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CONCEPTUAL ARTICLE

Assessing Suicide Risk in Christian Clinical Practice: Integrating Interpersonal Theory, SIGECAPS, and Faith-Based Care

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Abstract

This paper is intended to explore suicide risk assessment in Christian clinical practice using an integrative approach that integrates the Interpersonal Theory of Suicide by Thomas Joiner, a depression screening program called SIGECAPS, and the theological perspective of human suffering. It is based on a conceptual analysis and narrative review of the peer-reviewed literature published within the last five years, presenting the synthesis of the empirical evidence on perceived burdensomeness, thwarted belongingness, and acquired capability alongside the central themes of Christian theology, such as the imago Dei, communal responsibility, and hope amid despair. The needs of the survivors of suicide loss, the family members, and the members of the faith community are considered, and their grief might be impacted by trauma, guilt, or spiritual distress. The evidence indicates that religious identity and spiritual activities may serve as protective factors and risk factors, especially in cases when they are influenced by social invalidation, stigma, or the lack of theological meaning. Poor postvention assistance in faith communities could worsen the poor outcomes among suicidal bereaved persons. To counter this, this paper suggests a conceptual model where Christian mental health practitioners, pastors, chaplains, and ministry leaders join their efforts to combine clinical screening with spiritual practices that include prayer, Scripture engagement, and community accountability.

Keywords: *suicide risk assessment, Interpersonal Theory of Suicide, SIGECAPS, Christian theology, postvention, faith-based care.*

Statement of the Problem

Suicide is regarded as one of the most serious issues of public health in the United States and the world in general. It is also an existential crisis of meaning, identity, and spiritual conflict, which cannot be sufficiently explained with merely the aid of clinical instruments. To Christian clinicians, pastors, chaplains, and ministry heads, a body of knowledge that fuses psychological science and theological conviction is needed in assessing suicide risks. Without such an integration, the faith-based caregivers may prefer clinical evidence to spirituality or apply clinical instruments without taking into account the spiritual components of human life that influence the will to live.

A significant portion of the available literature addresses the concept of suicide risk assessment and Christian theology as two different fields. Journal articles concentrated on psychological constructs, and the theological works covering pastoral care give little concern to clinical screening instruments. By comparing the two fields (Thomas Joiner's Interpersonal Theory of Suicide and the SIGECAPS model of depression) and applying them to a Christian theological view of imago Dei, human suffering, hope, and social responsibility, this paper brings together these spheres. Also considered are survivors of suicide loss, but churches often have little to no training to serve them effectively.

This work is a conceptual paper and suggests a framework that can help the Christian caregiver to detect the risk factors of suicide related to cognitive, emotional, and behavioral symptoms; to interpret the symptoms in a manner that honors human dignity and hope, and to act in response to survivors of suicide loss in ways that are both clinically competent and spiritually sensitive. The model is conceived as a starting training, a tool in pastoral care curriculum, and as a guide in the process of clinical collaboration between churches and mental health services.

Method

The paper is a conceptual and narrative review. It summarizes results of peer-reviewed articles published in the past five years, and concentrates on three strands of literature: empirical tests of the Interpersonal Theory of Suicide, the issue of religion or spirituality as a risk factor in suicide, and the needs of suicide loss survivors. The literature review regarding depression assessment with the help of SIGECAPS was also reviewed to inform the clinical screening part of the model.

Sources were identified through targeted searches of PsycINFO, PubMed, and CINAHL for peer-reviewed articles published between 2021 and 2025. Search terms included combinations of "interpersonal theory of suicide," "perceived burdensomeness," "thwarted belongingness," "religion," "spirituality," "suicide bereavement," "postvention," and "SIGECAPS." Articles underwent inclusion criteria which included empirical results on the Interpersonal Theory of Suicide, religious or spiritual consequences of suicide risk, or survivors of suicide loss, and publication in English in a peer-reviewed psychiatry, psychology, or counseling journal. Articles were not included when the risk in non-human populations was discussed, when the article was not empirical or clinical in nature, or when it was not within the five-year range. It is not a comprehensive search and does not adhere to a systematic review guideline, like PRISMA. It is not aimed to find out the whole literature, but representative, recent empirical work to inform a conceptual model.

Being a conceptual paper, this work is a framework and not a test. Primarily, psychiatry, clinical psychology, and counseling journals were used as primary sources, and preference has been given to those studies that have been done in a faith-based clinical setting, when possible, to enable the review of patterns across adolescents, older adults, sexual minorities, and individuals who participated in spiritually integrated treatment programs.

The analysis goes through in three steps. The first one offers a summary of psychological constructs explaining suicidal desire and ability, and clinical signs of depression expressed through SIGECAPS. Second, it explains those constructs in the light of Christian theology. Third, it uses the two frameworks to the experience of survivors of suicide loss and provides realistic recommendations to ministry leaders and Christian mental health professionals.

Interpersonal Theory of Suicide

The Interpersonal Theory of Suicide by Thomas Joiner is used to explain suicidal desire and behavior in terms of three constructs (Van Orden et al., 2010). Perceived burdensomeness is a perceived liability within families and society. Thwarted belongingness is defined as a non-connection; that is, a lack of relationships that are mutually caring. When these two states are combined, they cause the development of suicidal desire, the desire to die in loneliness and blame oneself. The third construct, acquired capability, explains the change in desire into action. It evolves after exposure to pain, fear, or trauma numerous times and reduces the natural fear of death and enhances the acceptance of self-damage (Shim et al., 2021). Lack of learned ability seldom leads to a suicide attempt.

These constructs were tested in several populations during the last five years. Stressful life events were correlated with perceived burdensomeness in a clinical sample of adolescents in Spain, suggesting that stress does not in itself predict suicidal behaviors, but when combined with a sense of burden (Caro-Cañizares et al., 2023). Perceived burden, rather than thwarted belongingness, was a stronger predictor of suicidal ideation in older adults, meaning that one or another construct is more important than the other depending on the population (Shim et al., 2021). The same was also moderated by perceived burdensomeness, with the relationship between student engagement and suicidal behavior in schools differing across identity groups

(Western et al., 2024). These results are to show that risk is not a thing but rather a relative and situational phenomenon.

For Christian clinicians, these constructs offer a way to recognize risk that goes beyond surface-level symptoms. Someone who continually claims to be a burden to the family or one who secludes themselves from the community is articulating a well-known risk factor. The language is further enhanced by a theological system that deals with the burden, belonging, and the value of human life.

SIGECAPS and Clinical Depression Assessment

SIGECAPS is a medical abbreviation that is used to assess the needs of significant depressive disorder as stipulated in the Diagnostic and Statistical Manual of Mental Disorders. The acronym is sleep, loss of interest, guilt, low energy, poor concentration, decreased appetite, psychomotor agitation or retardation, and suicidal ideation. In order to diagnose major depressive disorder, a patient should possess at least five of the following symptoms within two weeks, or there should be both a depressed mood and loss of interest (Park et al., 2025). This is where the line that separates clinical and normal low moods is set.

This memory aid is commonly used in the context of primary care and community health in routine circumstances using standardized tests like the nine-item Patient Health Questionnaire (PHQ-9). The questionnaire will ask the respondent whether they have been having depressive symptoms in the last two weeks and will result in a score that reflects the potential severity of depression (Lu et al., 2024). This method offers a rapid means of assessing the urgency of the condition for individuals without specialized training. A PHQ-9 score indicates the likelihood and severity of depressive symptoms; it is a screening result, not a diagnosis, and elevated scores should prompt referral for full clinical evaluation.

SIGECAPS is an organized approach to determining when the plight of an individual has turned beyond the border of habitual sadness to a clinical pattern. Caregivers are expected to make such judgments of whether someone requires professional evaluation or not, even when they lack clinical training as Christians. As an illustration, once a congregant mentions that he has been experiencing poor sleep, he has lost interest in worship and fellowship, and he feels guilty all the time and is contemplating his death, the pastor is noticing one of the patterns that SIGECAPS is meant to identify. This acknowledgment does not substitute a referral to a mental health professional. Instead, it empowers ministry leaders to put such patterns into consideration, to be urgent, and to bridge the person with the clinical care without neglecting spiritual support.

SIGECAPS itself stops at symptom recognition and does not constitute a suicide risk assessment. Once the "S" for suicidality is flagged, or once any other warning sign appears, the caregiver has to shift into another and more in-your-face line of questioning. It involves asking a straightforward question, such as, " Is the individual thinking about killing themselves, have they a plan, do they have the tools to do it, and have they ever attempted a suicide in the past (Stanley & Brown, 2012). It also entails recognizing safeguarding variables, where the relations, faith commitments, or plans the individual can label in the future. A caregiver who stops at SIGECAPS and does not ask these direct questions has only completed half the task. The rest of this paper assumes that SIGECAPS is an access point into this larger process, but is not the process itself.

Table 1

SIGECAPS Criteria with Clinical and Pastoral Observations

Letter	Criterion	Clinical Description	Pastoral Observation
S	Sleep	Insomnia or hypersomnia nearly every day	Reports of not sleeping, sleeping all day, or appearing exhausted
I	Interest	Loss of interest or pleasure in most activities	Withdrawal from worship, fellowship, or activities once enjoyed
G	Guilt	Feelings of worthlessness or excessive guilt	Repeated statements of being a burden or unworthy of grace
E	Energy	Fatigue or loss of energy nearly every day	Difficulty completing daily tasks or attending services
C	Concentration	Diminished ability to think or concentrate	Trouble following conversations, prayer, or Scripture reading
A	Appetite	Significant change in appetite or weight	Noticeable weight change or comments about not eating
P	Psychomotor	Observable agitation or slowing	Restlessness or unusually slow speech and movement
S	Suicidality	Recurrent thoughts of death or suicide	Direct or indirect statements about wanting to die or disappear

Note. Pastoral observations listed here are warning signs that should prompt referral for professional evaluation. They are not diagnostic criteria and should not be used to diagnose depression.

Christian Theological Framework

Christian theology is a method of explaining the risks of suicide that can be applied together with clinical psychology. The first is the doctrine of the imago Dei, which states that every human being was created in the likeness of God and so has inherent dignity and worth. This instruction is directly opposed to perceived burdensomeness. A human being who was made in the image of God cannot, in the theological sense, be a burden,

because the existence of that person will be the testimony of the character and end of God.

The idea of thwarted belongingness has a spiritual counterpart in the concept of the church as the body of Christ, one that is a community of needy members who are interrelated and united to God. Although the Interpersonal Theory of Suicide acknowledges isolation as a risk factor, the Christian theology supplements the belonging of the members of the faith communities as a duty of the faith community. Failure by a church to play this role will expose the weak to the same loneliness that causes people to commit suicide.

The idea of suffering is very important in Christian thought, not to evade or advise against, but to have hope and bear. The Christian narrative does not ensure that one lives a pain-free life. Instead, it guarantees that God is present in suffering and that there is redemption outside suffering. This redemptive presence presents a counter-narrative to the despair, which the Interpersonal Theory of Suicide discerns as a precondition to suicidal desire.

Spiritual warfare is another theme. This language must be used with care. Considered properly, it describes the fact that despair and self-destructive thought are often weighed down more by the spiritual burden than is cleverly represented by the clinical terms, and it calls the community to pray, read Scripture, and be present. When put irresponsibly, this may imply that suicidal ideation is a consequence of individual sin or lack of faith, which further drives up shame and may make an individual unwilling to seek any help. The language of spiritual warfare in this paper is merely a supplement to clinical knowledge of the risk of suicide, never a substitute, and by no means a description that blames the suffering individual. This combined view is backed by recent research. Patients in an inpatient program that is spiritually integrated experienced low rates of depression and suicidal ideation. Individuals who were morally opposed to suicide and held beliefs related to coping with hardship had fewer symptoms, particularly when the beliefs were connected with a sense of spiritual transcendence and duty to God (Currier et al., 2025). Therefore, the theological belief does not exist as a separate phenomenon that can have a direct impact on clinical outcomes.

Lament and Nonjudgmental Presence

The practice of lament is also taught by Christian theology, the sincere endeavor of pain, bafflement, and even anger with God, without turning it into a comfortable nothingness. Lament allows an individual freedom to utter that life is unbearable without correcting, hurrying it along, or simply having to believe more. A caregiver permitting lamentation conveys that uncertainty and hopelessness do not put a person out of the community. This is important as shame is among the most apparent risk factors that have already been outlined in this paper, not just in suicidal desire, but also in the bereavement of the survivors of suicide loss. Any church that reacts to suicidal struggle or to suicide loss through correction, blame, or pressure to do faith is playing with a very dangerous isolating wave, as the Interpersonal Theory of Suicide recognizes. A nonjudgmental presence, a church that can sit with pain, instead of justifying this pain, is a counter-experience to the isolation (Mason et al., 2019). This is not a clinical intervention. It is a theological posture that should accompany, never substitute for, the clinical steps described elsewhere in this model.

Table 2

Interpersonal Theory of Suicide Constructs and Corresponding Christian Theological Themes

IPTS Construct	Clinical Description	Christian Theological Counterpoint	Supporting Evidence
Perceived Burdensomeness	Belief that one's existence is a liability to others	Imago Dei affirms inherent dignity and worth regardless of capacity	Mediates suicide risk following stressful life events (Caro-Cañizares et al., 2023)
Thwarted Belongingness	Lack of mutual, caring relationships	The church as a body calls members to mutual belonging and responsibility	Predicts ideation in some populations but not others (Shim et al., 2021)
Acquired Capability	Reduced fear of death through repeated exposure to pain or trauma	Hope and redemptive presence offer a counter-narrative to fearlessness about death	Religious identity weakens the link between fearlessness about death and ideation (Hart et al., 2024)

Findings

The literature reviewed indicates that there are a few intersections between the Interpersonal Theory of Suicide, SIGECAPS, and Christian theology.

Acquired capability and suicidal ideation have an intermediate relationship with religious identity. In one of the studies, fearlessness of death (a parameter of acquired capability) was correlated with increased suicidal ideation among non-religious patients but not among religious patients (Hart et al., 2024). Religious belief, therefore, can disrupt the process of suicidal desire to acquire the capability whereby a person has learned to be less fearful of death due to painful experiences.

Such perceived burdensomeness is alleviated by the strength of character attributes associated with the Christian practice. The relationship between meaning struggle and the risk of suicide among hospitalized adults in a Christian psychiatric hospital was mediated by gratitude and patience in response to adversity without the impact of depressive symptoms (Schnitker et al., 2021). This finding is associated with, though it does not prove, the theological claim that habits like gratitude, cultivated through prayer and worship, may offer some protective

benefit. The data are cross-sectional, so the direction of this relationship cannot be confirmed.

Both perceived burdensomeness and thwarted belongingness are related to social determinants and cultural context. A study of bipolar patients as outpatients discovered that socioeconomic disadvantage heightened the risk of suicide, implying the impact of financial strain and social disenfranchisement (Mulligan et al., 2025). An examination of Ghanaian youths showed that religiosity and traditional beliefs and suicide stigma augmented the elucidating ability of the Interpersonal Theory of Suicide, which is a view suggesting that religious belief comprises a cultural context within which risk is formed (Azasu et al., 2025). Risk cannot be singled out from the social world of existence in which an individual exists.

Both clinical and theological suicide prevention models are based on the involvement of family and community. The presence of collateral information collected by families and caregivers improves risk assessment, and approaches that involve family engagement through strength-based approaches can explicitly reduce risk (Edwards et al., 2021). This finding is consistent with the theological focus of the church as a community in which the members are responsible for each other. This task goes way beyond the Sunday worship service to the daily lives of the members. Rather, they act out of an integrated image whereby theological belief is one that influences the experience of psychological risk factors and how they are manifested and reacted to in real relationships and communities.

Suicide Loss Survivors

The needs of suicide loss survivors (family members, friends, and community members) are unique and unmet. Each suicide death directly affects dozens of people (Levi-Belz, 2023). This broad area of influence means that postvention is not an insignificant task for any community.

Suicide survivors face a risk of chronic emotional pain and inability to accept loss, followed by higher chances of depression and posttraumatic stress (Suicide loss survivors, 2025). The sense of guilt and shame is strong in this population. The Interpersonal Theory of Suicide was directly connected to the experience of a death by suicide in one of the studies that identified the mediation of the development of complicated grief and depression among survivors by suicide-related shame, where thwarted belongingness contributed (Levi-Belz, 2023). Therefore, a theory that is meant to answer the question of why an individual commits suicide can provide the answer to why the consequent grief is so excruciating.

Suicide aftermath social responses have a strong impact on the grief of survivors. The greatest predictor of long-term grief symptoms in survivors is social invalidation, the sense of being rejected, diminished, or stigmatized by other people. Conversely, a high level of meaning in life is linked to dejection and depression, having no relationships (Salom et al., 2025). This observation is very important to churches and communities of faith. A congregation that reacts to the loss of a loved one due to suicide with silence, condemnation, or religious cliches can exacerbate the consequences for survivors. Conversely, a congregation that provides presence, support, and aid in meaning-making leads to good health.

Although such needs exist, one of the significant problems is access to support. A national survey of suicide-bereaved found that the majority had never used support services and considered local bereavement services as insufficient, despite the loss having had a significant impact on the majority of the members surveyed (McDonnell et al., 2022). It is even demonstrated that short-term training of the people who contact the survivors of a suicide attempt, even those involved in organ procurement, can enhance their self-confidence and provide information on how to help the bereaved. Clergy and lay ministry leaders would also be helped by the same form of training since they are usually the first ones the survivor goes to after a loss (Tucker et al., 2021). One of the most viable things that a congregation can do is to close this training gap.

Practical Integration for Christian Caregivers

The model presented here requires Christian caregivers to integrate clinical screening and spiritual care rather than treating them as separate activities.

This integration depends on each caregiver staying within their training and role. Only licensed mental health professionals can fully complete a suicide risk formulation, clinically diagnose, and determine a course of treatment. This role is not supposed to be performed by pastors, chaplains, and leaders of lay ministries. Their opportunity lies in being able to be alert to warning signs, to ask direct and caring questions regarding suicidal ideation, and to act swiftly to refer the individual to professional help (Mason et al., 2018). The same is true in regard to confidentiality in these positions. A licensed clinician works in accordance with legal secrecy regulations and the safekeeping of a client who is at risk. A lay leader or pastor lacks the equivalent legal status and should never make any promises of complete confidentiality in the event that an individual shares suicidal ideations. In all positions, caregivers must simply explain to the individual that safety should come first, that the caregiver may have to call in other people, whether family or emergency services, and that it is an act of care and not betrayal.

In practice, a Christian pastor, chaplain, or lay counselor may refer to SIGECAPS to provide a glimpse into the signs and symptoms of depression, the Interpersonal Theory of Suicide to comprehend why an individual is at risk, and Christian theology to act in ways beyond sympathy. Once one of the congregants mentions that he/she feels like a burden, a caregiver with the knowledge of this model understands both the clinical and the theological counter-argument: the life of the person has inherent value as it is made in the image of God. Clinical treatment should be complemented by the spiritual

disciplines and not be substituted. With spiritual transcendence and moral conviction, the practices of prayer, working with Scriptures, and membership in a worshipping community relate to lower scores of depression and suicidal ideation in this sample, but do not prove that the practices caused the lower scores (Currier et al., 2025). These are best practices when provided concurrently with professional mental health services, and Christian care providers must be trained to make referrals when the symptoms are too intense to be considered normal. This integration is significant to the suicide loss survivors because churches need not only a theology of grief, but also knowledge of working postvention practices. A theology of grief allows the survivor to cry and live with unanswered questions about the death of their loved one.

Table 3

A Conceptual Model for Faith-Integrated Suicide Care Across Four Stages

Stage	Clinical Task	Theological Response	Caregiver Action	Survivor Support
Recognition	Use SIGECAPS to notice a pattern of depressive symptoms	Recognize language of burdensomeness and lost belonging as a spiritual signal, not just emotional distress	Ask direct, calm questions about suicidal thoughts without panic or avoidance	Watch for prolonged grief, withdrawal, shame, and guilt in bereaved individuals
Assessment	Evaluate all three IPTS constructs (perceived burdensomeness, thwarted belongingness, acquired capability)	Explore the person's sense of purpose, connection to God, and spiritual community.	Gather collateral information from family and trusted members of the community	Assess for complicated grief and social invalidation
Intervention	Conduct direct suicide-specific inquiry (thoughts, plan, intent, means, prior attempts), complete a safety plan, address lethal-means safety, and refer to a licensed mental health professional or emergency service when risk is present.	Offer prayer, Scripture, and communal accountability alongside professional care	Maintain pastoral presence throughout clinical treatment, not only before referral	Connect survivors to peer support groups and grief counseling resources
Postvention	Monitor for suicide contagion and secondary trauma in the wider community	Help the congregation process collective grief through lament, worship, and communal memory	Prepare the congregation in advance with clear language for responding to suicide loss	Validate grief without minimizing pain, and support meaning making over time

Conclusion

This paper has advanced a conceptual model that integrates Joiner's Interpersonal Theory of Suicide, the SIGECAPS framework for depression assessment, and core Christian theological themes, including the imago Dei, suffering, hope, and communal responsibility. By framing suicide risk assessment as both a clinical and spiritual endeavor, the model underscores the need to address psychological distress alongside theological meaning-making, particularly in the care of individuals and communities affected by suicide loss.

There are definite limits to this model. It is a synthesis of concepts rather than a protocol that has been empirically tested, and none of its elements have been tested as a unit intervention. The studies mentioned above are mostly correlational ones with different populations of study, and the conclusions made about gratitude, religiousness, or spiritual transcendence are to be interpreted as associations to be explored further rather than as evidence of a protective effect. It also highlights a Protestant evangelical framing of theology, and the model might not be directly applicable to other Christian traditions, as well as other religions. Readers should view the practical advice in this paper as a training and discussion starting point and not replace normal clinical risk assessment or empirical testing.

Future research is warranted to evaluate the effectiveness of integrative training models that combine evidence-based clinical screening tools with theological education for clergy and lay ministry leaders. Empirical studies should examine whether such training improves early detection, referral behaviors, and confidence in responding to suicide risk. Longitudinal research is needed to assess whether spiritual practices such as prayer, gratitude, and communal worship exert a causal and sustained protective effect against suicide risk, rather than merely demonstrating cross-sectional associations.

From a policy perspective, these findings highlight the critical role of faith communities as frontline responders in both suicide prevention and postvention. Given that individuals frequently turn to clergy during crises, faith-based organizations should be formally integrated into local and national suicide prevention frameworks. Strategic partnerships between mental health systems and religious institutions can facilitate bidirectional referral pathways, promote continuity of care, and reduce stigma associated with help-seeking. Policies that support training initiatives, resource sharing, and coordinated postvention efforts will strengthen both public health outcomes and community resilience.

This review yields several practical recommendations for ministry leaders. First, clergy and lay leaders should be equipped to recognize the language and indicators of perceived burdensomeness and thwarted belongingness within pastoral conversations, using these cues to guide further assessment and intervention. Second, ministries should establish proactive relationships with licensed mental health professionals, ensuring that clear referral networks are in place before crises occur. Third, congregations should be intentionally prepared to respond to suicide loss through presence, empathy, and validation rather than silence or avoidance, as communal responses significantly shape the trajectory of grief among survivors.

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