkward and risky. Speaking about thoughts of suicide or hospitalization due to suicidal thoughts or attempts are often only whispered. How the congregation and its leaders respond is critical to holding the body of Christ together.

Keefe works from the theological perspective that if a member of the body of Christ is sick, the whole body is sick. And if a member of the body of Christ is suicidal, the whole body is suicidal. If one person is living with depression and or considering suicide, most likely, others are as well.

Her story is compelling, and the resources in this book of 102 pages are helpful for those seeking to minister effectively with patients, clients, and parishioners. It is the story of how the body of Christ can be the living, loving Christ for those who are pondering suicide.

Diane is a retired ACPE certified educator living in Minneapolis who serves as a co-editor for Caring Connections.

News, Announcements, Events

In Times Such as These Zion 2019

ZION 2019 will gather on the beautifully wooded campus of University of St. Mary of the Lake in Mundelein, a north suburb of Chicago. The dates for Zion are September 26 through 29. The theme around which we gather is "IN TIMES SUCH AS THESE."

We find ourselves in troubling and uncertain times.

The national healthcare system in which many of us serve does not work well, is extraordinarily expensive, and the certainty of reimbursement is tenuous. Healthcare corporations are realigning in anticipation of a future not clearly seen, leaving their employees anxious about their roles, responsibilities, accountability, and job security.

Our society has been shaken by the dramatic demise of the myth of a post-racial America. We are newly aware of two Americas – one black and one white. We have experience greater suspicion toward the "other" who has made a home among us and greater hostility toward the "stranger" outside our borders.

The open secret of sexual abuse, exploitation, and devaluation has exploded and the shock waves continue to reverberate in politics, arts, sports, health care, entertainment, business, and religion. The "#MeToo" movement confronts not only overt behaviors, but also long-standing biases.

The many societal issues which impact us in times such as these are compounded by a loss of safe space for and civility in our public discourse. There is little consensus on facts, less on truth. That which is repeated most often and most loudly is accepted as normative. Social media serves as an echo chamber which confirms already held prejudices. Families, friendships, and even congregations are divided as people are no longer able to dialogue with one another.

It is in times such as these that we as chaplains, pastoral counselors, and certified educators are called to serve. We are "front-line Church" impacted through the people to whom we minister, through the institutions we are called to serve, and personally as members of this society. How shall we understand the issues which trouble us? Where do we see Christ at work in these uncertain times? Are there unique insights we might gain from our own Reformation tradition, born and nurtured in equally troubling and uncertain times? How might we best serve clients, patients, students, and families in this context? What can we teach the Church about the world we are encountering on the front line?

In light of the theme there will be three keynote speakers this year addressing Woman and Justice, Racism and Reaction, and Healthcare and Health. The Rev Kathie Bender Schwich, the senior officer for Mission and Spiritual Care in the newly-formed Advocate-Aurora health care system will address healthcare. The other keynotes will be confirmed shortly. The Reverend Peter Nafzger, Assistant

Professor of Practical Theology at Concordia Seminary, will serve as the Bible Study leader. The Reverend Lee Joesten, retired CPE supervisor, will serve as liturgist and the Reverend Elizabeth Palmer, book editor for *Christian Century*, will serve as homilist for the Saturday evening service which will follow the banquet and Christus in Mundo presentations. Please submit your nominations for this prestigious award by using either of the two nomination forms at the end of this issue of *Caring Connections*. The possibility of a visit to the Illinois Holocaust Museum in Skokie is being explored and there will be quiet time to take in the serenity of the St. Mary of the Lake campus.

Please put a hold on these dates, **September 26–29, 2019,** and watch for further information.

Evangelical Lutheran Church in America
God's work. Our hands.

Sisters and Brothers in Ministry:

The following are the procedures for nominating an ELCA colleague in chaplaincy, pastoral counseling and/or clinical education to be considered for the **Christus In Mundo (Christ in the World) Award.** Two people from the ELCA will be selected for this honor. The awards will be given at the **Zion XVII Conference, September 26-29, at the University of St Mary of the Lake, Mundelein, Illinois.**

Please fill in the form below. On an attachment, in approximately 250 words, state the qualities of the nominee and give examples of the person's ministry that distinguish this person as making significant, sustained contributions in the field of chaplaincy, pastoral counseling and/or clinical education within the ELCA and beyond. Contact the nominee and (a) gain his/her consent to be nominated, and (b) request a copy of the person's resume to accompany this nomination.

Nominee's information

Nominee's Name: _____ Title: _____

Address: _____

Place of Ministry *(if applicable)*:

_____

Home Church: _____

Personal Phone: _____ Work Phone: _____

Email Address: _____

Years in the Ministry: _____ Spouse: _____

Your information

Your Name: _____ Signature: _____

Address: _____

Personal Phone: _____ Work Phone: _____

Email Address: _____

Describe the nominee's association with you. _____

_____

_____

_____

ALL NOMINATIONS MUST BE RECEIVED BY JUNE 1, 2019.

Please return this form, the attachment, and the resume to:

John E. Schumacher, BCC
6241 West Eddy Street
Chicago, IL 60634
email: *jesjms@att.net*
phone: 773-283-4336

LCMS Specialized Pastoral Ministry
CHRISTUS IN MUNDO AWARD
Nomination Form

The following are the procedures for nominating an LCMS colleague in chaplaincy, pastoral counseling, and/or clinical education to be considered for the Christus In Mundo (Christ in the World) Award. Two people from the LCMS will be selected for this honor. The awards will be given at the Zion XVII Conference, September 26 – 29, Mundelein, Illinois.

Please fill in the form below. On an attachment, in approximately 250 words, state the qualities of the nominee and give examples of the person's ministry that distinguish this person as making significant, sustained contributions in the field of chaplaincy, pastoral counseling, and/or clinical education *within the LCMS and beyond*. Contact the nominee and (a) gain his/her consent to be nominated, and (b) request a copy of the person's resume to accompany this nomination.

Nominee's Name _____ Title_____
Address_____
Place of Ministry (if applicable) _____
Home Church_____
Personal Phone_____ Work Phone _____
Email Address_____
Years in the Ministry_____Spouse_____

*Your Name*_____*Signature*_____
*Address*_____
*Personal Phone*_____ *Work Phone* _____
*Email Address*_____

Describe the nominee's association with you.
_____
_____
_____

Please return this form, the attachment, and the resume to

LCMS Specialized Pastoral Ministry
spm@lcms.org
1333 S. Kirkwood Road
St. Louis, MO 63122.
Fax: 314-996-1124.
Phone: 800-248-1930, ext. 1388, or 314-996-1388.

All nominations must be received by June 1, 2019.