TTJ 12.1 (2009): 76-89 ISSN 1598-7140

A Review of Psychological Abnormalities in Suicide*

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While I was working on this article, former president of South Korea, Moo-Hyun Rho, committed suicide. Before he committed suicide, he wrote a final letter on his computer, "I do not want to cause any more suffering to other people's lives. I cannot even read or write any more because of my poor health." Rho concluded his letter with words that he is nothing but a burden to other people. According to the statistics from *Korea Suicide Prevention Association*, the suicide rate in South Korea in 2005 ranks first among OECD countries (Park, 2007). The rate rose to 26.1 per one hundred thousand people. The second highest suicide rate was found in Hungary (22.6 in 2003), third was in Japan (20.3 in 2003), fourth was in Finland (18.4 in 2004), and the last was in Italy (5.6 in 2002). Korean suicides include many well known actors and singers. There are indications that their behavior is influential to ordinary citizens. Also, it was discovered that certain internet communities have been encouraging people to commit suicide in groups. As we look into the suicide rate of South Korea by age groups, the 40s rank first and the 70s rank second; that is, 2,356 people have committed suicide in their forties and 2,352 people have taken their own lives in their seventies. Suicide is known to be the fourth leading cause of death in South Korea.

Chung conducted a survey on suicide among Korean Christians (Chung, 2008). Surprisingly, the research result shows that a fifth of those surveyed were tempted to commit suicide. Among the fifth who were tempted, 14.5% actually had planned to commit suicide, 34.1% of them answered that loneliness was major the reason for them to commit suicide. The research also reported a striking number: 82.1% of those who tried to commit suicide did not receive any help from churches. Those who received help from churches benefitted because they were sent to counseling, supportive prayer meetings, or worship services.

* I am grateful to Miss Myung-Hee Lee who aided in the research for article by collecting related articles and data.

Most of people in this survey believed that suicide is not an issue of faith, but a matter of psychological illness. Compared to other religions, even to Catholicism and Judaism, Protestants have the highest suicide rate according to the research data by Durkheim (recited from Hwang, 2007). Durkheim attributed the reason for the highest rate of suicidal attempts occurring among Protestants over against Roman Catholics and Jews to be rising from a lack of emphasis on rituals or tradition. He posited that this lack prevents them from building up unity in community, leaving individual members to feel disconnected. Cho interviewed extensively seven Christians - five men and two women - who overcame their suicidal tendencies (Cho, 2007). There were some external factors which provoked their attempts, such as a financial crisis, death of family member, and family discord. They were very passionate and hard working Christians at their churches. When they contemplated on killing themselves, their powers of reasoning and faith did not work to overcome their suicidal thoughts. Three of them shared that they stopped trying to commit suicide when they were reminded of their mothers, who would mourn deeply over their death.

As mentioned above, whether they are Christians or not, suicide is becoming the most threatening and prevailing problem in Korean society today. This study aims to examine psychopathological factors in suicide—some cognitive errors and problematic emotions. Afterwards, an attempt will be made to relate the findings of this paper to Scripture.

Suicide: Concept and Subtypes

WHO defines suicide as "a behavior which someone harms oneself with his/her clear intention and motivation to kill oneself" (Lee, 2008b). Suicidal behavior can be divided into three stages: suicidal ideation, suicide attempt, and completion of suicide (Beck, Kovacs, & Weissman, 1979). Other scholars have also subdivided the types of suicide according to different standards. First, Durkheim divided the types of suicide into three categories of altruistic suicide, egoistic suicide, and anomic suicide (Durkheim, 1951). Altruistic suicide is when someone commits suicide in order to save or at least do some good for other people. Egoistic suicide means that suicide is committed for self-centered reasons such as solving a financial problem. Anomic suicide can occur when a society cannot embrace its own member because of its own internal problems of confusion and disorganization. DeSpelder and Stickland also subgrouped suicides based on the suicidal intention and motivation: "suicide as escape," "suicide as crying for a help," and "suicide as half-intended and chronic behavior." Chronic behavior includes depression, anxiety, and some personality disorders. Drug users can be

included in the group of "suicide as half-intended and chronic behavior" because using drugs for over time a long period of time causes death (recited from Lee, 2008).

Moreover, Kim analyzed subtypes of suicidal behaviors presented in the Bible (Kim, 2008): self-punishing suicide of Judas Iscariot (Mattew 27:5), escaping suicide of King Saul (1 Sam 31:4), revenging suicide of King Zimri (1 Kgs 16:25-30), despairing suicide of Ahitophel (2 Sam 17:23), and altruistic suicide of Samson (Judg 16:30). Kim's typology also led to conjecture possible psychological causes of each suicide subtype listed above. Judas's greed for money might have caused his suicide. Strong pride could be a possible cause in King Saul's suicide. Excessive desire for power in Zimri, inescapable despair and frustration in Ahitophel, and awareness of God's covenant in Samson are all examples of causes of suicide.

This paper tries to review important psychological abnormalities in suicide. Theoretical models on suicide can offer a whole picture that explains suicidal behaviors and their specific causes. Blumenthal & Kupfer (1986) provided four different kinds of theoretical suicide models: overlap model, three element model, suicide trajectory model, and cubic model (Blumenthal & Kupfer ,1986). First, the overlap model explains suicide as a behavior followed by five accumulated causes which bring self-killing behavior: psychological environments, physical shortcomings, psychological abnormalities, individual traits, and family history or genetic factors. Second, the three elements model is based on three factors of suicide: trait factors, hidden factors, and threatening factors. Trait factors include emotional diseases such as depression, bipolarity, alcoholism or schizophrenia. Hidden factors include family history, social, and environmental. Threatening factors include severe physical disability and accessibility to a tool to commit suicide. Third, the trajectory model is a reciprocal and multi-dimensional model, which focuses on a critical event to induce suicidal behavior. The risk factors that cause this critical event are biological, psychological, cognitive, and environment risks. Among these risk factors, the psychological risk factor includes feelings of despair, hopelessness, low self-esteem, and a lack of coping skills. Cognitive risk factors include cognitive rigidity and various cognitive distortions. The last cubic model suggests that an entire cube is composed by one hundred and twenty five small cubes. The whole cube has three cross sections which represent pressure, pain and anxiety. Pressure represents accidents that lead individuals to kill themselves. Pain represents psychological suffering because of a distorted psychological need. Anxiety is mostly related to a cognitive or perceptive restraint.

After reviewing the models above, some conclusions can be made. First, suicide cannot be explained by one definite factor or cause. Instead,

suicide can be understood as a behavior that is interactively influenced by psychological, environment, and family factors. Second, each model commonly points to psychological, physical, mental and environmental factors in relation to suicide. Third, all models see psychological factors to be important, such as distorted cognition and emotional vulnerability, which produce severe mental problems that lead to suicide.

Psycho-Abnormalities in Suicide

In addition to examining the causes of suicide and types or models of suicide, it is also important to look into the most commonly reported psycho-abnormalities that directly contribute to suicide. Psycho-abnormalities can be determined by statistics, social norms, and functioning level. People who are beyond the normal range in terms of statistics and social expectation, and who cannot function enough in their work place and families might be diagnosed as psychologically abnormal. It is complicated to diagnose people according to the standards mechanically suggested. However, most extreme cases (psycho-abnormalities related to suicide) may represent well a certain phenomenon (the psychological characteristics of suicide). Therefore, figuring out the main psychological characteristics in typical psycho-abnormalities that cause suicides may be very helpful for understanding the mindset of those who attempt suicides.

Nam said that more than 90% of the people who commit suicide have been reported to have been diagnosed with various kinds of mental illnesses (Nam, 2008). Specifically, statistics from European, American, Australian, and Asian countries show that 90 to 95% of suicides occur because of severe mental illnesses (Jamison, 1999). Emotional disorders (serious depression and bipolar disorder), schizophrenia, anxiety disorder, substance abuse disorder, and some personality disorders (borderline and anti-social personality) are known to be the most frequently observed mental illnesses that cause suicides. In fact the same source states that around 30 to 70% of suicide attempts is caused by emotion disorders such as major depression and bipolar disorder. Jamison also reported that diseases such as AIDS, Huntington's disease, brain vascular disease and cancer are also related to suicide. People with these diseases might want to die because they see no hope or progress in life. Harris and Baarclaud reported that approximately 250 clinical cases (Klair, Harris and Baarclaud, recited from Jamison, 1999) showed the following occurrence rates in an abnormal people group compared to normal people: emotion disorders (depression - 20 times higher than healthy people in committing suicide, bipolar disease –14 times, substance use disorders (alcohol dependence – 7 times), personality disorder

(8 times), schizophrenia (8 times), AIDS (6 times), anxiety disorder (6 times), Huntington disease (4 times), brain vascular disease (4 times), and cancer (2 times).

Of course, not all abnormal people commit suicide. In order to understand the core cognitive belief and emotional condition for suicide, the main psychological state of each abnormal behavior which contributes to suicide must be determined. First, depressed people usually suffer from very specific cognitive errors called "a cognitive triad" (Beck, John, Shaw & Every, 1979). These three elements of thinking combined perform the main role in depression: a negative perspective on self (i.e., "I cannot do anything to overcome this difficulty."); a negative interpretation about a world or an environment (i.e., "The world will be never changed."); and a negative opinion of the future (i.e., "My future will never be different."). For people with bipolar disorder, the activity and energy level are tremendously high during the manic stage. But this stage of high level activity and energy is known as rebound behavior of compensating for the depressive stage. In other words, depressed people usually try to feel high by behaving very energetically in order to overcome their dark moods. Moreover, sometimes, in their impulsiveness and violent state, explosive anger and feelings of despair can be hidden (Jamison, 1999). Hence, the manic fantasy such as "walking on the water'" or "no danger in attacking the police" might cause them to commit suicide. For people with schizophrenia, the risk factors of their suicidal tendency can be induced from the hallucinated perceptions or wrongly associated thinking. Statistics say that about 10% of schizophrenic people kill themselves because of hallucinations and delusion. Nam also reported that 4 to10% of schizophrenic patients in Korea have committed suicide (Nam, 2008). Some of them might have heard a voice in their fantasy state saying "Kill yourself. You deserve to die." Some people hallucinate about snakes and run into water to avoid them. Therefore, suicides committed under these circumstances may be understood as accidental.

Anxiety disorders can cause suicide with different psychological dynamics. In DSM-IV, TR (Diagnostic and Statistics of Mental Disease, the 4th edition), seven different kinds of anxiety disorders are listed (American Psychiatric Association, 2000). They are general anxiety, panic disorder, special phobia, social phobia, obsessive compulsive disorder, acute stress disorder and PTSD (Post Traumatic Stress Disorder). It is reported that those who have anxiety disorders might attempt suicide because they feel that they are in despair and that there is no way to escape from their situation. People with panic disorders can suffer from extreme fears and anxieties about death because they experience severe heart pumping, pain in the heart, sweat, and a feeling of helplessness

and madness. They might see committing suicide as the only way to end the difficulties of life.

Borderline personality and antisocial personality are known as the most suicide producing personality disorders (Jamison, 1999). Borderline personality is characterized by possessing extreme impulsiveness and anxiety in human relationships. They mainly suffer from the fear of abandonment by people who are close to them and from a feeling of emptiness. They show a rapid change of emotional state. For them, committing suicide is an attempt to control people and to avoid being abandoned by them. The characteristics of antisocial personality can be categorized into two types: ignoring others' right and showing aggressiveness or cruelty. In this personality, impulsiveness, explosive anger, and physical fights are the main causes for their deaths.

Substance abuse disorder can be understood as a narcissistic illness by its nature. Narcissistic means "self-pleasing." Choi showed that substance addiction (of narcissistic nature) may have the nature of alternative object when infants lose their "idealizing self" (Choi, 2005). In object relation theory, infants who fail to learn to delay this pleasure might long to satisfy their desire by other of means. This explanation is related to the understanding of addiction as an "oral phase disease" by the traditional psychodynamic model. According to the classical psychodynamic theory, infants who lost a good and satisfying object, or who experienced the extreme satisfaction by good objects in the first year after the birth tend to form addictive personalities.

Substance use disorder refers to people with addictive personalities, and it can lead them to replace the ideal or satisfying object with substance or alcohol. So, by nature, those who use drugs have more difficulties bearing suffering and pain, and they seek after other objects to give them a relief from pain or a pleasure to avoid the difficulties. Hence, they may commit suicide when they feel that they cannot avoid pain or suffering. Another related factor to suicide of substance users is uncontrollability. Statistics tell us that half of all suicide cases occur while people are using alcohol or other drugs (Nam, 2008). The report shows that around 40% of alcoholics attempted suicide at least once or more and that 18% of alcoholics actually die because of suicides (Nam, 2008). The psychological cause for this suicide is directly related to the intention of ending suffering, and indirectly related to the uncontrollable use of substance while they are drunk. The third factor of substance users who show a high risk in suicide can be found in a dual diagnosis with other mental diseases such as depression, bipolar disease, panic disease, or schizophrenia. The research shows that one third of bipolar patients, one fourth of depression and schizophrenia patients have substance dependence simultaneously. Furthermore, the possibility to

commit suicide may increase when people have these dual diagnosed mental diseases. However, it is difficult to make a clear-cut explanation about major psycho-abnormalities relating to suicide. Some mental diseases that provoke suicide are internally related to one another, and some mental diseases directly contribute to suicide behavior.

In reviewing the previous studies on psycho-abnormalities in suicide, four main psychological factors are found to be related to suicide behavior. First, suicidal people may see the only way to end their sufferings is by killing themselves. They feel there is no way to escape (inescapability). This is the reason why committing suicide is often called "self-saving behavior." Second, an extremely negative expectation for the self, the world, and the future can be the causes of suicide. The first factor "inescapability" may come from this second factor "negativism." Third, uncontrollability over their self-killing behaviors may be another cause for substance dependence, schizophrenia, and anti-social personality disorder. Fourth, suicide behavior can be a controlling behavior. For example, borderline personality patients might attempt suicide as a means to hold people close to themselves who would otherwise abandon and leave them. However, this can be understood as a different kind of trial for them to avoid the extreme pain of being abandoned. In this sense, the fourth factor can be part of the first factor, wishing to finish their pain and suffering.

Risk Factors and Protection Factors in Suicide: Negativism & Rigidity vs. Positivism & Flexibility

Up to now, this paper has searched for major psycho-abnormalities related to suicide behavior. Also, psychological factors in psycho-abnormalities such as cognitive distortion, like inescapability from suffering and extreme negativism, and emotional uncontrollability, were examined. The purpose of this section is to explore the main cognitive and emotional risk factors for suicide and discuss its protection factors as well. It is obvious that the cognitive and emotional characteristics of suicide attempters are overlapped with those of mentally abnormal people. Looking at suicide behavior in terms of risk factors and protection factors might be helpful to understand suicide behavior more broadly and generally. Christian counselors can take these risk and protection factors and reexamine them in light of biblical teachings in order to make suicide interventions.

Risk factors in suicide may be divided into cognitive area and emotional area. Kim examined some cognitive and emotional factors which are related to suicide. She searched a suicide pathway with related variables as follows: overgeneralization of memories, hypersensitivity of

emotion, cognitive rigidity, and dysfunctional problem solving skills. According to her conclusion, among these variables, a cognitive rigidity is the major intermediate variable mediating suicide (Kim, 2008). This implies that people who commit suicide may have very rigid perspectives over life experiences, which leads them to react to suffering too sensitively. In other words, people with rigid perspectives on life fail to consider alternative solutions to their suffering except to end their lives. Baumeister (1990) explained suicide behavior as follows: "Suicide occurred when people perceive a stress too seriously which is an unavoidable fault between the expectation and the reality though, people desire to escape from this stressful situation." In Kim's study, even the feeling of hopelessness did not mediate a stress and suicidal ideation directly; it only mediated a stress and depression indirectly. Hopelessness can be defined as a belief, "I cannot do anything to escape from suffering in the future" (White, 1989). With broader social perspectives on adolescents, Kim (2008) and Cho (2006) also showed that depression is the most influential factor to suicide attempts followed by a feeling of isolation, a lack of self esteem and a communication problem. Compared to Kim's study above, Choi's study implied that the relationship between the suicide attempter and friends or family members should be considered as well.

Choi (2006) pointed out that anger was another emotional factor to suicide. In his clinical experience, suicide attempters say, "There is someone I want to kill." When clients were asked later whom they wanted to kill, they answered, "Me" (Choi, 2006). Choi explained that this interview is quite relevant to the Freud's theory on suicide. Freud divided man's instinct into two–instinct for life and instinct for death (Shizco, 2007). The instinct for death, which is very destructive, may be guided into two different directions: *self and others*. When the instinct for death is directed towards the *self*, a suicide may occur, while a murder may be committed when this instinct is directed to *others*. Choi demonstrated that parents who force their children to meet their expectation strictly can create a mix of anger where children are also angry with their parents. In this sense, anger performs the main role in "revenge or self-punishment" type of suicide.

Another interesting study on suicide was performed by Lee (Lee, 2008a). She explored a risk factor of suicide as well as a protection factor. Depression, drug use, exposure to a suicide experience, and stress were main variables that mediate between suicide and ego-resilience, where the later is functioning (acting) as a protection factor to suicide. Ego-resilience can be defined as a type of personality reacting to stress more flexibly, overcoming stress and suffering better (Block & Block, recited from Lee, 2008). It is also open to change and tends not to be

oversensitive about one's anxiety. This study showed that ego-resilience controls depression, stress from school and substance use. Koh and Yoon also mentioned ego-resilience in adolescents. In their study, ego-resilience had a controlling effect on suicidal ideation and stress. Through these studies, ego-resilience can be understood as an ability to react to stress in a more flexible way and to adjust to stress better (Koh & Yoon, 2007). Furthermore, ego-resilience implies the ability or a psychological resource to control the emotions, to actively change a situation and environment, and to enable people to adjust to a world. This ego-resilience is comprised of several elements such as positivism, activism, insight and warmth, and an ability of self-expression (Lee, 2008a).

Ego-resilience can provide some crucial tips to counselors for helping suicide attempters because several elements can provide some helpful direction in counseling. Counselors should give their efforts to develop these elements in ego-resilience. Positivism is the opposite concept of negativism where people's psychological tendency is to look at one's self, world, and future brightly and positively. Activism means to possess an active behavioral attitude to solve life's problems. Insight and flexibility in life may help people to look at themselves, world, and future with more choices. The ability to express oneself may provide individuals to control their negative feelings by discarding them through costructive means.

Some studies have indicated that depression and stress are risk factors that provoke suicide (Beck, John, Shaw & Every, 1979). Other studies indicated hopelessness, low self-esteem and a lack of communication skills are major risk factors (Nam, 2008; Jamison, 1999). As a protection factor against suicide, two studies pointed out ego-resilience, which can control depression and hopelessness, help people to adjust to stress which can be considered as the main cause of suicide (Kho & Yoon, 2007; Lee, 2008a). The following are some emotional factors that may induce suicide : 1) Negativism may cause agitated or forced feelings ("I should meet my own expectation but I cannot."); 2) Rigidity may cause a feeling of helplessness ("I have no ability and power to meet this expectation."); 3) Will to control may cause a hopeless feeling ("I want to change this world according to my desire but I cannot"); and 4) Inescapability may cause a despair feeling ("My pain will continue forever in the future"). On the one hand, in the midst of these cognitive errors and emotional hurts, extreme negativism and rigidity in thinking may perform a major role in causing a suicide. On the other hand, one prominent protection factor, ego-resilience, can play a positive role that can prevent suicide.

Conclusion: Suggestions for Christian Counselors Regarding Suicide

Psychological abnormalities in suicide can be summarized in two aspects, cognitive and emotional. In suicidal people's thoughts, three main characteristics can be observed: 1) Inescapability and rigidity refers to when people believe that committing suicide is the only way to avoid pain; 2) Extreme negativism concerns individuals who believe that they cannot be improved, and there will be no better world and future for them; 3) The will to control their situation and surroundings ("I can control my own life or others' lives by taking my life."). Emotions like hopelessness, helplessness, and despair follow these thoughts. Therefore, from a Christian perspective, we must ask, "What does the Bible say about these psychological problems?" The overall message of the Bible is that God has ownership over the entire creation and that He is sovereign over history and destiny of His people.

Walter mentioned that suicide is a contradiction to God's creation for two reasons.(Walter, 1993) First, God created human persons to have a positive influence over the world he created, but suicidal people do not possess this belief (Ps 19:1-16, Rom 1:20). Second, suicide is an expression of displeasure toward God's good construction. Ji, who studied Martin Luther from a Christian anthropological perspective, states that humans do not have the ability to know who they are, what they must do, and what they have unless they find themselves in God, the only source of wisdom (Ji, 1967). Also, Wilkerson insists that committing suicide is sin because it is a sign of atheism, hypocrisy, pride, and lie (Wilkerson, 1978). He supports this idea by stating that an incubated suicidal thought starts with "abandoned beings," and that pride can lead to suicide by putting man where God should be. According to him, suicide is the biggest lie of all because committing suicide is man's way, not God's way, of proclaiming to the world "God put me here by mistake. There is no purpose to it." A person's own decisive act to end his/her own life as if the person owned it without any respect to God is sinful because such thought and action discount God and his goodness.

Moreover, Black points out that human beings are created as covenantal beings (Black, 2000). According to him, the core problem of suicide comes from "man-centeredness" rather than "God-centeredness." It is explained by three different perspectives in regard to the main psychological causes of suicide. First, suicide is committed when people judge that they cannot endure the pain associated with an "unmet need," which is the source of stress in life. This is an extreme expression of man's self-declared autonomy (Black, 2000). As a creature he is designed, maintained, and owned by God (Psalm 139:13). The charge

given to human beings over creation and over their own bodies is to be grounded in a sense of stewardship (Gen 1:28). Only when a person is united with God, all his or her needs are met. Crabb states that a person has two basic needs: one is a need for significance, and the other is a need for security (Crabb, 1976). A person, who desires to meet these needs by his or her own efforts yet fails to meet them, may take his or her life because of the pain and agony which stems from these "unmet needs." This raises another question in terms of stewardship, "Who owns our life and body?" God created and owns us. Our lives belong to God and only God is sovereign over life and death. Suicide is an action to end a life when a person feels hopelessness and finds no escape from this life but through death. Suicide occurs with a combination of beliefs: 1) When people attempt to meet their own needs; 2) When people try to find their own hope in life; and 3) When people judge that they have the right to take away their own life and thus pain. However, only God can give life and has the right to take a life (Job 1:21).

A Christian counselor, Black, explains well about how psychological factors can interact in suicide behaviors in the following sentence: "A sense of hopelessness or inescapability, is combined with a pattern of poor coping, a limited tolerance and a flight from help coalesce in some manner to form suicidal intent. (Black, 2000, p.14)" In other words, a person who has no hope, no way to escape, and no life skills to overcome stress is exposed to the danger of suicide (risk factors). However, a person who can see the world with hope and is able to deal with stress is less likely to commit suicide (protection factors). In this sense, Black also provides very clear explanation about sin in relation to suicide. He emphasizes that sin cannot be made "explicable" and cannot be explained in terms of its component factors. But when people have a "feeling of hopelessness," this can be considered as a sin in terms of men being a "covenantal being" as well as a "created being" (Black, 2000). Hopelessness is a failure to recognize Christ as Redeemer. The Bible portrays persons with humility but who still have hope (Psalm 32, Luke 23:39-43). Hopelessness means a failure to desire what God desires. If people would desire what God desires, there will be no disappointment or failure because God is good and almighty. The more people trust in the good and almighty God, the more positively and flexibly they are able to live their lives. Black mentioned that frustration enters when we try to find hope in our fleshly desires because God continually thwarts our pursuit of those desires. God calls us to desire better things instead and to live with fundamental gratitude in Christ (Phil. 3:7-15; 4:3-9). Black points out another aspect of sin in "hopelessness." Hopelessness is an unwillingness to view the time as God does (Black, 2000). Hopelessness enters in when a person looks for his or her hope and reward in this

present time, even though God has called the person to live with a view of seeking eternity.

In conclusion, it is obvious that Christian counselors are to help suicidal people with warm, comforting, and supporting hearts and to help them deal with their current acute behavioral problems. Greence, as a person who attempted suicide and recovered from a bipolar disorder, confessed in her book as follows: "I value myself for the One who created and redeemed me and who will raise me on the last day" (Greence, 2006). Therefore, Christian counselors should help clients who are suffering from depression to take good nutrition and even medication to decrease depression symptoms. For substance addicts, Christian counselors should help them to quit the abuse, begin treatment, and maintain a good quality of life. For panic disorder clients, Christian counselors should help them by teaching them how to be released from acute breathing problems. Christian counselors should help people not to commit suicide and help them to hold onto a visible hope in life. However, even if the main symptoms of mental illness decrease, Christian counselors should inquire about a client's relationship with God: "Did this person accept Jesus Christ as his savior and does he believe that God is his creator?"

References

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR*. Washington, DC: American Psychiatric Association.

Baumeister, R. F. (1990). Suicide is Escape from Self. *Psychological Review, 97*, 90-113.

Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of Suicidal Intention: The Scale for Suicidal Ideation. *Journal of consulting and clinical Psychology, 47(2)*, 343-352.

Beck, A., John, R., Shaw, B. F. & Every (1979). *Cognitive Therapy of Depression*. NY: The Guilford Press.

Black, J. S. (2000). Making Sense of the Suicide of a Christian. *The Journal of Biblical Counseling. 18(3)*, 11-20.

Blumenthal, Sl, & Kupfer, D. (1986). Generalizable Treatment Strategies for Suicidal Behavior. In J. Mann, & M. Stanley(Eds.), *Annals of the New York Academy of Sciences, 487*, 327-340.

Cho, S. D. (2007). The Need of Suicide-Prevention Education. *Ministry and Theology. 218*, 80-85. (Korean)

Choi, E. H. (2006). Suicide Prevention Movement and Upcoming

Tasks. *The Pastoral Monthly, 356*, 80-89. (Korean)

Choi, E. Y. (2005). Application of Larry Crabb's Counseling Model to Addiction Counseling. *Torch Trinity Journal , 8 (1)*, 146-162.

Chung, J. Y. (2008). Perception of Christians and Responsibilities of Churches for Suicide. *Theology & Practice, 218*, 72-29. (Korean)

Crabb, L. (1975). *Biblical Principles of Biblical Counseling*. Grand Rapids: Zonderan Pub. House.

Durkheim, E. (1952). *Suicide: A Study in Sociology*. In J. A. Spaudlding, & G. Simpson(Eds.). London : Routledge and Kegan Paul.

Greene, K. (2006). *Darkness Is My Only Companion: A Christian Response to Mental Illness*. Grand Rapids, Michigan: Brazos Press.

Hwang, H. Y. (2007). How to Understand Christians Committing Suicide. *Living Waters, 643*, 24-28. (Korean)

Jamison, K. R. (2004). *Night Fall Fast: Understanding Suicide*. Seoul: Roots & Leaves. (Korean)

Ji, W. Y. (1967). *Luther's Thought*. Seoul: Concordia Press.

Kim, C, R. (2008). Pastoral Understanding of Christian Suicide, *Ministry and Theology. 234*, 230-237. (Korean)

Kim, E. H. (2008). The Relationship between Clinging, Dysfunctional Problem Solving, Mindfulness and Suicidal Ideation. *The Korean Journal of Counseling and Psychotherapy. 20(4)*, 1107-1125. (Korean)

Kim, H. S. & Kim, B. S. (2008). Verification of the Structural Relationship Model of Suicidal Ideation to Its Related Variables. *The Korean Journal of Counseling and Psychotherapy*. *20(2)*, 201-219. (Korean)

Koh, J. H., & Yoon, K. R. (2007) Stress and Suicidal Ideation of Youth: Buffering Effect of Ego-resilience. *Studies on Korean Youth, 18 (1)*, 185-212. (Korean)

Lee, Y. J. (2008a). Controlling Effect of Ego-resilience on Suicide Risk Factors among Middle School Students. *Counseling Studies, 9 (2)*, 659-674. (Korean)

Lee, Y. J. (2008b). *Suicide Counseling for Youth*. Seoul: Hak Ji Sa. (Korean)

Nam, Y. Y. (2008). Depression and Suicide among Christians. *Ministry and Theology. 234*, 224-229. (Korean)

Park, J. H. (2007). Korean Society and Suicide. *Ministry and Theology. 213*, 218-219. (Korean)

Shizco (2007). *Ethical & Theological Review and Pastoral Alternative of*

Suicide. Unpublished Master's Thesis, the Graduate School of Theology, Seogang University. (Korean)

Walter, J. (1993). Choose Life, Not Suicide. *Missions Today, 64-4,* 119.

White, J. L. (1989). *The Troubled Adolescent*. New York: Pergamon Press.

Wilkerson, D. (1973). *Suicide: A Killer is Stalking the Land*. Old Tappan: Spire Books.