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Canada

RESOURCES FOR THE CHURCH IN THE PREVENTION OF SUICIDE

by

Robert Ian Cuthbertson

B. A., David Lipscomb College, 1965
M. Div., Mc Master Divinity College, 1993

THESIS

Submitted to the Faculty of Waterloo Lutheran Seminary in partial fufilment of he requirements for the degree of Master of Theology in Counselling.

1995

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ABSTRACT

This paper is an analysis of the history and signifcance of suicide in relation to the church and its mission to be "the salt of the earth". It will be an analysis of the types of suicide and its frequency in Canada. The paper will also review the resources, both literary and community, which are available for the minister. Interviews were conducted with ministers of various denominations, primarily in the Hamilton Region to determine the extent of their contact with suicidal situations. Possible reasons for the lack of interest on the part of the church in this issue are discussed.

The appendix also includes material from the Hamilton Council on Suicide Prevention which can be posted on church bulletin boards.

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CHAPTER 1: INTRODUCTION

Sir Winston Churchill once described Russia as "*an enigma wrapped inside a mystery*. This same description could equally apply to suicide. It is a strange, perplexing problem whose causes are still not fully understood, due to the many variables associated with such deaths. Although suicide rarely makes the news, it is not a rare phenomenon which touches only a few people and toccurs in a few isolated cases.

According to Health and Welfare Canada, in the /report Suicide in Canada, (1987), suicide is one of the highest causes of death in Canada. According to this report, the primary causes of "early death" - i.e. death between the ages of one and seventy - listed in order of highest frequency are: 1. motor vehicle accident; 2. ischemic heart disease; 3. all other accidents social and respiratory disease; 4. lung cancer; 5. suicide. The annual rate of death from suicide in Canada rose from 11.9 per 100,000 in 1970 to 15.1 per 100,000 in 1983. Expressed another way: 2,000,000 years of life were prematurely lost between

1963 and 1976. (Task Force, p. 4)(Also see accompanying statistical data in the appendix). Given this high rate of deaths due to suicide, it is interesting that suicide does not receive a high profile in the church. The Health and Welfare task force report on suicide considers ministers to be key people in the prevention of suicide. However, the actual experience of ministers with suicide is extremely low. They are more likely to be called upon to conduct a funeral service for a suicide than to be called in to intervene in a potential/attempted suicide.

I know from my own experience as a parish minister and in talking with other ministers that direct contact with a suicidal situation does not occur with a high degree of frequency within the local congregation. Since there is a low level of contact with suicidal situations, there is not a felt need for an awareness of resources to assist the minister in dealing with suicide. Thus, ministers may not be sufficiently informed about the high frequency of suicide as a cause of death. Therefore, they are not really aware of the numerous resources available. This lack of awareness

may also be due to:

> The Task Force's review of the core curriculum content of several schools of theology and ministerial training centres established that there was minimal concentration on education and training in the area of suicide. In general, exposure to the area of suicide and bereavement occurred either indirectly, through courses on the subject of death and dying, or through field placements where the student would be directly involved in aspects of suicide prevention. (Task Force, p. 42)

My own interest in suicide is the result of my work with telephone crisis lines. For the past twenty-four years, I have been involved with telephone crisis centres in Barrie and Hamilton. My involvement with these centres has been on several levels: 1. As a volunteer working on the phones, taking the crisis calls; 2. As a Resource Person the telephone worker is continuously backed up by a Resource Person (usually a minister) who can either handle a call which is beyond the worker's ability to handle or who can go out in person where the situation is drastic enough to require a personal visit; 3. As Director of the local centre and 4. as a member of the National Board.

Although suicide calls are the lowest in terms of

total volume of calls to the centres (the highest being loneliness), they are the most drastic in their impact upon the telephone volunteer. I have handled potential (Telecare classifies Suicide as Contemplated, Threatened and Attempted) suicide calls both on the phones as a volunteer and as a Resource Person called to deal in person with a potential suicide.

Many of the loneliness calls (numbering in the 100's each year) are desperation calls in which the caller feels that he/she has no-one who will listen to their story and so they turn as a last resort to the telephone crisis centre. Of those loneliness calls which are tinged with desperateness, many are on the verge of contemplating suicide. However, when an attempt is made to refer these callers to their minister, there is a strong reluctance on the part of the caller to have their minister involved. This is not so much a lack of trust as a feeling that they would be lowered in the esteem of the minister if they were to reveal their problem to him. In the attempted suicides with which I have dealt, although there was a church

connection of some sort, as with loneliness, there was a reluctance to communicate the severity of the problem with the local minister.

Thus, I have begun to speculate as to whether or not ministers are aware of the warning signs of potential suicide. Since there is a reluctance on the part of people to talk to their minister about their problems, the minister may have a pastoral visit and leave, unaware of the potential for suicide. If, however, the minister is aware of the warning signs of impending suicide, he/she would then be able to work with the parishioner to prevent the crisis from developing into a suicide attempt (which could be successful). Also, if the minister is aware of the resources in the community which could help the suicidal person, these additional resources could be tapped to provide the suicidal person with on-going support.

CHAPTER 2: THE THESIS.

Ministers are not generally aware of the warning signs of suicide nor of the resources which are available to them for the prevention of suicide. My hypothesis, based upon my experiences in dealing with suicides in all three categories, both on the phone and in person, is that ministers generally are not aware of the warning signs of suicide which could alert them to this danger and enable them to intervene while intervention is still possible.

I. The Purpose

The purpose of this research is to determine what resources are available for the minister in a local congregation for the prevention of suicide. Also, how can their level of awareness of these resources be increased?

II. The Research Question:

What are the most effective methods and resources

which ministers can use for the prevention of suicide?

III. The Field:

The field is that of Suicidology which deals with issues surrounding suicide such as prevention, intervention and postvention (i.e. Suicide Bereavement Groups).

IV. Entry into the Field

For the purposes of this paper, ministers in Hamilton, Toronto, Selkirk and Orangeville have been interviewed. Some of the ministers in Hamilton have been Resource Ministers for Telecare Hamilton and therefore are likely to have been called on to deal with a suicidal situation. (I was responsible, while director of Telecare Hamilton for recruiting the ministers who are on the Resource Panel and thus had personal contact with them). The other ministers in Hamilton, Selkirk and Toronto are known to me personally. I was able to interview the minister in Orangeville as the result of my covering letter of

introduction (see Appendix) and his interest in suicide prevention.

VII. Method of Research

The method of research would be primarily qualitative and hermeneutical. The hermeneutical aspect would deal with the history and background of suicide as well as an analysis of the resources which are available to the local minister. The qualitative aspect would be the interviews to determine how familiar local ministers are with the resources which are available to them for the prevention of suicide.

A semi-standardized system of questions will be used in these interviews. The primary questions (enclosed) will provide the basic information as to their level of knowledge of suicidal symptoms. The purpose of the questions which will result from their answers will be to further explore their level of interest. There will be two sets of questions: one for those who have dealt with an attempted or contemplated suicide and one for those who have never had to deal

with this particular issue.

VIII. Benefit to Ministers.

Through increasing their awareness of the resources available to them in the field of Suicidology, they will be better equipped to prevent possible suicides. Also, by increasing their awareness of the high degree of suicide as a cause of death, they may be prepared to have literature on the prevention of suicide (see appendix) available in their church literature racks.

CHAPTER 3: DEFINITION AND FREQUENCY OF SUICIDE

I. Definition

"There is only one truly serious philosophical problem, and that is suicide." Albert Camus, The Myth of Sisyphus (Handbook for the Caregiver on Suicide Prevention). Emile Durkheim (Suicide, 1897, p.44) defines suicide as follows: "*suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result.*" Durkheim (p. 45) further states that:

> ...suicides do not form, as might be thought, a wholly distinct group, an isolated class of monstrous phenomena, unrelated to other forms of conduct, but rather are related to them by a continous series of intermediate cases. They are merely the exaggurated form of common practices. ...They result from similar states of mind, since they entail mortal risks not unknown to the agent, and the prospect of these is no deterrent; the sole difference is a lesser chance of death.

A popular definition of suicide is that it is "*A permanent solution to a temporary problem*". Unfortunately, people in desperate situations still see suicide as the only

solution to their problems. Despite the efforts of organizations such as Suicide Councils to inform the public of the alternatives to suicide, and the ready availability of telephone crisis lines such as Telecare, and community agencies, people still commit suicide. (Health and Welfare in their 1987 report on suicide calculates that between 1963 and 1976, more than 2,000,000 years of life were lost to suicide).

II. Frequency

Suicide is one of the more difficult causes of death to classify. For example, is a single car accident in which the driver is killed, an accident or a suicide? Police investigating such an accident would most likely say that the driver lost control and crashed. "Elevated blood levels of alcohol are found in 40 percent of victims of fatal Traffic accidents. It is debatable as to how "accidental" these accidents really are." (Grollman, 1988, p.7). Thus, statistics on suicide gathered by agencies such as the Council on Suicide Prevention (Hamilton & District) do not include incidents which are classed as "accidental death" but

which in fact may be suicide. Accordingly, these statistics may be considered to be on the conservative side.

Even the high statistics reported by Health and Welfare Canada would be on the low side since suicide as a cause of death is under-reported. Only a minority of deaths come to a coroner for autopsy and coroners are perhaps reluctant to identify a death as suicide in order to minimize family distress. Research (Health & Welfare, 1987,) exploring suicidal ideation discovered that 13 per cent had seriously considered suicide; 4.5 per cent had engaged in deliberate self-harm (para suicide) and 4 per cent had actually attempted suicide. From 1990 to 1991, 13 persons per 100,000 committed suicide. With 3,500 completed suicides a year, Canada has one of the highest suicide rates. Of those who try to kill themselves, one in twenty-five succeeds. (University of Toronto, Health News, Vol. 11 Number 3). Since World War II, suicide has increased on a cumulative level, and research indicates that this increase may be correlated with factors such as: lack of strong family and social networks, economic declines

and unemployment (Health & Welfare).

III. RANGE

Suicide is not limited to Indian young people living in hopeless conditions on reserves or to people in jail. It can be found in every income level and at every age. As can be seen from the enclosed charts, suicide or attempts at suicide are not limited to particular segments of society. Although in terms of volume of calls in any given year (see attached tables for 1992 and 1993) it remains the smallest percentage of calls to a telephone distress line. These figures only represent the people who called out for help, they do not include others who, for one reason or another, do not try to reach out for help by this method.

The other difficulty in dealing with suicide is that of culture. For example, the Japanese *kamikaze* pilots during the Second World War considered it an honour to crash their planes on a ship of the enemy even though it meant their certain death. The same kind of thinking is exemplified by the Palestinian terrorist

who is prepared to die when he deliberately crashes a car filled with explosive. Another example is that of Holland where physician assisted suicide is considered to be anacceptable option. This also raises the ethical question as to whether or not a person has the right to take his/her own life when suffering from an incurable illness. Thus the social context in which a suicide or suicide attempt occurs must also be taken into consideration when thinking of prevention or intervention.

The trauma of suicide is not limited to the relatives and friends of the one who has committed suicide. It also includes the factors which have driven that person to this desperate solution to the problems of life. Thus, in dealing with suicide and the trauma associated with it, not only the after effects of suicide must be examined, but also the events leading up to that attempt. Since suicide is an action and not an illness, determining the particular chain of events which may trigger a suicidal action is difficult. The causes are many and varied and determining the best method of prevention is difficult. Although suicide

awareness may be said to be everybody's business, it is particularly that of the caring professions such as the church. The task force on suicide refers to clergy, police, custodial officers and school personel as "gatekeepers", suggesting that these professions are in a position to help suicidal persons (Task Force p. 42). The prevention of suicide begins with an awareness of the popular myths concerning suicide.

IV. Prevention

A. Myths

Suicidal symptoms are a cry for help by a person who is feeling overwhelmed by the trauma of life and is looking for help to enable him/her to resolve the trauma. Unfortunately, these cries for help are often not heard because they are misconstrued as not being valid signs of suicidal thoughts. One of the difficulties in preventing suicides is the existence of myths which can hinder intervention. Shamoo (1990) describes some of these myths and the counterbalancing facts:

MYTH	FACT
People who talk about suicide don't do it.	People who *do* talk about suicide *do* kill them-selves. Talk of suicide, of not wanting to go on anymore, of despair, and of hopeless-ness are cries for help. These

	are signals which should be taken seriously.
Suicidal people are fully intent on dying.	There is an ambivalence about dying. People need to end the pain, but there is always the wish that someone or something will remove the pain so that life can continue.
People only need to look on the bright side of life to feel better.	For those who are thinking of suicide, it is difficult, if not impossible, to see the bright side of life. To acknowledge that there is a bright side confirms and conveys the message that they have failed; otherwise their life, too, could have a bright

	side.
People who make suicide attempts are only looking for attention.	It is true that such people are looking for some attention, but they are also looking for a way to ease the pain, for someone to hear their cries for help.
People who attempt suicide are mentally ill.	People who attempt suicide are stressed beyond their coping abilities. They aren't necessarily mentally ill. Depressed, yes; stressed, yes; but rarely mentally ill.
Talking about suicide puts the thought into people's heads.	If the clues are being broadcast, talking about suicide won't put the thought there. It is

there already. Talking about suicide removes people's fears that they are crazy and alone, and also takes away the guilt for thinking that way.

Children don't know how to kill themselves.

Children do know how to hurt and/or kill themselves. Television provides the model, means, and methods. Significant others in a child's life may also provide the model of suicide as a way of solving a problem.

Parents are responsible if their child attempts suicide.

Parents do the best they can with the information and coping skills they have. There is often denial and disbelief

because the thought of suicide is so frightening. Also, some parents are too fragile, emotionally and psychologically to meet their children's needs.

Once people contemplate or attempt suicide, they must be considered suicidal for the rest of their lives.

When the crisis is over and the problems leading to suicidal thoughts are resolved, suicidal ideation usually ceases. It is possible, however, that suicide will still be a subdued option for individual, but as long as coping skills are adequate, it is not acted on. When coping skills fail, suicide again may become a strong option.

B. Symptoms

In many cases, warning signs are evident. If people are aware of these danger signs of potential suicide, friends and relatives can intervene to prevent a suicide. The earliest known compilation of symptoms is found in an 1637 work by an English country gentleman John Sym, entitled *Lifes Preservatives Against Self-Killing*. He listed the symptoms as:

> "gastly lookes, wilde frights and flaights, nestling and restlesse behaviour, a mindlessnesse and close dumpishnesse, both in company and in good imployments; a distracted countenance and carriage; speaking and talking to, and with themselves about that fact, and their motives to it, in a perplexed disturbed manner, with the like." (Colt, 1991).

According to the Council on Suicide Prevention (Hamilton & District), in a 1993 brochure: Suicide! My Friend At School, some of the warning signals of potential suicide are:

1. Depression
2. Mood Changes
3. Extreme changes in attitudes and ideas

4. Talking about suicide
5. Writing about death
6. Drawing pictures involving death
7. Loss of interest in well liked activities
8. Change in habits
9. Change in appearance
10. Eating habits change

Other warning signs which may lead to suicidal thinking are described on the following page from the Hamilton Council for the Prevention of Suicide:

SOME CONTRIBUTING FACTORS FOR SUICIDAL THOUGHTS

Break-up of a relationship

Death of a loved one

Family problems

Loss of a loved one

Low self esteem

Peer pressures

Serious Illness

Suicide of an acquaintance, friend, or relative

Work, home, or school pressures

Suicide Prevention Coalition, 1995

For more information call
the Council On Suicide Prevention (Hamilton & District) Inc. (905) 388-0933

C. Causes

"Knowledge of the various sociological factors associated with suicide may be helpful in evaluating the risks for the individual." (Grollman, p.35) In 1897, in a work entitled **SUICIDE A STUDY IN SOCIOLOGY** the author, Emile Durkheim (trans. by John A. Spaulding and George Simpson, 1951) analyzed European suicide statistics and suggested that every suicide could be classified as one of three types: altruistic, anomic, or egoistic according to its social context. An egoistic suicide occurs when an individual is left to his own resources; an altruistic suicide occurs when a society has too strong a hold on certain individuals who sacrifice their own lives; an anomic suicide occurs when a person's life changes so abruptly he is unable to cope (Colt, 1991). Further research has modified Durkheim's work, and although his categories do not cover every type of suicide, they do provide a useful tool for the analysis of probable causes of suicides.

I. Social/Religous Causes (The Altruistic Suicide) (Durkheim, p. 217)

Examples of altruistic suicide are the Indian suttee, Japanese *seppuku*, the aged Eskimo who walks off into the snow rather than burden his community and the Palestinian terrorists who served as human bombs in the eighties. A more recent example is the nineteen year old Palestinian who blew himself up with a car bomb at a bus stop in northern Israel, killing seven people in addition to himself and wounding forty-five people, many of them Israeli high school students. Responsibility for the attack was claimed by Hamas, the Islamic Resistance Movement, saying it was in retaliation for the Jewish settler's Feb. 25 massacre of some thirty Muslim worshippers at a Hebron temple. (Hamilton Spectator, Thurs. Apr. 12, 1994, p. A12).

Examples of religously motivated suicides where the death of the religous leader includes the death of his followers are the deaths of the 912 followers of Jimmy Jones who swallowed cyanide laced Kool Aid in 1978, and the Waco debacle in 1993 where the followers of Koresh

died in the deliberately set fire which destroyed his buildings. In these instances, it means the majority of the followers are so enamoured of their religous leader that they are prepared to follow him into death, even if it means the death of their children.

II. Emotional Causes (The Anomic Suicide) (Durkheim, p. 241)

Although factors such as unemployment or financial concerns are reasons for these suicides, there are other contributing causes such as marital breakup or highly stressful jobs. Suicide among the elderly may also have an emotional base such as loneliness, loss of a loved one, abuse from others, low self-worth, living in an institution and uprooting/moving. (Suicide Council, Suicide Among the Aged, 1994). For teenagers, emotional problems such as the breakup of a relationship, low marks, low self-esteem, and problems at home such as alcohol or drug abuse or parental role failure (violence, abuse) can lead to depression and suicide. (Lester, 1993).

Marriage separation produces a sense of loss "of

what has been the central means of bringing meaning and order to life". (Handbook) The resultant sense of failure and low self-esteem, the possible lowering of standard of living, the difficulty of establishing new relationships are all significant life events which can have a direct bearing upon a person's mental health.

III. Illness (Egoistic) (Durkeheim, p. 152)

This category of suicide is one which is predominately found in elderly people where the quality of life has deteriorated. This is particularly true of couple suicides. These couples feel that their physical health has deteriorated to "...the point our lives [is] so pathetically poor we no longer wish to live." (Wickett, p. 130) According to Wickett's research, in the period from 1920 to 1987, double suicides, i.e. both husband and wife mutually agree to commit suicide together, are steadily increasing (Wickett, p. 125). According to Wickett, the precipitating factors in these deaths were the fear of prolonged institutionalization and pain of separation. (Wickett, p. 135).

The increase in this category also may be due to the increased use of "Living Wills" and readily available narcotics which may be stocked and used to produce a painless death. In cases such as these, intervention is not possible since the couple usually have been planning this double suicide for some time and have made sure that there is no possibility of someone intervening at the last minute.

Recently, there have been cases such as that of Sue Rodriguez in British Columbia where a debilitating disease has been the major factor in deciding to commit suicide. The other major disease which cuts across all age lines is that of AIDS. Some who have contracted the disease have chosen to commit suicide rather than wait for the disease to finally destroy their body. "A study of AIDS patients in New York City, one of the few systematic studies of suicide and AIDS, found that AIDS patients are thirty-six times more likely to kill themselves than other men aged twenty to fifty-nine, and sixty-six times more likely than the general population." (Colt, 1991).

CHAPTER 4: THE CHURCH AND SUICIDE

The recent desperate search for survivors in the bombed rubble of the Oklahoma city office building and in the earthquake ruins on the Russian island indicate the value which we place upon human life. Even now, some fifty years after the close of the Nazi death camps, society still seeks to bring to justice those responsible for the deaths in those camps. We feel that all human life is worth preserving, that it is not something which can be regarded as so cheap that it can simply be thrown away. Dante considered life to be so valuable that he placed those who take their own lives on the seventh level of hell below the greedy and the murderous.

The church has had as a basic tenet a firm belief in the sanctity of life: that man is not the ultimate guardian of his soul. "He is only a faithful and watchful custodian of it, and has to give an account of his guardianship to God." (Blazquez, p. 63). Thus, since we have not come into life of our own volition,

but as a gift from God, we are stewards of our lives, not the owners. As stewards then, we are responsible for not simply abandoning our lives when we hit the low spots.

Although death is an inevitable part of human life, death has, for the Christian, a divine aspect. "For the Christian then, death signifies the ultimate helplessness of man before God and his ultimate dependence on God. His faith bids him wait upon God in patience and hope...Quite clearly, suicide might in certain instances be the expression of a refusal to trust in God, an embracing of death for its own sake, a form of self-justification, a desertion to the enemy. A final act of despair is substituted for a waiting in hope." (Baelz, p. 82).

Scripture has very little to say directly on the topic of suicide. There are only seven suicides recorded in the Bible, and these events are related without comment: Samson prayed: "...please strengthen me just once more, and let me with one blow get revenge on the Philestines for my two eyes." (vs. 28). "Samson

said, "Let me die with the Philestines!" Then he pushed with all his might, and down came the temple on the rulers and all the people in it." (Judges 16:28,30); King Saul took his own sword and fell on it rather than be captured by his enemies: "...so Saul took his own sword and fell on it (1 Samuel 31:4); "When the armor-bearer saw that Saul was dead, he too fell on his sword and died with him." (1 Samuel 31:5); "Ahithophel ... put his house in order and then hanged himself". (2 Samuel 17:23); "When Zimri saw that the city was taken, he went into the citadel of the royal palace and set the palace on fire around him". (1 Kings 16:18); "So Judas...went away and hanged himself." (Matthew 27:5).

In the early days of the church, many of its members were martyred at the hands of the Romans, and the church was alarmed at what appeared to be an active seeking out of martyrdom. Augustine, the Bishop of Hippo, argued that life is a gift from God and therefore should not be destroyed. He did not consider suicide to be justified under any circumstances. This led to the concept that suicide is an unpardonable sin.

Therefore anyone who commits suicide will be eternally dammed. (Blackburn, p. 29). Similarly, Thomas Aquinas wrote, "To bring death upon oneself in order to escape the other afflictions of this life is to adopt a greater evil in order to avoid a lesser...". (Hazelip, p. 7).

Although the sixth commandment: "You shall not murder" (Exodus 20:13) is understood to prohibit the taking of someone else's life, since humanity is made in God's image (Genesis 6). However, it is also understood to include a prohibition against the taking of one's own life. A seventeenth century commentary on this commandment said, "The sixth commandment forbiddeth the taking away of our own life, or the life of our neighbour unjustly, or whatsoever tendeth thereto". (Hazelip, p. 6). Similarly, in the twentieth century, Deitrich Bonhoeffer, the German theologian martyred by the Nazis said: "God has reserved to himself the right to determine the end of life, because he alone knows the goal to which it is his will to lead it." and "Even if a person's earthly life has become a torment for him, he must commit it intact to God's

hands from which it came." (Hazelip, p.7).

Another early Christian writer, St. Thomas, argued that life is a gift from God, and God alone can deal in life and death. Therefore, anyone who deliberately takes his own life sins against God. He believed that death is the last and greatest evil that man suffer, thus committing suicide is to commit an act of evil. Since man's life is dependent upon God, he does not have the moral freedom to dispose of it as he chooses. (Pohier and Meith, p. 69).

The prohibition against suicide by the early church is also seen in decisions of early church councils: The council of Guadix (305) excluded from the ranks of martyrs all those who took their own lives; the Council of Carthage (348) condemned pseudo-martyrs; the Council of Braga (563) excluded those who killed themselves from liturgical intercession and were to be taken to burial without the solemnity of psalm-singing. In 806, Pope Nicholas I ruled that suicides must be buried without the liturgical ceremonial usual in the offices for the dead and mass was not to be said. (Blasquez, p.

71).

In 1917, the Codex forbid ecclesiastical burial to all those who consciously and deliberately attempt to take their own life. The Codex also implied suppression of the requiem mass and mass on the anniversary of the death. However, the Codex of 1983 entrusts the question of possible denial of ecclesiastical burial to suicides to the decision of the bishop who will "... decide whether or not to refuse such burial in such a way as to make a public judgement on the act of suicide, which is always objectively to be condemned, while at the same time displaying the maximum of Christian Charity toward and understanding of human weakness." (Blasquez, p. 73).

The sanctity of life in the sixth commandment: "You shall not murder" (Deut. 5:17) is reinforced by Jesus in Matthew 19:18: "Do not murder". The International Standard Bible Encyclopedia in its analysis of the Biblical word "murder" defines its meaning as that of murder of another person. The Biblical context of the frequent use of the word "murder" or "kill" is thus

generally taken to mean a prohibition against killing someone else. However, although the specific textual context is that of the "murder" of another person, given the Hebrew respect for the sanctity of life and Jesus' commands to "love one another" (John 15:12), the prohibition of "self murder" as a basic tenet of the church would still be valid.

Jesus in his final prayer for his disciples in John 17:26 expresses the thought that "... the love you have for me may be in them and that I myself may be in them." Also, 1 Cor. 6:19 points out that our body is "...a temple of the Holy Spirit who is in you whom you have received from God? You are not your own; You were bought at a price. Therefore honour God with your body." Thus there is a strong scriptural base for not committing suicide.

Scripturally, we also have the example of Job who refused to "...curse God and die." (Job 2:9). There were times when he wished he had never been born and he cursed the day of his birth: "Let its stars turn dark before dawn. Let it hope for light and receive none.

Let it not see the first light of dawn because it did not shut the doors of the womb from which I came or hide my eyes from trouble(Job 3:9-10). He went on to ask in vs. 11: "Why didn't I die as soon as I was born?" In spite of these gloomy thoughts, Job wanted to debate with God, not decide to take his own life.

Although the Christian can echo with Paul, " O death where is your victory, O grave where is your sting" this is not a justification for suicide. Rather, the Christian looks to the book of Hebrews and the inspiration of Jesus who "for the joy set before him endured the cross." Jesus endured torture and painful death, but the end of his life was in God's hands, not his own.

Paul writes in Romans 6 that "...we know that our old self was crucified with him, so that the body of sin might be done away with, that we should no longer be slaves to sin...". If this is a valid statement, then there is no cause for a Christian to commit "self-murder" (suicide). Suicide could then be classified as a sinful act, but to do so is merely to stigmatize the

person without seeking to understand the circumstances which led to such drastic action. It is acting like Job's friend, Eliphaz, who implicitly accuses him of wrong doing: "Blessed is the man whom God corrects; so do not despise the discipline of the Almighty." (Job 5: 17).

Joni Eareckson Tada, in her book, WHEN IS IT RIGHT TO DIE?, describes her feelings of hopelessness after her accident left her paralyzed. On the first day of her honeymoon, she wondered if Ken really knew what he was getting into - marrying someone who was paralyzed: "A provoking thought. A strong inclination. An inducement, an enticement to give in and give up. A crazy idea that settles in and begins to sound pleasing and plausible. Thoughts leading to death begin that way." (Eareckson, p. 96).

She goes on to say:

> The tempter. Murderer from the beginning. Father of lies. The devil's goal is to destroy your life, either by making your existence a living nightmare, or by pushing you into an early grave. Take heed: If you have ever been enticed to prematurely end your life, then you've been listening not just to something but

someone. (p. 97).

Joni has not found life to be easy - living for twenty-five years in a wheel chair. There have been times, such as that in 1991 when pressure sores forced her to bed for three weeks. She longed to be healed of the sores and free from the confines of the bed (p. 26). However, even though depressed and toying with suicidal thoughts, her faith in God kept her from giving up: "Right now it (your banged up bruised body) screams for your attention, but if you place your trust in Christ, it will one day take a backseat." (p. 179).

Harold Hazelip, in his article, God - Given Life in the magazine Up Reach quotes Paul Ramsey, a teacher of ethics at Princeton:

> So also religous faith affirms that life is a trust. And not to accept life as a trust, to abandon our trusteeship, evidences a denial that God is trustworthy, or at least some doubt that he knew what he was doing when he called us by our own proper names and trusted us with life. We are stewards and not owners of our lives.
>
> Or again, if as Christians we believe that death is the "last enemy" that shall be destroyed, then to choose death for its own sake would be a desertion to the enemy and a

> kind of distrust in the Lord of Life, the Lord over the death of death. (Hazelip, p. 11).

There is a shift in theological thinking from simply regarding suicide as "sin" to seeking to understand the forces which have driven this person to suicide and to helping the survivors cope with their grief. Examples of people such as Joni Eareckson Tada inspire us because: "they have had the strength to overcome immense obstacles and because they have been helped to do so, inasmuch as faith assures us that God is close to all human life and that it has value in his eyes at least, persuades us not to assert too easily that any existence (one's own or *a fortiori* that of another which is to be abandoned when it meets with a setback) is lost, 'because it does not have and no longer will have any meaning' " (Jossua, p. 86).

The challenge which the church faces today is to develop a theology which deals effectively with the problem of euthanasia. Should the "plug be pulled" simply because a person is old and physically weak? Medical science today has the ability to prolong the existence of the physical body. Can the church condone

the stance of the Hemlock Society which describes in detail now to take one's own life painlessly? Can it condone the actions of a doctor who actively assists people to take their own lives?

The church has always held that life is a sacred trust from God. God as Christ suffered on the Cross to give solidarity to his love for humanity. Christ's suffering gives meaning to suffering, that "...this suffering with all misery which God established in Christ transcends that misery with a promise which is certainly inconceivable, but by no means ludicrous." (Jossua, p. 89). Thus, suicide is not considered to be a viable option for the Christian. The task of the church today is to provide people with meaning in their lives and the spiritual resources which will enable them to adequately cope with life's struggles.

CHAPTER 5: POSTVENTION

"The word *postvention* comes from the Latin *post* meaning "after," "subsequent," or "later," and the Latin word *venire* (to come)." (Grollman, p. 88) It is the process of assisting the family and friends *after* the death of a loved one through suicide. It's purpose is to help the grieving, and it is important that the survivors of suicide understand that it is natural and normal to grieve.

Death is not a comfortable topic under the best of situations, and death by suicide is even more difficult, particularly when it occurs within the context of a church situation. Given the fact that suicide is the fifth highest cause of death in Canada, it is likely that the church will be involved with survivors of suicide. The church, as the physical body of Christ must, therefor, be prepared to minister to the survivors of suicide.

The effects or consequences of suicide do not end

with the death of the individual. Rather, the suicidal death will affect close friends and relatives who will have difficulty in accepting this "unnatural death". The "suicide" of a soldier who throws himself upon a grenade to save the lives of others can be accepted as an heroic action. Although his death will result in grief by his loved ones, it is a grief which is tempered by the "heroic" method of his death. However, in the case of a suicide, this tempering or "justification" is not available, and the survivors have a greater degree of trauma.

Survivors of suicide, in addition to their natural feelings of grief at the loss of a loved one, must also deal with feelings of rejection, failure and guilt. One woman, whose daughter killed herself said of her feelings: "You think if you had been kinder, better, loved more, listened more carefully, she wouldn't have died...In no other death do people say, 'Oh, that poor family, They must feel terribly guilty.' We don't make this assumption with other deaths." (Robinson, p. 62). "No other death creates such a backlash of guilt, remorse and shame." (Schneidman, p. 547).

When the death is that of a suicide, in addition to the feelings of guilt there are initial emotions of anger which are often suppressed. Unless this anger and grief is resolved immediately after the incident, it will simply surface later under circumstances where there is no-one to help with the grief process. As Schneidman points out (p. 153) suicide leaves a skeleton in the survivor's psychological closets, and may leave lasting emotional scars.

Suicide creates problems such as the meaning of existence and the value of life. The survivor wonders what role he had in the suicide and tries to evaluate events prior to the death, wondering where he went wrong and what could he have done to prevent the death. "Guilt does not originate in "objective" situations. but in the perception of the individual...The crucial element in determining whether a person will experience guilt is not what he did but how he perceives what he did, how he perceives or defines his role in the event." (Henslin, p. 219).

In addition to guilt, there is often the feeling

of anger which may go in different directions. It may be directed at the deceased for not having accepted help or towards other people who may appear to be insensitive to the pain the mourner is experiencing, or towards God and the clergy. Hinrichs says of his own anger: "Some of the anger I felt was directed toward myself because I felt I had failed to be the kind of father I should have been for my daughter." (Hinrichs, p. 114).

Fortunately, the church today no longer regards suicide as a sin and recognizes the need to reach out and heal the survivors. "I would counsel anyone the same as with any other bereavement...I would emphasize that the person was under stress and strain and that his motives are left to God," adds Sister Jane Francis. (Robinson, p. 65). Hinrich has found that directing people to the Psalms has been particularly useful in helping people to acknowledge and express their anger to God. "It can be a relief to discover that the psalmists were able to lash out at God in the context of prayer, and that he listened and accepted when they communicated". (Hinrichs, p. 116).

The death of a teen is particularly traumatic as society assumes that the family was disturbed, and the parents are at fault. Thus the stigma of suicide can produce extreme feelings of guilt in the family along with the other symptoms such as disbelief and denial. The survivors of the suicide may have auditory and visual hallucinations involving the deceased. (Hinrichs, p. 111).

Postvention is particularly important with the suicide of an adolescent. Typically, the adolescent has had as close a relationship with his peer group as with his friends. Postvention must take place as soon as possible with these friends to enable them to understand their feelings, to get a dialogue going to prevent possible idealization and romanticization of the suicidal act which might produce what has been called "the cluster effect" where one adolescent suicide is soon followed by several others. (Lukas, p. 180).

A typical reaction of a surviving parent is that of Elizabeth. Elizabeth's adopted son, Charlie, killed

himself by Carbon Monoxide poisoning. Elizabeth, in her effort to deal with his death became a robot, working as much as possible because she couldn't face coming home to the memories. She overate, gaining eighty pounds as a punishment for not somehow preventing Charles' death. She even reached the point where she slashed her own arm a few months after Charles' death. She stood there, an operating room nurse, watching her arm bleed, saying to herself, "So what if I die. Its fine." Then she decided that she *didn't* want to die and put a tourniquet on. (Lukas, p. 127).

Although Elizabeth went to pastoral counselling for a year and half, she still hadn't come to terms with her loss and was still working too hard. Fortunately, her supervisor insisted she call her counsellor, and between that and the survivors support group, she now wants "To help people who have been through this." (Lukas, p. 130).

Her experience as well as other cases which have been documented, indicate the importance of having a support group or groups to which the survivor can turn

for help. The survivor needs the help of others to become unstuck by being a part of a group in which the survivor is a participant, not an observer and by responding instead of reacting. The purpose and goal of a typical suicide support group is:

> To provide a **safe** and **confidential** place for the giving and receiving of support.
>
> The goal of the group is that people bereaved by suicide will have the opportunity to heal from their loss by learning and sharing together. (Mental Health, Suicide Bereavement Support Group [Hamilton Wentworth])

These groups are a part of the healing process which needs to take place in the bereavement process. The healing which takes place in these groups is the result "...of sharing experiences with people who will understand these experiences and be sympathetic." (Lukas, p. 158). Postvention involves not only self-help groups, but also a recognition on the part of the bereaved that:

> Past failures need not doom a person forever. The willingness to build the temple of tomorrow's dreams on the grave of yesterday's bitterness is the greatest evidence of the unquenchable spirit that

> fires the soul of humankind. ...Suicide victims can't expect to forget, but with time they will be better able to cope. (Grollman, p. 104)

Survivors of suicide are not only family members. They may also include friends (peers), counsellors and therapists. All of them need to grieve. As Earl Grollman says, "Grief is an emotion, not a disease. It is as natural as crying when you are hurt, eating when you are hungry, and sleeping when you are weary." (Grollman, p. 90). What is even more important is that help be available, not just immediately after the funeral, but also on the anniversary of the event.

The Jewish tradition of seven days of intense mourning when the family members don't leave the house, but people come to them is of great help. The survivors don't have any idea of what is expected of them, and the family members are comforted because nothing is expected of them. For the next thirty days, the grieving is not as intense, but the family is still free not to do anything. Then, at the end of a year, the ceremony to dedicate the tombstone takes place. (Robinson, p.69). This extended period of formal mourning provides the family with the means, not only

of openly expressing their grief but also in coming to terms with the loss.

Death of a loved one, especially when it is a sudden, unexpected death is often a traumatic experience. In the case of death by suicide, the trauma is often increased by feelings of guilt on the part of surviving relatives. The minister needs to be aware that the person may confess to lesser crimes and not speak of his real guilt feelings. The person may feel that he in some way caused the death or feels that he is a failure because of his spouse's death. (Stone, p. 94).

The minister can be particularly effective in helping the survivor deal with guilt by helping the survivor to accept forgiveness and absolution by confessing their guilt. In some cases Stone (p. 94) suggests that some form of amendment of life: "The individual, after evaluating his relationship with the deceased, makes a commitment to act differently and acts upon his commitment." (Stone, p. 95).

> With regard to the availability of God's forgiveness for the guilt-ridden person, I believe God's love is present simply in another person listening and accepting. God, too, is suffering along with the guilt-ridden person. A person needs to go through a feeling before being able to get beyond it. This journey can be facilitated by the caring presence of an understanding listener as a manifestation of God's caring and love. (Hinrichs, p. 114)

Confession as such, is not the sole perogative of the Catholic church. It is a crucial tool for any minister involved in pastoral counselling, particularly when dealing with a survivor of a suicide. The value of confession is that it re-directs the person's feelings into healthier channels that produce greater self-esteem. Confession to a minister who listens non-judgementally will enable the client to accept himself more fully. (Stone, p. 94).

For the survivors of suicide, accepting the sudden, unexpected death of a loved one for no apparent reason can lead to feelings of suicide in themselves. Survivors feel depressed, helpless, unloved, angry, lonely, and abandoned. (Lukas, p. 138). These people need the help of someone who will do more than just say, "I'm sorry". They need help in putting the pieces of their lives back together again, to sort

out their feelings, to recognize that their feelings, including suicidal thoughts are normal and to move on.

Postvention is available in the community to help the survivors of suicide through self-help groups such as the Suicide Bereavement Support Group (Hamilton Wentworth), community agencies such as the Burlington Bereavement Council and other agencies. Although these particular resources are specific to the Hamilton-Wentworth Region, their counterparts exist in other cities.

For the survivors of such a tragedy, the church or synagogue can provide a source of comfort and reassurance as they try to arrive at a method of not only accepting the suicide, but of living in spite of the loss. Particularly in the funeral, the "uniqueness and authenticity of each life needs to be understood, and encompassed by the eulogy". (Rabbi Marx, p. 125). The church in the person of the minister must be non-judgemental, supportive and nurturing. They must be acutely aware of the natural tendency to blame God in the person of the minister since he is close at hand

and visible. The minister should also encourage the creation of rituals which can help provide a healthy forum for people to remember their dead. (Rubey, p. 130).

Although support groups such as those mentioned above provide a useful resource for the survivors of a suicide, they must not be considered to take the place of the church in supporting the bereaved. As Father Rubey states:

> We as clergy are called upon to play a variety of roles as our parishioners journey through the grieving process. We must be supportive and nurturing, helpful in the creation of rituals, and loyal guides. We can perform a service if we have a realistic and honest approach to the grief experience. Though we act as the caretakers of people's lives, this in no way implies that we must be a shield or protective force for them. Certain events are devastating, and suicide is only one of these experiences. We have a golden opportunity to hold the hands of the survivors and guide them through this painful time. (Rubey, p. 133).

CHAPTER 6: RESOURCES

I. Basic Literary Resources

Given the low incidence of involvement in suicide in the congregations, obviously a minister would not want to spend a great deal of money just to have books which he might never read occupying space on his shelves. One minister who was interviewewd was not interested in literature on suicide since it would just gather dust in his files. His reaction was on the extreme side - the other ministers interviewed were interested in learning more about the issue of suicide prevention.

However, if the church is to become more aware of the frequency of death by suicide, then it has to have some information which will enable it to be more active in the prevention of suicide. The following pamphlets are readily available through the Hamilton Council for the Prevention of Suicide and present relevant information in an easy to read format. These are ideal

for placement in a church literature rack where they can be quickly browsed through. Often, friends and acquaintances of a potential suicide see the warning signs, but since they don't recognize the signs, they don't take the steps which could result in its prevention.

Suicide Assessment Pamphlet, The Council on Suicide Prevention, Hamilton & District, Inc. This pamphlet, as are the others in the series (Suicide and the young Person; Suicide and Depression; Suicide! Intervention and Management) are designed as supplements to the Council's Handbook. The format of these pamphlets makes them easy to read. Each page has the pertinent information placed in boxes or within a border, with the chapter title and sub-headings in bold print at the top of the page.

The cost of these bound packages is reasonable ($10.00 and $15.00) and they provide a quick summary of pertinent information relating to the topic of the particular pamphlet. Some of the chapters and sub-headings in these pamphlets are:

A. Suicide Assessment:

ASSESSMENT! WHAT IT IS

ASSESSMENT! WHAT IT DOES

CLUES TO SUICIDE

WHAT ARE SOME OF THE RISK FACTORS?

B. Suicide and the Young Person:

WHO IS A CAREGIVER?

DON'T PANIC !

SOME CAUSES OF SUICIDAL THOUGHTS

C. Suicide and Depression:

DEPRESSION IN THE ELDERLY:

Some Factors Contributing to Depression

Losses

DEPRESSION AND RELIGION:

Religous People Also Have Problems

Factors Which Prevent Getting Help

FEELINGS OF DEPRESSED PERSONS

These pamphlets are an excellent resource for the minister in enabling him/her to quickly review the danger signs of possible suicidal thoughts. The pamphlet on Suicide and the Young Person is a useful resource, not only for a youth minister, but also for anyone working with young people. I have found this particular pamphlet useful in presentations on Suicide Prevention to high school classes.

II. EXTENDED LITERARY RESOURCES

The following review is not an inclusive review of the literature on suicide, but rather provides a

broader overview of some of the books on suicide, many of which are available in a public library.

Boerman, Alan L., and Jobess, David A. (1991). Adolescent Suicide Assessment and Intervention. Washington: American Psychological Association.

This is a clinically based book which is written for the person who is involved in the study of suicidology. "*The group as a whole has definable properties and attributes of import to us.... We have much to learn from both the statistical set (and its scientific base....our task has been to preserve and integrate the science and art of suicidology....Suicide is rarely studied prospectively. Our theories, our hypotheses, our assumptions are generally built upon retrospective analyses of behavior and character studies.*"

Crook, Marion. (1990). Teenagers Talk About Suicide Toronto: NC Press, Ltd.

This book consists of dialogues with teens who have contemplated suicide. It's usefulness lies in providing insights into the ways in which teens have thought about suicide, thus enabling the teacher not only to

recognize danger signs, but also understanding the ways in which teens think about suicide. This is a good book for teens to read since the comments in it are made by their peers.

Durkheim Emile SUICIDE A Study In Sociology, (1897). trans. by John A. Spaulding & George Simpson, (1951): The Free Press.

This translation of the French Sociologist's work provides the base for studying Suicides. It was Durkheim who first created the three major categories of suicide: Egoistic (suicide caused by a society for religous purposes such as Waco, Texas), Altruistic (suicide caused by a sense of self duty and honor - also the individual feels himself useless and purposeless) and Anomic (when a person's life changes so abruptly he is unable to cope. i.e. when a society is disturbed by some painful crisis).

It is not a hand book which would be used by someone interested in the prevention of suicide. Rather, as the subtitle states, it is a sociological

study on types or classification of suicides. Its usefulness comes in providing a system of classification which helps the researcher who is examining the underlying causes of suicide and suicide attempts.

Clark, David C. (ed.). (1993). Clergy Response to Suicidal Persons and Their Family Members, Chicago: Exploration Press.

As the subtitle: An Interfaith Resource Book for Clergy and Congregations indicates, this book is designed as a resource book, a function which it accomplishes. Each chapter deals with a separate issue such as: *Fundamental Knowledge and Skills for Clergy; Physical Illness and Suicide; Supporting the Family of a Suicidal Person*. In the chapters dealing with specific issues such as that of chapter 7: *Supporting the Family of a Suicidal Person: Those Who Live in Fear*, a case history is presented and then analyzed from the medical as well as the clergy perspective. This is a practical book which is designed to meet the specific needs of clergy who have to deal with suicide. The chapters form distinct units and the language is clear

and understandable. The solution to the case histories enable the reader to see how the different approaches deal with the presenting problem.

Grollman, Earl A. (1988). Suicide Prevention, Intervention, Postvention. Mass.: Beacon Press.

Rabbi Goldman is a Jewish Rabbi who has written over 16 books and is the recipient of Yeshua University's Distinguished Service Award for Bereavement & Grief. This part'cular paper back provides a basic summary of the causes of suicide, recognition of the signs and how to help a suicidal person. "*Everyone has a tendency to self-destruction which varies in degree from individual to individual and from one society to another.*" It is useful in terms of providing a basic understanding of the issue, and its language is suited to the person who wants some understanding of what suicide is and how to help survivors of a suicide. Sample chapter titles: *Death: A Practical Guide for the Living; Talking About Death: A Dialogue Between Parent and Child.*

Guetzloe, Eleanor G.. (1989). Current Trends & Issues

Related to Youth Suicide. Reston, Virginia: Council for Exceptional Children.

Dr. Guetzloe's book is aimed directly at teachers in a classroom environment. Some of the chapter titles are: *Assessment of Suicide Potential: Crisis Intervention in the School*. Although designed for a school environment, the topics covered would also help someone who is engaged in a youth ministry.

Haffen, Brent Q., Ph.D. and Frandsen, Kathryn J. (1986). Youth Suicide Depression and Loneliness. Cordillera Press.

This book, as its title indicates, focuses upon the causes of youth suicide. It looks at the development of the adolescent in terms of individuation and egocentrism as clues for possible tendencies for suicide, pointing out that this is the age when the child is struggling to become an individual person. The book's case studies all come from the Southwestern United States. Given that the culture of that region of the States is quite different from that of Southern

Ontario, the examples do not have exact parallels here, but the principles of being aware of loneliness in youth do apply here.

<u>Handbook for the Caregiver</u>. (1988).Hamilton: The Board of Education for the City of Hamilton. (Available from the Council on Suicide Prevention (Hamilton and District) 205 Queensdale Avenue East, Room 3, Hamilton, Ont. L9A 1L1

This handbook which has received world wide distribution (negotiations are underway with countries such as Australia for permission to insert their own statistical data) is an excellent resource for the person/agency actively involved in suicide prevention.

This is a technical book which summarizes the whole field of suicide prevention, intervention and postvention. It is not designed for casual reading or for a quick glance through, but rather is meant for those who are either training others in suicide prevention, intervention, and/or postvention or as a basic resource for those who regularly come in contact

with suicidal situations.

Johnston, Jerry. (1988). Why Suicide, Jerry Johnston, Author.

Jerry tried to commit suicide as a teenager and has devoted his life to speaking to high school audiences about the danger of suicide. "*It is a plea from one who has been there and who has endured the trauma.*" The book is written for teens, but the approach is such that parents can read the book and gain insight into problems which their children may be encountering and which may lead them to think of suicide as an answer.

Lester, David, PhD. (1989). Questions and Answers About Suicide. Philadelphia: The Charles Press.

Sample chapter titles: *'Is Jumping Off Buildings A Common Method of Suicide?; Do You Have To Be Mentally Ill to Commit Suicide?; Can Suicide Be A Rational Act? What is A Suicidal* Crisis? Each chapter consists of a one to two page answer to the question for that chapter. This is a basic primer for people who

do not have any knowledge of what suicide is or why it occurs.

Madison, Arnold. (1978). Suicide and Young People, New York: Clarion Books.

"*This book will investigate the causes, seeking answers for those who call for help.*" This book, as its title indicates, is primarily directed towards, those who work with young people. It is based upon interviews with young people who have attempted suicide, the experiences of the San Francisco Suicide Prevention Centre as well as surveys conducted in regional high schools. This is a non-technical book designed to educate people who work with young people.

III. COMMUNITY RESOURCES

These vary from community to community, and ministers in rural congregations do not have ready access to as many resources as do ministers in urban locations. For example, the Selkirk minister who was interviewed, basically had the police and the emergency department of the local hospital for immediate help in the suicidal situation, as compared to the accompanying page of resources for the Hamilton area. However, crisis lines are available throughout the province (in the Nothern areas of the province, many small, isolated communities are linked by an 800 number crisis line).

Many ministers are not comfortable with any form of crisis counselling, feeling that this is not what they were called to do. However, within a local ministerial there may be ministers who do have professional training in counselling and to whom a minister could turn for assistance in a suicidal crisis.

CHAPTER 7: ANALYSIS OF INTERVIEWS

NOTE: Abbreviations for quotes are as follows: United Church - U; Church of Christ - C; Anglican - A; Baptist - B.

A. Degree of Involvement: Direct/Indirect

Six of the eight ministers interviewed had some dealings with the problem of suicide. Of the two who have not, one [U] is new to the ministry as a second career within the last five years. The other [C] has been involved in the parish ministry with several congregations in Ontario for over twenty years, but has not experienced any suicidal situations.

The Anglican priest who is Executive Director for a community outreach programme of her church has, by the nature of her job, been involved in helping potential suicides: "*I've dealt with more than one potential suicide. In one situation, I received a request from the family... a member had become very paranoid and threatening to take his life.*" For the other five ministers, direct *involvement* with a suicidal crisis came as a result of their relationship to Telecare (a 24 hour telephone

crisis line) as Resource Personnel; "*I was working with Telecare as Resource Minister for Telecare. So when they get a particularly tough case or a potential suicide, they get me in touch with this person...* " [C]; "*I could say that I've had a couple of experiences through Telecare, and one that I didn't realize was a potential suicide and that was in another community.*" [U] For the rest, as far as suicidal *situations are* concerned, they either had no experience of them in their congregation, or it was extremely low: "*Those are the only two in twenty-five years of ministry in which there was an actual suicide. But only two in twenty-five years, that's not many.*" [U]

Due to the virtual non-existence of what might be classified as actual suicidal situations: i.e. there is a direct threat to commit suicide, the ministers did not consider emotional distress to be a possible precursor to suicide:

"*Yeah, I suppose I could think back over the years to other instances in which the uh potential was there and in which I didn't recognize it. Obviously, people may have been contemplating... whether they follow through or not. They were in desperate straits and I supported them through their crises without even being aware of the possibility in this particular case or these particular cases.*" [U]

Of the six ministers who have been directly involved in suicide attempts, the four Hamilton ministers dealt with the attempt(s) as the result of being a Resource Minister with Telecare." The other two ministers are from out of town [Selkirk and Orangeville]. The Selkirk minister was involved in two cases. The first was a result of marital counselling: " *...the man involved had made a covenant with me that if he ever had decided to hurt himself he would call.*" The second was the result of a phone call from a woman who was significantly depressed because of a background of sexual abuse and "*I ended up going over there, basically talking her out of her intended actions and convincing her that it was necessary to seek further help and ultimately took her to a hospital.*"

One minister **[B]** had a suicidal referral from Telecare: "*The telephone answerer though said that the person was definitely and legitimately suicidal and asked me to go and meet with the person. But after searching for a couple of hours, I could not find him and had no further contact with him.*"

B. Awareness of Resources

The resources available to the ministers varied directly according to their location. The Hamilton ministers have abundant resources: "*...Hamilton Psychiatric, Pastoral Counselling Centre, St. Joes, other agencies listed in the Red Book* [**Note: this is a listing of all the community agencies, their services offered, their key personnel, location, hours of service, which are located in Hamilton. The book is published annually by Community Services and takes its unofficial name from the colour of the cover**] *and the reading I have done in suicide over the years.*" [A]; "*There are lots of agencies that are available to me through the Red Book. Some I've worked with for long periods of time. Worked for four years for the Province of Ontario in the London Psychiatric Hospital.* " [B]

However, despite the abundance of resources in Hamilton, three of the ministers who had been called in by Telecare to deal with a suicidal situation were not aware of these resources: "*The only resource I knew was Telecare. And of course, I knew that Telecare had the 'Red Book'* " [C]; " *...because I don't really know where the resources are for helping.*" [U]; "*I'm trying to think of 3 or 4 names right now of people that I would call. That's probably the*

first thing I would do in a situation like that. Say, uh, what are the resources for this? " [U]; "*I don't think of myself as specifically aware of things in the community beyond a psych unit at a hospital or emergency or whatever. ... I'm just not aware of that.* " [U]

However, for the minister in a rural congregation: "*I would say the resources in a rural area are very limited. Mental Health is there. Hamilton resources for the most part, their priority of course is for the Hamilton people, and so if you move outside the city limits you are on a waiting list.*" [C]. For the Baptist minister in Orangeville: "*Just yesterday at the hospital, I met a man who is involved in the crisis centre, especially in dealing with suicide. Someone I knew year ago in a former parish. So I wouldn't hesitate to call them. ...if it's someone who is of the age of the Children's Aid Authority, one would have to get in touch with them without any doubt. In this case, I got in touch with the police.* ".

C. Interest in further education/training

One of the ministers [B] was not interested in further training in suicide awareness: "*It's not a high priority for me and it's not a high priority for our community or for the ministry here. I don't perceive it as a high priority need. I don't want to invest time or energy or training resource dollars in that area.*". The Anglican priest

had a qualified "yes": "*It would depend on what the subject matter was. Or the topic area. If it was very general. It really would depend on what the subject matter was.*". This response was conditioned by the fact that this particular minister has had an interest in the prevention of suicide and "*...all the reading that I have done myself;*". Another response was that of mild interest: "*Had I been more directly involved with a potential suicide...maybe that would be the trigger to say: well you better get yourself more on top of this.*" **[U]** The response of other ministers who have not done a lot of reading is more positive: "*...the centre that I'm envisioning that would allow us to go there and be trained, to get to know the resources that are already there.*"**[C]**; *...one thing that would help would be some sort of education programme. Some sort of training that might be available for those of us that are new in that area.*" **[U]**; "*Oh yes. By all means. I would try to get in as fast as possible.*" **[B]**; "*Yes, yes. I would attend that.*" (replying to question about attending a seminar on suicide prevention); "*...would be in-service programmes where clergy are invited to participate in hospital in-services.*" **[C]**

C. Utilization of Available Resources

The utilization of available resources varied directly as the knowledge which the ministers had of

the available resources. In the case of the Anglican priest, she was well aware of the various resources which were available to her. In the particular case which she used as an example, she chose "*...to follow up with a referral to the psychiatrist under whose care the individual was at that time.*". The Selkirk minister had moved from Alberta where the provincial government sponsored a suicide awareness seminar "*...which was just splendid in giving details: role playing and working through and being able to evaluate risk levels and follow up procedures.*". In one of the cases he described which occurred in Ontario, there was a weapon involved and so the police were involved: "*...these fellows were excellent... we'd work together on the whole thing, to ensure that I got there first, that I was able to calm him down, that I was able to gather up weapons in the home...* ". The Baptist minister in Orangeville also utilized the police "*... because there was apparently a police officer who was a good friend of this person.*"; "*Mostly I've depended on my own ability to listen and be supportive in general as I've done.*" [U]

The other ministers in Hamilton basically felt that their own relationship with God: "*So mostly the resources that I've depended upon is me and my relationship with God...*"[U] was their primary resource. Similarly the Orangeville minister:

"*Of course I'm in an Evangelical setting, and just preaching regularly to the congregation on the value of life and the resources available by the grace of God are themselves a preventative you see.*" [B].

D. Encounter with Suicide within the congregation

None of the ministers interviewed had a potential suicide from within the congregation: "*I've had three or four suicides, but none of them has been a regular member of the church. I was just called on to be of service at that time.*"; [B] "*I haven't been aware of that in my ministry...*' [U]; "*The first was as the result of marital counselling* ". [C]; "*They were in desperate straits and I supported them through their crises without even being aware of the possiblity....*" [U]. Two of the ministers [A] and [C] are presently in ministries other than that of a congregation. The Anglican priest is Executive Director of an outreach house which provides multi social services to the community, and therefore her contacts with suicide do not rise out of "murder" a congregational setting. The other minister [C] is administrator of a Bible College in Toronto, but even when he was directly involved in a parish ministry, when asked if he had encountered a suicidal situation, his response was "*No. No I haven't.*" The other United

Church minister has not been in the ministry long enough to be able to say whether or not a suicidal situation would occur in his congregation.

Although two of the ministers had people in their congregation who knew directly someone who had committed suicide, it was not someone who was a member of their congregation. The suicidal cases described by the Baptist minister in Orangeville did not involve members of the congregation: *"... the most recent one was just someone who came into my office"*.

The solution is not in saying: "Where there is smoke, there must be fire" but rather in reaching out to these desperate people so that they will realize that the church can provide a solution to their problems. The church as a whole or specifically the minister cannot wave a magic wand and vanish all the problems. What it and/or the minister can do is to provide the support and guidance such that the person in distress will not seek out suicide in desperation.

Certainly, the church would consider the

prohibition against murder to include the taking of one's own life since life is considered to be a gift from God (thus the church's strong opposition to abortion). However, given that the term "murder" or "kill" is usually thought of in terms of killing another person rather than killing oneself, ministers do not think in terms of suicide when analyzing this prohibition.

In the normal course of events in a parish ministry, ministers are not likely to encounter a suicidal situation with any kind of regularity. In fact, a minister is more likely to be called in to deal with the aftermath of a suicide than as a resource to prevent a suicide. The Orangeville Baptist church which is a congregation of several hundred and has been the major congregation in Orangeville in terms of size for over twenty years, has not experienced a high rate of potential or attempted suicides in its history. The current minister who has been with the congregation for a couple of decades could only recall two incidents involving potential suicides. The high rate of involvement of the Anglican priest with suicide

situations is due more to the nature of her ministry as director of an outreach than as a result of a church based ministry.

Given the low incidence of encounters with these types of situations and given the lack of training in the awareness of suicides, it is not surprising that there is a general lack of interest in this particular issue. Further complicating this is that ministers are not considered to be an essential part of a suicide prevention team. A social worker in Hamilton who has worked with psychiatric hospitals and has been involved in suicide crises pointed out that in these cases, the medical profession is always considered as a prime resource rather than a minister. Even in cases where the minister is directly involved in getting the person to the hospital, once the hospital takes over, the minister is no longer considered to have any input into the situation.

The Baptist minister in Orangeville felt that providing a warm, nurturing environment is the best solution for the prevention of suicide. Certainly the

relationship of the minister to the congregation will have an impact upon the possible development of a crisis situation into one in which suicide is considered to be a viable alternative. For example, the United Church minister in Hamilton with over twenty-five years in the ministry, and who had minimal contact with suicides (either actual or probable) is working with several couples in his congregation who are trying to cope with Alzheimer's in their spouse. By ministering to these people throughout their crisis, he is providing the Fruit of the Spirit of Galatians 5 which provides these people with the spiritual resources necessary to cope with the crisis. By doing this, the problems do not develop to the life threatening stage. However, this still does not satisfactorily answer the question of how to help the people who are outside of this loving environment.

The support which those ministers interviewed give their congregation is typified by the following statement: "They were in desperate straits and I supported them through their crises without even being aware of the possiblity in this particular case or

these particular cases..." [U.]. These ministers were not aware of the warning signs of suicide - they simply dealt with emotional problems as basically emotional problems without thinking that perhaps this individual was considering suicide as a solution. Thus, for the ministers interviewed, the idea that suicide might be a consideration of the person they are working with does not surface.

The casual attitude of ministers towards suicides may be a reflection of the fact that they do not occur within the context of the congregation. Usually, a suicide is someone who either is not connected with the church in any way, or at the most has a nominal, arms-length relationship. For example, in my own work on different occasions I have done extensive door knocking and have asked people if they belong to a particular church. I would almost always receive a positive answer, but when I ask how often they attend church, the response drops to either occasionally, such as at Easter or Christmas, or never. As Reginald Bibby points out in Fragmented Gods (1987), people today, while they may not attend church regularly, still look to the

church for the rites of passage such as Baptism, Marriage and Funerals. However, these are "formal rituals" which, for the most part, do not have anything to do with life crises. The difficulty is that people today no longer consider the church as a primary resource for life crises. Thus, when their contact with the church is at the most, once or twice a year, then the possibility of the church being considered a resource when someone is in difficulties is minimal.

There is one major stumbling block. Although the persons who are in the extremity of crisis such that there appears to be no solution may consider themselves to be a Christian, their actual Christian faith is so minimal as to be virtually non-existent. Therefore, lacking the awareness of the spiritual resources of the church, they may see suicide as the only solution to their problems.

Given this lack of direct involvement with the church, it is not surprising that nearly all suicides occur outside the framework of the church. It is these unchurched people who lack both the spiritual resources

and the spiritual contacts to provide them with the strengths needed to prevent a crisis from developing to the point where suicide is considered to be a viable alternative.

Another difficulty which the church faces is the heritage of the British "Stiff Upper Lip" which may prevent people from adequately expressing their grief:

> Because of social fear, many people sustain a relationship which does not seem on the surface to deviate too much from social expectation, but within which negative emotions must be repressed and guilt over the known failure to perform one's role adequately is increased. (Switzer, Dynamics of Grief, 1978, p.27).

When people are unable to express their grief through sanctioned channels, the result can be a feeling that the only solution is suicide since the situation is intolerable. If these people have only a nominal contact with the church, they will not readily find a means of adeaquately dealing with this grief (which may be caused by such things as a break up of a relationship or the inability of a young person to meet parental standards). Since these people do not have a framework within which they can cope with grief, the

grief is responded to as a threat (Switzer, 1972). This threat to one's self-identity can also lead to a loss of meaning and non-being. Since life no longer has meaning, there is no point in continuing to live and suicide becomes a consideration.

The real difficulty for the church comes in somehow becoming more involved in prevention of the suicides which occur in the community. Hamilton averages fifty suicides a year, but the church is not involved in their prevention (It may be involved in the postvention aspect, treating the survivors). Admittedly, it is hard for a minister to consider taking on addtional responsibilities when the congregational load is already high. Thus it is natural for ministers to place a low priority on suicide awareness since it occurs with such low frequency in their ministry and their time is already taken up with other problems.

The government's task force on suicide considers ministers to be gate keepers for suicidal situations:

> The clergy play a key gatekeeping role in suicide prevention. Suicidal individuals often feel less threatened by clergy than other professionals, frequently approaching them for guidance in times of distress. Thus it is important that all clergy be knowledgable and trained to effectively deal with the suicidal individual and be prepared to face the difficult task of counselling the families of the bereaved. (Task Force, p. 42).

However, when suicides simply have not arisen within their congregations, it is difficult for ministers to consider themselves as "gatekeepers". As one minister expressed it: "*...only two in twenty-five years, that's not many* ." [U]. For the ministers who have been involved with suicide through their contact with a Telephone Crisis Line, this would be a valid concept. Ministers, on the other hand, who have minimal contact with suicide would probably not consider themselves to be "gatekeepers".

Because suicide occurs with such a low frequency in the context of a congregational ministry, ministers tend to deal with the crises which they encounter as simply emotional crises rather than as the precursors to suicide: "*There were two women arriving about an hour and a half in*

real personal crisis who just needed to talk....I don't think there was any sense that it was suicidal" [U].

In Hamilton, from 1979 to 1993, there was an average oi fifty-two suicides each year. Yet, if one were to check back through the newspapers for these fifteen years, there would not be references to an average of fifty-two suicides in any one year. Those which do rate newspaper coverage are the spectacular ones where there is a double murder-suicide. Other examples are the case last year, where a woman committed suicide with her mentally and physically disabled child by carbon monoxide poisoning, and where someone threatens to jump off the Burlington Skyway. Although the sample interviews do not begin to cover all the churches in Hamilton, it would appear from the interviews that ministers simply are not aware of the potential for suicide or that suicide is the fifth highest cause of death in Canada (Task Force, p. 42).

The Anglican priest had training in suicide in her seminary. The Selkirk minister had some training during his undergraduate work in the States and had training

in suicide prevention while in Alberta. The others, however, had not had any specific training in suicide prevention in seminary: "*And I might say that I think this is one of the areas where clergy training is really deficient* ." **[U]**.

The lack of training in suicide intervention for these ministers fits in with the Task Force findings that: "...that there was minimal concentration on education and training in the area of suicide." (Task Force, p. 42). However, the lack of interest in Suicide Prevention is not just due to a lack of knowledge or personal encounter with a suicidal situation. In Orangeville, a Presbyterian minister was not interested in being interviewed on the topic of suicide prevention (even though Dufferin County has a high rate of suicide). She had encountered attempted suicides while doing volunteer chaplaincy duties at the local hospital, but since they did not occur within her congregation, she did not see any need for further knowledge.

At the beginning of this paper, I suggested that suicide could be defined as "an enigma wrapped inside a

mystery". Perhaps the same definition could be applied to answer the question as to why the church is not more involved in the prevention of suicide. Perhaps it is because ministers are more often involved in conducting funeral services for a suicide than in preventing a suicide. However, this also raises the question as to why these ministers have not become more sensitive to the issue of suicide.

Certainly, the ministers in this study, with one exception, are interested in further training in the area of suicidology. In fact, they would like *some kind of team centre that would have some medical resources, some psycho-therapy resources, that would have some pastoral resources and you can feed into that and work with a place that had all of that* ". [C]. Suicide does not receive the high profile which abortion does, yet it is just as much of a destroyer of life. The real issue is how to get the church more aware of suicide by putting events such as Suicide Prevention Week in the church bulletin and by providing material such as that in the appendix for church literature racks.

Ministers are interested in learning more about

the resources available for them in the prevention of suicide. However, until they actually come in contact with a suicide, these resources are placed in the category of "nice to have, but not really necessary". The ministers in this study, when shown the reasonably priced literature available liked the material, but did not go so far as to say that they would actually buy it and use it.

The place to begin training in this area is in the seminaries where a specific focus can be given to the prevention of suicide. Given the finding of the government Task Force that seminaries do not equip ministers for the prevention of suicide, perhaps those responsible for the training of ministers should be asked why they do not.

Although training in seminaries in awareness of the warning signs of suicide would certainly be of value to the minister, they would not be considered a high priority of attention and time when the incidence of possible suicide within a congregation is extremely low or non-existent. The minister must somehow be able

to reach out beyond the immediate context of the congregation to those who are not in the congregation, but who are more likely to consider suicide as a possible solution.

People turn to crisis lines for help because they do not see the church as being of any use in helping them. The bulk of the calls to a crisis line are loneliness calls: people who have no support system and therefore turn in desperation to what they perceive as the only place where their concerns will be heard with a sympathetic ear.

The fact that nearly all suicides take place outside the boundaries of the church suggests that the church needs a fresh vision in order to reach out to these people to provide them with "a shelter in a time of storm". The prevention of suicide is not the sole perogative of the minister, it is the task of a group of committed Christians - men and women who are prepared to live Christ as a reality in their lives:

> Its (the church) visible embodiment will be a community that lives by this story (the reality of

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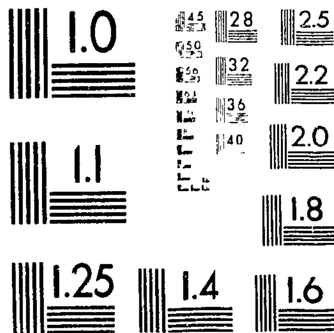


> the risen Christ), a community whose existence is visibly defined in the regular rehearsing and reenactment of the story which has given it birth, the story of the self-emptying of God in the ministry, life, death and resurrection of Jesus. ...In this they find enacted and affirmed the meaning and goal of their lives as part of the life of the cosmos, their stories as part of the universal story. (Newbiggen, The Gospel in a Pluralistic Society, 1989, p. 120).

The church must become more aware of the emotional needs of the unchurched in our society if it is to be effective in enabling people to discover more rational ways of dealing with problems than suicide. For example, a single mother writes a note to a cub leader saying that she cannot afford to buy her son a cub shirt. If this problem is not resolved, not only the mother's self-esteem will suffer, but also the child's self-esteem. A minor problem, perhaps. But one minor problem on top of another problem becomes a compound problem, and if the church is not there to stop this avalanche, suicide may be the last desperate solution.

The suicide attempt is the final, desperate act of a long series of events (see: *SOME CONTRIBUTING FACTORS FOR SUICIDAL THOUGHTS p. 22*). If the church is not sensitive to these warning signs: " *Are you aware of the*

warning signs of suicide?" Answers: "*No*" [C] ; "*...missed all sorts of signs that would have said this is what you should have been thinking about....*" [U], then the people in these desperate circumstances will certainly not look to the church for help.

There is a general reluctance to report suicides as suicides, perhaps because there is a felt unexpressed stigma to the taking of one's own life. Everybody goes through periods of depression - its just that for most of us, the depression is not severe enough, nor long enough to cause us to commit suicide. One of the tasks of the church is the "equipping for every good work" Heb. 13:21. Christ, in His final prayer for His disciples in John 17:15 said: "My prayer is not that you will take them out of the world but that you protect them from the evil one". Given this mission, ministers must be the leaders in involving the church in a keener sense of the problem of suicide.

Ministers have been commissioned to quench the thirst of the thirsty and to feed the hungry:

> Matthew 25:37 "Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? When did we see you a stranger and invite

> you in, or needing clothes and clothe you? When did we see you sick or in prison and go to visit you? The King will reply, 'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me.'

Ministers would certainly agree with the principles given in this passage. The problem is that in our society today in which the church is no longer a focal point, it is difficult for ministers to reach the stranger to invite him in. There are many specialized ministries such as food banks, hospices for those terminally ill with AIDS, shelters for the homeless and shelters for battered women. These agencies are both volunteer and governmental which take care of specific needs of the disenfranchised of our society. It is easy then to justify inaction on the grounds of enough work load within the congregation and that the problem is being taken care of by these agencies. Unfortunately, an annual rate of fifty-two suicides in Hamilton would indicate that the problem of coping with life's difficulties is merely being scratched. Obviously, the problem is not going to disappear on its own.

Jesus, in His parable of the lost sheep (Matt. 18:

12 - 14) in effect is telling ministers to actively search out the lost sheep. The ministers are the shepherds who have been put in charge of God's flock. The lost sheep are those outside the flock who see only futility in continuing to live and so commit "self-murder". Are we fufilling the charge given to visit those in prison, the prison of despair, who are the lost sheep by blissfully ignoring the existence of suicide?

CHAPTER 8: CONCLUSION

There are written resources available in Hamilton at a reasonable price, as well as free pamphlets from the Hamilton Council on Suicide Prevention. Also, the council has a speaker's bureau and puts on seminars on Suicide Prevention. However, it would appear from this limited sample that ministers are not generally aware of the readily available resources for the prevention of suicide. This lack of awareness could be due in part to the extremely low incidence of this type of crisis in their respective ministries.

It is interesting to note that even ministers who have been called on by the Telecare Crisis Line to deal with attempted or potential suicides are not aware of the available resources. However, five of the ministers expressed an interest in receiving more training in this area, perhaps through seminars sponsored by the local ministerial association. One minister's interest would depend upon the content of the training, since this particular minister is well informed in this area. Unfortunately, ministerial associations (such as the

Orangeville Association) are reluctant to become involved in such seminars. The ministers feel that they have enough demands on their time as it is, and that there are too many special interest groups wanting to speak to them.

The ministers interviewed who had been directly involved with a suicide attempt were interested in further training and awareness of resources for the prevention of suicide. However, those ministers who had not been directly involved with a suicide attempt were not interested, feeling that the low incidence of suicide in their congregations placed it low on the list of priorities. It would appear then, that there is a direct correlation between a minister's interest in the issue of suicide and whether or not he has been called on to intervene in a suicidal crisis. Also, the lack of awareness of resources for the prevention of suicide may be due to the common belief that to talk about suicide is to encourage it.

Churches will often have tract racks in their foyer. There will be literature on A.A. groups, bulletins about other social groups, but no literature

on suicidal symptoms. One of the conclusions of the government task force on suicide is that ministers can play a vital role in the prevention of suicide. If this is so, then ministers and churches need to place a higher profile on the resources available for suicide prevention. As noted previously, ministers, for the most part, do not encounter suicidal situations in the course of their work with their congregations. However, if material on suicide warning signs was readily available to the congregation, they could alert their ministers to the danger which a friend or acquaintance is facing. The need for churches and ministers to be aware, not only of the warning signs, but also of the resources for the prevention of suicide is even more critical with the recent introduction on the internet line of a service by the Hemlock Society in B.C. which promotes ways to commit suicide:

DeathNet a how-to on committing suicide

By the Canadian Press

Graphic, step by step instructions on how to commit suicide using plastic bags, barbituates, gassing and other methods are now available to anyone with a computer.

And experts say a Canadian Internet site advertising the how-to manual threatens the safety of teenagers and others prone to suicide.

"It would be a good idea to ban (this) outright," said Sheena Meurin, director of suicide services at the Canadian Mental Health Association.

"I would be quite disturbed about what could happen if this information fell into the wrong hands," she said.

DeathNet, an on-line InterNet service based in Victoria, has been dispensing advice on how to commit suicide since it opened Jan. 10.

The InterNet site was founded by John Hofsess, president of the Victoria-based Right-To-Die Society

and Derek Humphry, the American author of Final Exit, a controversial best-seller giving details on suicide methods. Mr. Humphry said the service was established as part of a "campaign for physician-assisted suicide. Mr. Hofnes, who refused to discuss details of the service, was once an advocate for Sue Rodriquez, a B.C. woman who had an incurable neurological disorder commonly known as Lou Gehrig's disease. She was reported to have died last year with the help of an unidentified physician.

People who want the how-to manuals must join the Right-to-Die Society before receiving them, although DeathNet offers special temporary memberships to those who only want to buy its wares. There is even an eerie guarantee that manual orders will be filled within 24 hours of receipt of payment.

DeathNet includes offerings from Jack Kevorkian - the Michigan doctor who helped several people in the United States take their lives with his suicide machine - and his book The Goodness of Planned Death.
More than 4,000 Internet surfers have already logged on to the program, according to a counter recording activity at the site. Critics fear users may be curious

teens since this age group makes up a large percentage of those cruising the InterNet. "If you make methods available to teens others who may be vulnerable, it makes it seem more acceptable and they may just decide to use it," said Ms. Meurin. But Mr. Humphry dismissed those suggestions and said he would not feel if a teenager killed himself using manuals using methods obtained through the Internet. "It's the job of their family, those close to them, to look after these people," he said. "There's a thirst for tthis material out there."

Although "Ristricted" and "Adults Only" signs are posted throughout "DeathNet, anybody with a computer can read passages like this one: "Ending your life with a plastic bag is the most effective way unless you possess - and carefully use - fast acting barbituates." For $6. staff at DeathNet will mail anyone the complete details in a discrete brown wrapper. And for those who would prefer swallowing chemicals to end their life, there is a Departing Drug section.

An RCMP spokesman said police are investigating but there is likely nothing illlegal about the service. Officials at Calagary's Suicide Information and

Education Centre say they plan to set up their own site on the Information highway by April to provide suicide prevention support." (Hamilton Spectator, NEWS, March 13, 1995).

Increasingly, ministers are becoming computer literate and are cruising the InterNet Highway. If they are aware of the resources for suicide prevention they can effectively dialogue with someone who has come upon the DeathNet in their cruising and have serious questions.

The responsibilty of the church and of ministers in the prevention of suicide cannot be evaded by saying that it does not occur in their parish ministry, so therefore it is not significant. Suicide, as the fifth highest cause of death in Canada, must be a concern of ministers who have been called to tend the Lord's sheep. The lost sheep will not necessarily be found in the flock, although this may occasionally happen. In the parable of the lost sheep, the shepherd goes out to look for the lost sheep. Ministers, today have the same responsibility - to find the lost and hurting sheep by

1. Becoming aware of the warning signs of suicide and the resources available for its prevention; 2. By making themselves known to the staff at drop in centres such as Wesley Centre as a resource for young people in distress. This active involvement is also implicit in the parable of the Good Samaritan (Luke 10:25-37). Ministers, although they are busy with the concerns of their own flocks, must also make the time to be concerned with the wounded who do not have regular contact with the church.

CHAPTER 9: REFERENCES/BIBLIOGRAPHY

Baelz, P.R. (1980). Suicide, Some Theological Reflections. In M. Pabst Battin & David J. Mayo, (eds.), Suicide the Philosophical Issues. New York: St. Martin's Press.

Barraclough, Brian M. and Shepherd. The Origin and Uses of "Suicide". In Suicide and Life Threatening Behavior, Volume 24 Number 2, Summer 1994, New York: The Guilford Press.

Bibby, Reginald. (1987). Fragmented Gods, Toronto: Irwin Publishing.

Blackburn, Bill. (1982). What You Should Know About Suicide, Waco, Texas: Word Books.

Blazquez, Nicedto. (1985).THE CHURCH'S TRADITIONAL MORAL TEACHING ON SUICIDE. In Jacques Pohier and Deitmar Mieth, (eds.), Suicide and the Right to Die, Edinburgh: T. & T. Clark Ltd.

Eareckson Tada, Joni. (1992). WHEN IS IT RIGHT TO DIE? SUICIDE, EUTHANASIA, SUFFERING, MERCY, Grand Rapids Michigan: Zondervan.

Colt, George Howe. (1991). The Enigma of Suicide, Toronto: Summit Books.

Council on Suicide Prevention, (1988).(Hamilton and District). Handbook for Caregivers.

Durkheim, Emile. (1966). Suicide A Study in Sociology, trans. by John A. Spaulding and George Simpson, The Free Press, Don Mills. (Original work published 1897).

Grollman, Earl. (1988).Suicide, Prevention, Intervention, Postvention, Mass.: Beacon Press.

Hazelip, Harold, God-Given Life.In Herald of Truth, Vol. 10, Number 1, January/February 1988, Highland Church of Christ, Abilene, Texas.

Health and Welfare Canada. (1987). Suicide in Canada.

Heinrich, Rev. Elmo E. Hinrichs. (1993). Surviving and Healing After a Suicide: A Pastoral Perspective. In David C. Clark, (ed.), Clergy Response to Suicidal Persons and Their Family Members, Chicago: Exploration Press.

Henslin, James N. (1972). Strategies of Adjustment: An Ethnological Approach to the Study of Guilt and Suicide. In Albert C. Cain, Charles C. Thomas, (eds.), Survivors of Suicide, Springfield.

Jossua, Jean-Pierre. (1985). LIFE NO LONGER HAS ANY MEANING FOR ME. In Jacques Pohier and Deitmar Mieth, (eds.), Suicide and the Right to Die, Edinburgh: T. & T. Clark Ltd.

Lester, David, PhD. (1993). The Cruelest Death, The Enigma of Adolescent Self-Destruction, Philadelphia: The Charles Press.

Lukas Christopher and Seiden, Ph.D., Henry M. (1987). Silent Grief Living in the Wake of Silent Suicide, Macmillan: Toronto.

Marx, Robert J. (1993). Supporting the Family After a Suicide. In David C. Clark, (ed.). Clergy Response to Suicidal Persons and Their Family Members, Chicago: Exploration Press.

Robinson, Rita. (1989). Survivors of Suicide, Santa Monica, California: IBS Press.

Newbiggin, Leslie. (1989). The Gospel in a Pluralist Society, Nashville: Abingdon.

Rubey, Father Charles T. (1993). The Role of the Clergy for Survivors of Suicide. In David C. Clark, (ed.), Clergy Response to Suicidal Persons and Their Family Members. Chicago: Exploration Press.

Schneidman, Edwin. (1970). The Psychology of Suicide, New York: Science House.

Stone, Howard W. (1972). Suicide and Grief. Philadelphia: Fortress Press.

Shamoo, Tonia K. and Patros, PhD. (1990). Helping Your Child Cope With Depression and Suicidal Thoughts, Toronto: Lexington Books.

Switzer, David K. (1978). The Dynamics of Grief, Its Source, Pain and Healing, Nashville: Abingdon.

BIBLIOGRAPHY

Baelz, P.R. (1980). Suicide, Some Theological Reflections. In M. Pabst Battin & David J. Mayo, (eds.), Suicide the Philosophical Issues, New York: St. Martin's Press.

Barraclough, Brian M. and Sheperd, Daphne M. (1994 Summer). The Origin and Uses of "Suicide". Suicide and Life-Threatening Behavior, The Official Journal of the American Association of Suicidology. Vol. 24, Number 2.

Bibby, Reginald, (1987). Fragmented Gods, Toronto: Irwin Publishing.

Blackburn, Bill. (1982). What You Should Know About Suicide, Waco, Texas: Word Books.

Blazquez, Nicedto. (1985).THE CHURCH'S TRADITIONAL MORAL TEACHING ON SUICIDE, in Jacques Pohier and Deitmar Mieth, (eds.), Suicide and the Right to Die, Edinburgh: T. & T. Clark Ltd.

Boerman, Alan L., & Jobess, David A.. (1991). Adolescent Suicide Assessment and Intervention Washington, D.C.: American Psychological Association.

Canadian Mental Health Association [Brochure], Suicide Toronto.

Canadian Mental Health Association (1993). [Brochure]. Coping With Bereavement.

Clark, David C. (ed.). (1993). Clergy Response to Suicidal Persons and Their Family Members. An Interfaith Resource Book for Clergy and Congregations. Chicago: Exploration Press.

Cobb,. S. L. (1990). Guidelines for dealing with traumatic events in the school community. J. D. Morgan. (ed.), The Dying and Bereaved Teenager Philadelphia: Charles Press.

Colt, George Howe, (1991).The Enigma of Suicide Toronto: Summit Books.

Crook, Marion.(1990).Teenagers Talk About Sucide Toronto: NC Press, Ltd.

Durkheim, Emile. (1966). Suicide A Study in Sociology, Trans. by John A. Spaulding & George Simpson. Toronto: Maxwell Macmillan. Free Press Edition.

Eareckson Tada, Joni. (1992). WHEN IS IT RIGHT TO DIE? SUICIDE, EUTHANASIA, SUFFERING, MERCY, Grand Rapids, Michigan: Zondervan.

Giovacchini, P. L. (1981). The Urge to Die: Why young people commit suicide. New York: MacMillan.

Goodman, E. (1990, March 27). Choosing death: Perhaps it is time for new thoughts on suicide. London Free Press.

Guetzloe, Eleanor G. (1989). Youth Suicide, What the Educator Should Know. Council for Exceptional Children. Reston, Virginia.

Guetzloe, Eleanor G. (1989). Current Trends & Issues Related to Youth Suicide Council for Exceptional Children. Reston, Virginia.

Grollman, Earl A. (1988).Suicide: Prevention, Intervention, Postvention, Boston: Beacon Press.

Haffen, Brent Q., Ph.D. & Frandsen, Kathryn J. (1986). Youth Suicide Depression and Loneliness. Cordillera Press.

Hazelip, Harold, God-Given Life in Herald of Truth, Vol. 10, Number 1, January/February 1988, Highland Church of Christ, Abilene, Texas.

Health and Welfare Canada. (1987). Suicide in Canada.

Henslin, James N. (1972). Strategies of Adjustment: An Ethnological Approach to the Study of Guilt and Suicide. In Albert C. Cain, (ed.), Survivors of Suicide, Springfield: Charles C. Thomas.

Herzog, Alfred, and H. L. P. Resnik. (1968). A Clinical Study of Parental Response to Adolescent Death by Suicide with Recommendations for Approaching the Survivors. 381-90. In Norman L. Farberow, (ed.), Suicide and its Prevention: Proceedings of the Fourth International Conference for Suicide Prevention. Los Angles: Delmar Publishing Co.

Johnston, Jerry, (1987). Why Suicide? Jerry Johnston: Author.

Jossua, Jean-Pierre. (1985). LIFE NO LONGER HAS ANY MEANING FOR ME. In Jacques Pohier and Deitmar Mieth, (eds.), Suicide and the Right to Die, Edinburgh: T. & T. Clark Ltd.

Kolehmainen, Janet & Handwerk, Sandra. (1986). Teen Suicide Minneapolis: Lerner Publications.

Kalman, J. Kaplan & Schwartz, Matthew B. (1993). A Psychology of Hope: An Antidote to the Suicidal Pathology of Western Civilization Westport, CT: Praeger.

Kirk, William G. (1993). Adolescent Suicide A School Based Approach to Assessment and Intervention

Kushner, Howard. (1989). Suicide in the Promised Land New Brunswick: Rutgers University Press.

Lindemann, Erich. (1953). A Study of Grief: Emotional Responses to Suicide. Pastoral Psychology IV: 9-13.

Lester, David, PhD. (1993). The Cruelest Death, The Enigma of Adolescent Self-Destruction Philadelphia: The Charles Press.

Lester, David, PhD. (1989). *Questions and Answers About Suicide* Philadelphia: The Charles Press.

Lester, David, PhD. (1993). *The Cruelest Death, The Enigma of Adolescent Self-Destruction*, Philadelphia: The Charles Press.

Lukas, Christopher and Seiden, Henry M., Ph.D. (1987). *Silent Grief Living in the Wake of Suicide* New York: Charles Scribner's Sons.

Marx, Robert J. (1993). Supporting the Family After a Suicide. In David C. Clark, (ed.), *Clergy Response to Suicidal Persons and Their Family Members*, Chicago: Exploration Press.

Robinson, Rita. (1989). *Survivors of Suicide*, Santa Monica, California: IBS Press.

Madison, Arnold. (1978). *Suicide and Young People* New York: Clarion Books.

Maltsberger, John, T. (1993,Spring).Dreams and Suicide. *Suicide and Life-Threatening Behavior*, The Official Journal of the American Association of Suicidology, Vol. 23, Number 1.

Newbiggin, Leslie. (1989). *The Gospel in a Pluralist Society*, Nashville: Abingdon.

Richman, Joseph, PhD. (1994). *Family Therapy for Suicidal People*. New York: Springer.

Rubey, Father Charles T. (1993). *The Role of the Clergy* for Survivors of Suicide. In David C. Clark, (ed.), *Clergy Response to Suicidal Persons and Their Family Members*, Chicago: Exploration Press.

Schneidman, Edwin. (1970). *The Psychology of Suicide*, New York: Science House.

Schneidman, E. S. & Farberow, N. L. (1959). *Clues to Suicide*. New York: McGraw-Hill.

Shamoo, Tonia K. and Patros, PhD. (1990). *Helping Your Child Cope with Depression and Suicidal Thoughts*.

Toronto: Lexington Books.

Stone, Howard W. (1972). Suicide and Grief. Philadelphia: Fortress Press.

Switzer, David K. (1978).The Dynamics of Grief, Its Source, Pain and Healing, Nashville: Abingdon.

The Council on Suicide Prevention, Hamilton & District, Inc. (1988). Handbook for the Caregiver.

The Council on Suicide Prevention, Hamilton & District, Inc. (1994). Suicide Among the Aged. [Brochure].

The Council on Suicide Prevention, Hamilton & District, Inc. (1993). Suicide! My Friend At School Is Talking About It. What Can I Do? [Brochure].

The Council on Suicide Prevention, Hamilton & District, Inc. Suicide and Depression [Brochure]

The Council on Suicide Prevention, Hamilton & District, Inc. Suicide and The Young Person [Brochure]

The Council on Suicide Prevention, Hamilton & District, Inc. After Suicide You Are Not Alone [Brochure].

The Official Journal of the American Association of Suicidology, Suicide and Life Threatening Behavior New York: The Guilford Press.

Young People in Crisis. Video. The National Committee on Youth Suicide Prevention & American Associaiton of Suicidology in consultation with Harvard Medical School Dept. of Psychiatry - the Cambridge Hospital.

CHAPTER 10: APPENDIX

I. TYPICAL QUESTIONAIRE

1. Have you personally dealt with a potential suicide? If so, what were the circumstances in which the encounter occurred?

2. What resources were available for your use in dealing with this crisis? How effective/useful were they?

3. In your experience, what have you found to be he most useful resources available to you in the prevention of suicide?

4. What additional resources (if any) would you like to have for future use?

5. Have you attended any of the Suicide Awareness Days sponsored by the Hamilton Council for Suicide Prevention? If so, did you find them useful in terms of resources for the prevention of suicide?

NOTE: If answer to question # 1 is "No", then question # 2 will be:

2. Are you familiar with the warning signs of potential suicide such as: changes in sleep patterns, change in social activities?

3. If you were to encounter a possible suicide, what are some possible resources which you could use?

4. Are you aware that there are community resources available to help you deal with potential suicides?

5. What additional resources (if any) would you like to have for future use?

II. LETTER OF REFERENCE

Dear fellow minister:

The purpose of this letter is to identify myself. I am a graduate of Mcmaster Divinity College, and am the minister with the Grand Valley Church of Christ in south-central Ontario.

I am presently studying for my M. Th. in Pastoral Counseling at Waterloo Lutheran Seminary in Waterloo, Ontario. I am conducting research on the most effective methods and resources which are available for ministers for the prevention of suicide.The purpose of this interview is to gather data for this research question. My research interviews are being supervised by Dr. Peter VanKatwyck, a member of the Waterloo Lutheran Seminary faculty and a director of Interfaith Counselling Centre in Kitchener Ontario.

This interview will last approximately forty-five minutes, and of course, any identifying remarks will be altered so as to protect the anonymity of all persons. The transcript of the tape is for the purposes of information only, and will be seen only by myself and Dr. Van Katwyck. Once the relevant information has been extracted, the material will be stored in my office under lock and key.

Dr. VanKatwyck may be reached at his office at the Waterloo Lutheran seminary (519-884-1970: extension 3586) and my home phone number is 519-928-5725. My home address is: 21 St. John Street, R.R. #1, Grand Valley, LON 1G0.

In His Service,

R. Ian Cuthbertson

III. Consent Forms

I agree that all information obtained in this interview is for the purposes of research only, and that the identities of the interviewees shall remain confidential. The tape of this interview is strictly for the purposes of obtaining data. Similarly, the transcripts of the tape are for research purposes only.

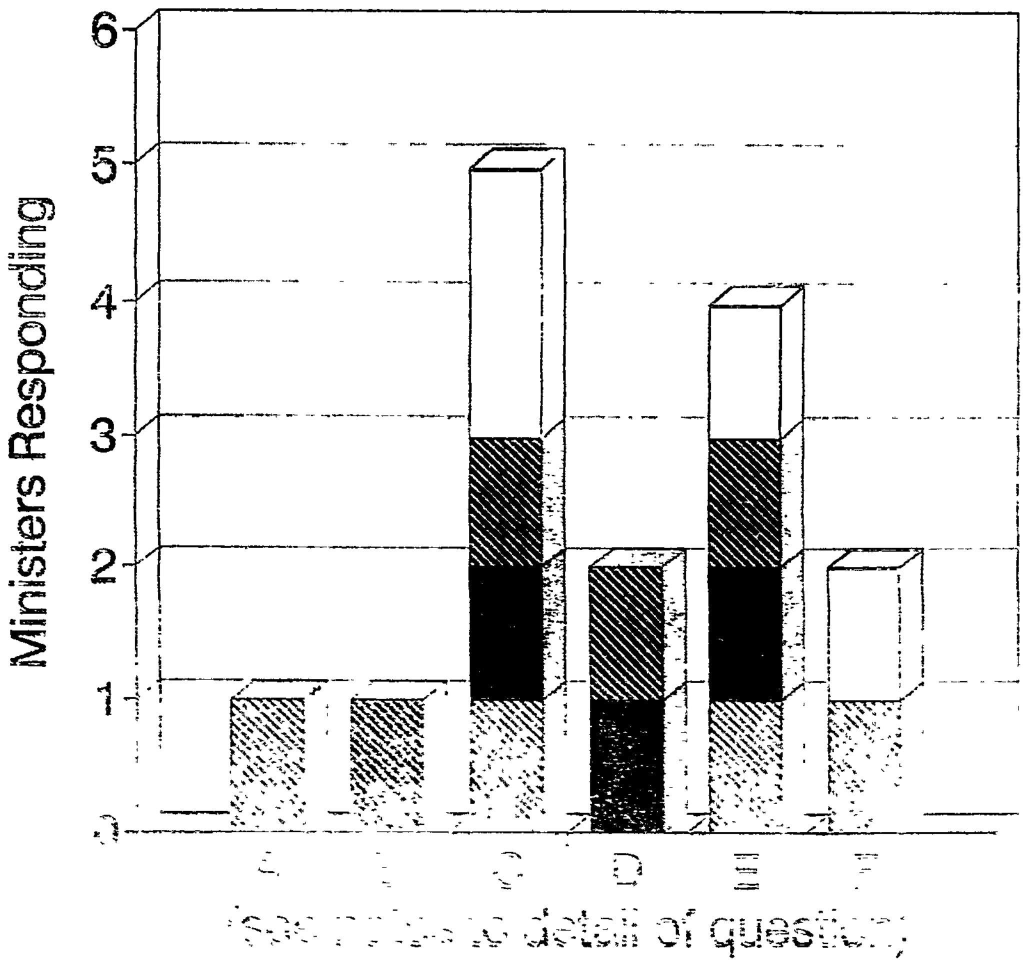
Signature ______________________ Date _____________

Witness ______________________

Rev. Ian Cuthbertson

Ministers Suicide Awareness

Experience Dealing with Suicide Attempt



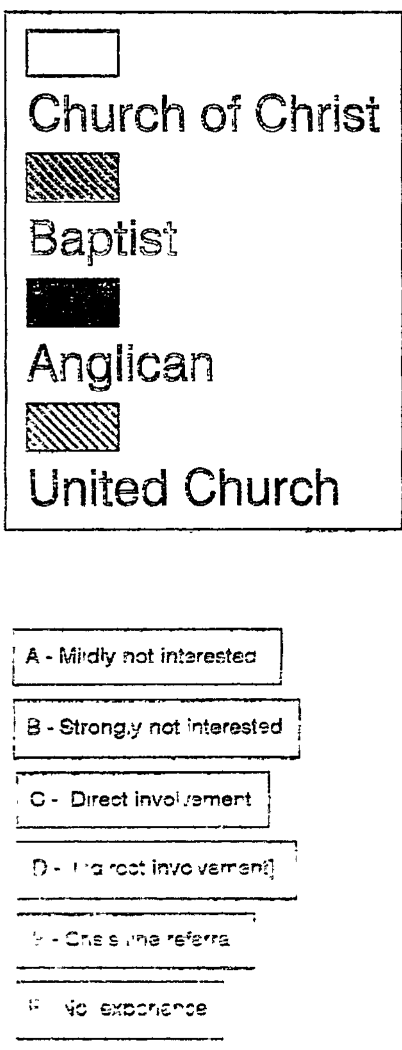
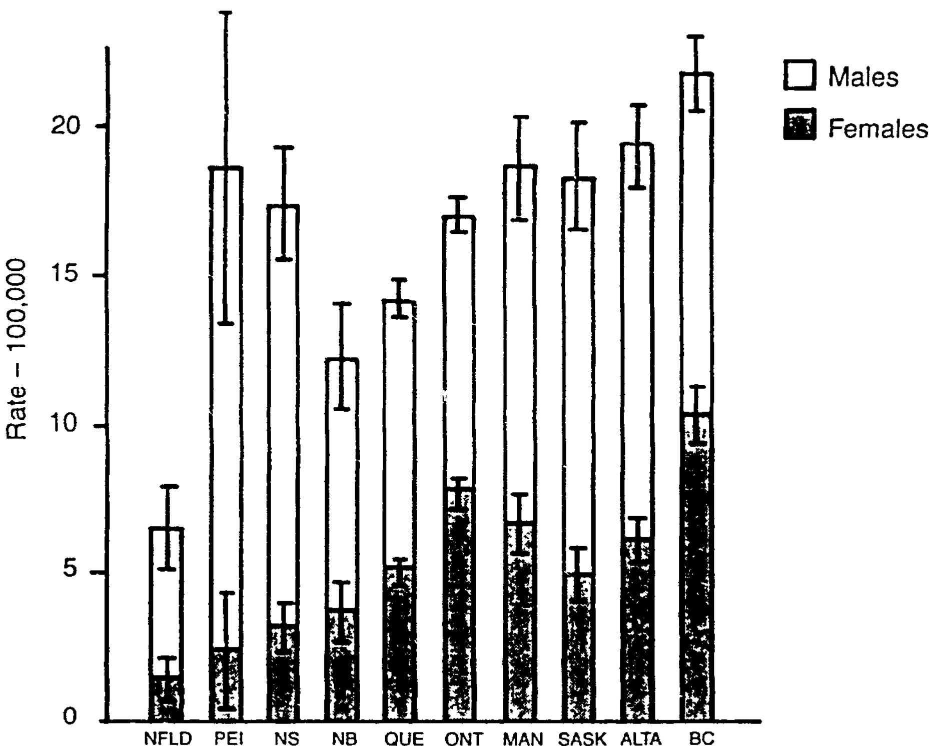
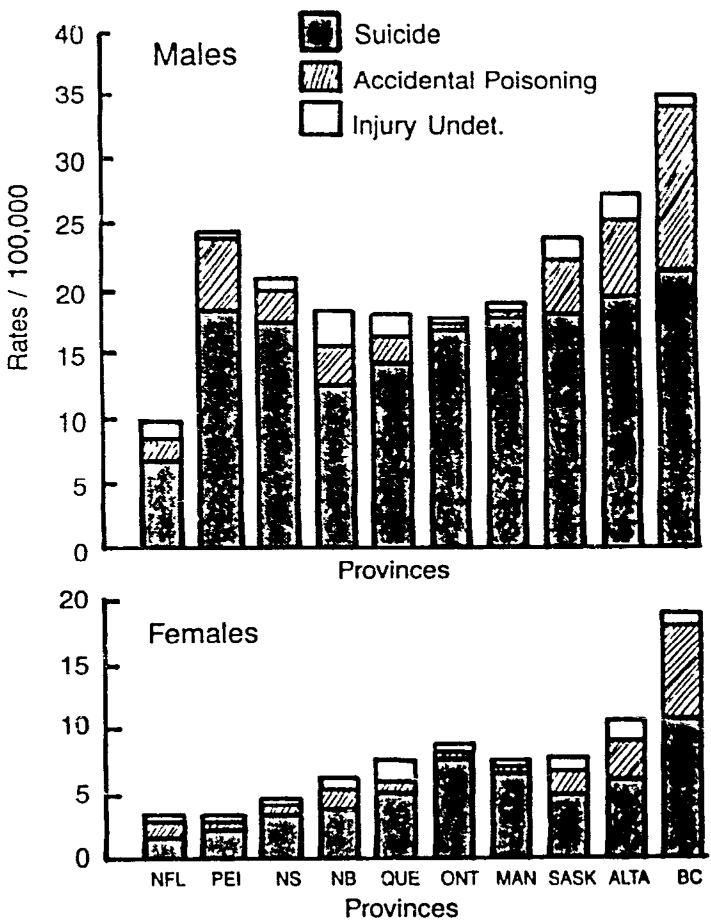


Figure 12. Averaged Standardized Suicide Rates by Sex, Provinces of Canada (1969–1973)



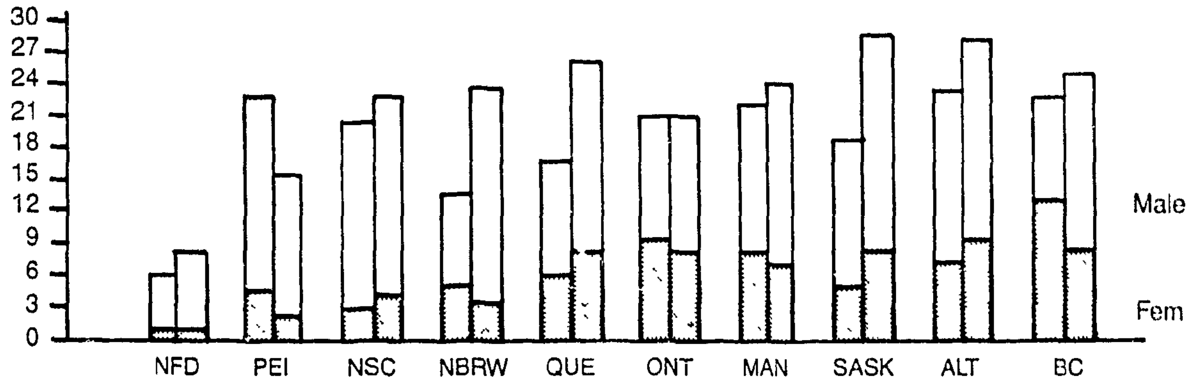
Source : Sakinofsky, I. and Roberts, R. The Ecology of Suicide in the Provinces of Canada. In B. Cooper (Ed.), Psychiatric Epidemiology: Progress and Prospects (provisional title). London: Croom Helm, in press.

Figure 13. Suicide and Other Causes of Death, by Province and Sex. (STD. Ave. Rates 1969–1973)



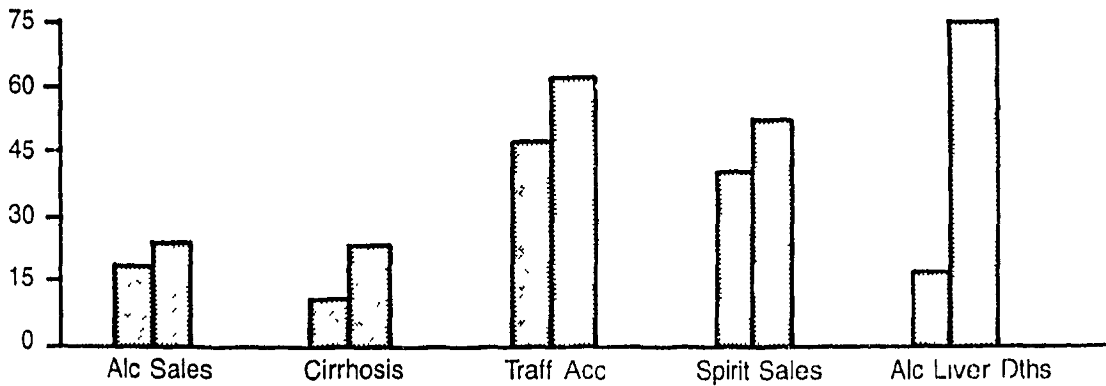
Source: Sakinofsky, I. and Roberts, R. The Ecology of Suicide in the Provinces of Canada. In B. Cooper (Ed.), Psychiatric Epidemiology: Progress and Prospects (provisional title). London: Croom Helm, in press.

Figure 14. Standardized Average Suicide Rates Provinces of Canada (1969–71 and 1979–81)



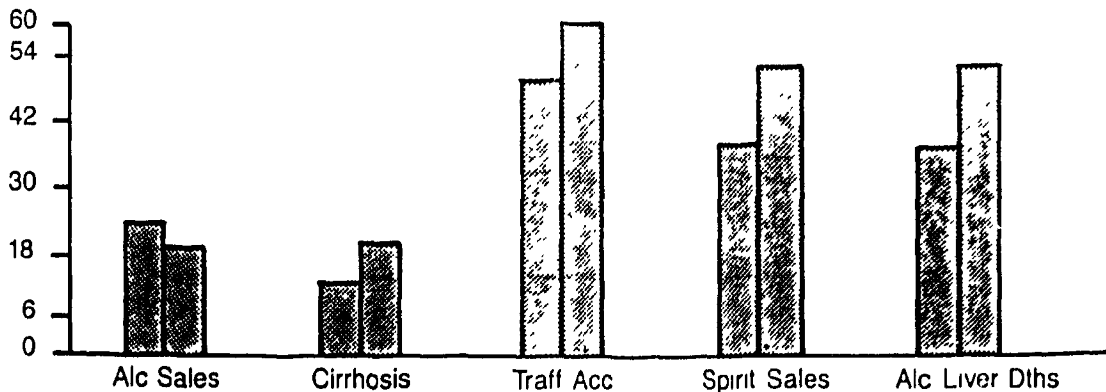
Source : Sakinofsky, I. and Roberts, R. The Ecology of Suicide in the Provinces of Canada In B. Cooper (Ed), Psychiatric Epidemiology: Progress and Prospects (provisional title) London: Croom Helm, in press.

Figure 15a. Provinces with Low and High Change in Male Suicide 1971–81: Alcohol Related



Source: Sakinofsky, I. and Roberts, R. The Ecology of Suicide in the Provinces of Canada In B Cooper (Ed), Psychiatric Epidemiology: Progress and Prospects (provisional title) London: Croom Helm, in press

Figure 15b. Provinces with L[illegible] and High Change in Female Suicide [illegible]–81: Alcohol Related



Source: Sakinofsky, I. and Roberts, R. The Ecology of Suicide in the Provinces of Canada. In B. Cooper (Ed), Psychiatric Epidemiology: Progress and Prospects (provisional title). London: Croom Helm, in press.

Table 1 Deaths from suicide in the European Region of the World Health Organization (latest year available)[a] and Canada[b]

Country	Year	Males		Females		Total	
		No.	Rate per 100,000 population	No.	Rate per 100,000 population	No.	Rate per 100,000 population
Austria	1980	1342	37.8	590	14.9	1932	25.7
Belgium	1977	1201	25.0	673	13.4	1874	19.1
Bulgaria	1980	842	19.1	364	8.2	1206	13.6
Canada[b]	1983	2885	23.4	870	6.9	3755	15.1
Czechoslovakia	1975	2345	32.5	896	11.8	3241	21.9
Denmark	1980	1039	41.1	579	22.3	1618	31.6
Finland	1978	963	43.9	237	9.7	1200	26.2
France	1978	6447	24.7	2711	10.0	9158	17.2
German Federal Republic	1980	8332	28.3	4536	14.1	12868	20.9
Greece	1979	786	4.0	91	1.9	277	2.9
Hungary	1980	3644		1465	26.5	4809	44.9
Iceland	1980	14	12.2	10	8.8	24	10.6
Ireland	1978	106		57	3.5	163	4.9
Italy	1978	2863	9.3	1092	3.8	3657	6.4
Luxemberg	1980	35	19.7	12	6.5	47	12.9
Malta	1977	0	—	0	—	0	—
Netherlands	1980	901	12.8	529	7.4	1430	10.1
Norway	1980	370	18.3	137	6.6	607	12.4
Poland	1979	3766	21.8	732	4.0	4498	12.7
Portugal	1979	701	16.0	251	4.8	952	9.7
Spain	1978	1094	6.1	413	2.2	1507	4.1
Sweden	1980	1137	27.6	473	11.3	1610	19.4
Switzerland	1980	1128	36.7	493	16.2	1621	25.7
United Kingdom							
England & Wales	1980	2629	11.0	1692	6.7	4321	8.8
Northern Ireland	1978	38	5.0	32	4.1	70	4.5
Scotland	1981	339	13.6	177	6.6	516	10.0

Source: a. World Health Organization. Prevention of Suicide (Public Health Papers, No. 35), Geneva, Switzerland: WHO, 1982b.
b. Canadian data from Statistics Canada, Vital Statistics and Health Status Section, Ottawa.

Table 2 Estimated number of years of life lost to suicide in Canada (1963 – 1976)

Age group	Total number of suicides	Total life-years lost
10 - 14	214.3	12,429
15 - 19	2,406.7	127,556
20 - 24	5,333.4	256,005
25 - 29	5,704.7	245,303
30 - 34	5,885.7	223,657
35 - 39	7,423.8	244,985
40 - 44	9,297.0	260,316
45 - 49	10,524.6	242,067
50 - 54	11,492.0	206,856
55 - 59	10,817.8	140,631
60 - 64	9,060.9	72,487
65 - 69	7,011.1	21,033
		2,053,325

Source: Peters, R. and Termansen, P.E. Trends in the demography of suicide in Canada. Unpublished document, 1982.

Table A-1 Canada: Suicide rates per 100,000 total population age ten years and over, by 5-year age groups, 1960-1985

YEAR	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +	Total
1960	0.3	3.3	7.3	9.9	9.7	9.5	10.7	14.9	16.5	18.4	19.1	15.4	12.7	7.6
1961	0.4	2.3	5.7	7.0	8.6	10.2	12.8	16.0	17.7	17.6	19.0	19.7	13.8	7.5
1962	0.6	3.2	6.8	8.1	9.2	10.1	10.9	14.5	18.4	18.3	17.3	13.8	9.2	7.2
1963	0.7	3.9	8.1	8.4	9.8	11.3	12.8	13.3	17.5	17.1	17.6	15.1	11.6	7.6
1964	0.6	3.5	7.7	9.2	12.2	12.3	13.7	16.1	19.4	19.7	20.1	15.8	10.8	8.2
1965	0.8	3.7	8.3	9.7	11.4	13.1	14.8	15.3	21.0	20.7	21.9	19.6	11.1	8.8
1966	0.9	3.7	9.1	10.8	9.9	13.7	13.0	16.7	20.2	22.2	18.1	14.5	11.4	8.6
1967	0.6	5.0	10.1	11.5	12.8	12.4	16.7	16.9	17.9	21.2	17.1	18.2	9.9	9.0
1968	0.8	4.6	10.9	12.2	13.4	15.1	17.8	16.9	20.6	22.2	19.5	18.5	9.9	9.7
1969	0.7	6.2	13.9	12.4	12.9	16.4	18.5	22.2	21.7	24.4	20.8	15.6	13.4	10.9
1970	0.7	7.0	14.0	13.8	15.3	18.2	19.7	21.2	21.3	22.6	19.9	19.6	11.0	11.3
1971	0.7	7.9	14.4	14.1	15.6	17.3	21.8	22.0	23.8	23.3	22.1	16.3	10.9	11.9
1972	1.0	9.3	16.9	16.9	16.0	17.6	21.2	20.5	22.4	20.0	18.3	16.8	10.6	12.2
1973	1.0	9.1	16.6	15.5	15.5	18.7	17.5	23.0	21.5	23.7	24.6	21.5	9.8	12.6
1974	0.7	10.8	19.0	17.6	15.1	19.3	20.3	20.9	23.2	19.5	18.5	19.2	12.1	12.9
1975	0.9	10.1	18.8	16.8	13.1	17.5	19.1	18.9	21.0	19.9	17.7	19.9	9.6	12.3
1976	1.0	10.7	18.6	18.1	17.2	16.3	19.6	21.0	20.7	19.3	17.9	13.6	10.1	12.8
1977	1.4	12.6	22.6	18.5	17.5	19.9	18.7	22.3	24.8	20.5	17.5	19.6	10.6	14.2
1978	1.4	12.0	22.2	22.1	19.0	18.1	21.7	21.5	21.8	21.3	20.7	18.0	10.6	14.8
1979	1.1	12.9	21.7	18.8	17.3	17.7	20.9	21.9	20.5	21.0	20.3	18.4	9.4	14.2
1980	1.1	11.8	18.8	20.3	17.2	17.1	16.8	22.2	22.1	19.3	20.6	18.4	13.2	14.0
1981	1.8	12.7	19.6	16.1	17.7	16.4	20.1	19.6	21.3	21.9	17.1	17.5	13.7	14.0
1982	1.4	12.6	19.1	20.5	18.1	17.3	18.4	20.6	22.2	22.3	17.5	17.5	11.9	14.3
1983	1.2	13.4	19.8	20.5	19.3	17.3	20.8	22.0	19.4	21.9	21.2	19.3	14.5	15.1
1984	1.5	12.3	18.8	17.3	17.4	16.2	18.6	17.1	22.1	21.0	17.7	16.0	12.4	13.7
1985	0.9	11.2	17.7	16.8	16.7	15.9	17.0	17.7	17.8	18.2	15.5	16.2	15.8	12.9

Table A-2 Canada: Suicide rates per 100,000 female population age ten years and over, by 5-year age groups, 1960-1985

YEAR	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +	Total
1960	0.1	1.2	2.4	4.0	4.1	3.2	4.5	5.8	7.6	7.1	8.4	6.2	5.7	3.0
1961	—	0.9	2.5	2.9	4.3	4.7	4.5	9.0	6.9	7.0	4.8	7.3	3.8	3.0
1962	0.2	1.4	2.6	3.6	5.3	5.0	5.2	6.9	7.4	6.5	6.1	6.0	3.3	3.1
1963	0.1	2.4	3.2	5.3	5.2	5.9	5.9	7.3	10.7	8.7	5.6	7.1	4.8	3.8
1964	0.1	1.7	3.7	4.9	6.4	7.8	6.7	8.0	11.0	10.8	6.4	8.5	3.5	4.1
1965	0.3	1.8	2.9	4.5	7.5	7.9	8.0	9.3	10.9	10.4	10.3	8.7	5.9	4.5
1966	0.1	1.3	3.0	6.3	4.9	8.5	6.6	10.2	11.0	13.9	9.0	4.7	4.2	4.3
1967	0.2	1.5	4.1	6.0	7.5	7.2	12.0	9.1	10.2	11.0	8.2	8.8	4.8	4.8
1968	0.3	1.3	5.3	5.9	7.3	10.3	12.1	9.8	13.7	9.0	8.5	10.0	5.3	5.2
1969	0.3	1.8	6.4	7.2	8.4	9.3	11.2	15.5	13.5	15.2	13.5	9.3	5.2	6.2
1970	0.3	3.8	5.8	8.2	9.4	9.7	11.9	15.1	13.9	13.2	8.9	11.2	5.5	6.4
1971	0.4	3.1	5.7	5.7	10.2	9.9	13.2	14.9	14.6	13.3	11.1	9.6	6.1	6.4
1972	0.5	4.3	5.7	11.2	9.3	11.8	14.7	12.2	13.1	12.6	9.8	10.8	6.7	6.9
1973	0.3	4.3	5.9	9.5	10.1	9.9	9.5	15.2	13.0	15.3	14.7	13.3	7.7	7.1
1974	0.3	3.2	6.7	9.9	9.1	12.9	11.2	13.8	15.7	13.5	12.1	11.6	5.7	7.1
1975	0.3	4.2	7.9	8.5	7.4	11.6	13.0	13.5	13.2	11.9	8.1	12.1	5.7	6.8
1976	0.4	4.3	8.2	7.8	11.8	11.0	12.2	13.7	11.2	14.0	11.1	8.6	6.6	7.2
1977	0.7	4.7	7.1	9.4	8.9	10.9	9.4	14.3	15.6	13.4	12.6	11.1	6.2	7.3
1978	0.5	4.4	7.1	9.8	8.3	9.3	14.0	11.1	14.1	13.0	13.4	11.5	7.3	7.3
1979	0.7	4.9	8.4	8.3	7.5	10.8	11.0	10.8	15.0	11.7	8.5	10.6	6.9	7.0
1980	0.6	3.8	7.0	8.2	8.0	8.7	8.8	12.9	14.5	10.9	13.6	9.6	7.3	6.8
1981	1.0	3.8	5.9	6.9	8.1	8.5	12.1	11.9	12.7	13.6	8.9	11.0	8.0	6.8
1982	0.4	3.2	6.2	8.0	8.0	10.0	9.9	10.5	11.7	12.9	8.5	8.9	5.6	6.4
1983	0.3	3.7	5.2	7.6	8.7	10.4	11.6	14.0	10.9	11.2	11.5	11.0	7.3	6.9
1984	0.4	3.2	5.2	6.5	7.7	7.6	11.2	9.0	12.0	10.9	10.4	9.9	6.1	6.1
1985	0.6	3.6	4.2	6.1	7.0	7.8	8.3	10.4	7.6	8.8	7.3	8.0	6.2	5.4

Table A-19 Ontario: Suicide rates per 100,000 total population age ten years and over, by 5-year age groups, 1960-1985

YEAR	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+	Total
1960	0.7	3.6	7.2	9.8	10.4	10.3	10.7	16.1	19.2	24.0	18.8	19.2	14.0	9.8
1961	0.7	2.5	7.8	9.5	8.9	11.7	13.8	13.3	19.7	25.2	21.0	22.8	13.7	10.0
1962	0.6	3.2	7.4	8.7	10.1	11.2	12.0	16.9	22.4	21.9	17.5	13.1	8.7	9.3
1963	0.9	4.0	9.3	8.3	10.1	12.5	15.6	15.4	21.2	20.7	21.2	10.6	12.8	10.0
1964	1.2	3.9	7.9	6.3	14.0	13.4	11.4	17.7	17.3	17.6	25.4	17.2	9.1	9.7
1965	0.9	3.2	9.9	9.3	10.8	10.2	16.4	15.0	23.5	23.1	29.0	15.9	11.1	10.5
1966	1.3	4.0	6.4	9.9	12.1	14.6	13.4	18.7	22.1	23.5	22.9	13.6	14.1	10.6
1967	0.6	5.1	9.9	12.1	12.0	14.2	18.6	20.0	23.3	27.4	21.9	24.6	8.7	11.8
1968	1.1	3.5	9.8	13.9	13.7	14.5	21.4	22.6	26.1	27.0	23.6	20.6	11.1	12.5
1969	0.3	5.7	12.3	11.8	12.7	15.4	19.2	23.7	21.8	28.3	26.1	17.7	17.2	12.8
1970	0.6	6.6	13.0	13.2	14.3	17.5	22.7	19.9	25.1	24.4	23.2	27.1	10.1	12.1
1971	0.4	8.8	15.4	14.5	15.9	17.9	25.9	26.8	32.0	29.7	30.4	18.0	9.8	13.9
1972	1.3	9.5	13.6	18.5	14.8	17.7	26.2	24.1	24.3	22.9	21.1	18.5	13.1	13.4
1973	0.6	6.6	13.7	14.8	12.3	20.3	18.7	23.5	20.5	24.3	25.5	24.3	11.6	12.4
1974	0.7	9.8	17.9	16.1	15.0	22.2	25.1	23.7	26.1	23.4	21.1	20.8	12.2	14.0
1975	0.9	10.7	17.7	17.8	11.5	18.2	21.7	21.1	25.3	23.2	21.6	24.5	12.1	13.4
1976	0.9	8.9	15.7	17.9	14.7	19.2	21.3	22.7	23.2	21.9	18.4	15.7	9.8	13.0
1977	1.2	10.8	20.9	19.1	14.6	18.8	19.2	26.7	23.9	21.5	20.1	25.1	12.2	14.5
1978	0.7	9.6	18.2	21.2	17.9	15.3	22.7	24.7	23.7	22.5	18.0	17.5	14.0	14.3
1979	0.8	9.2	18.7	15.0	16.0	17.0	18.2	19.9	19.1	19.8	23.2	19.4	10.7	13.0
1980	0.9	9.9	14.7	18.6	13.3	14.6	18.6	21.9	22.1	20.3	19.0	18.1	13.5	13.1
1981	1.0	9.6	14.8	12.4	14.1	12.4	17.9	20.3	21.1	20.5	16.8	20.3	14.8	12.5
1982	1.8	9.3	14.8	16.3	13.7	15.8	16.0	19.5	20.4	21.7	21.0	19.7	11.2	12.7
1983	0.9	9.4	16.3	15.1	13.4	14.9	17.1	21.2	17.4	22.4	17.8	20.7	14.0	12.9
1984	0.9	9.0	16.0	15.8	13.6	13.4	15.9	15.3	19.0	20.0	17.0	18.1	12.9	12.3
1985	0.3	8.5	15.1	13.9	16.2	13.5	14.8	16.3	15.4	15.3	13.1	18.2	15.5	11.4

Table A-20 Ontario: Suicide rates per 100,000 female population age ten years and over, by 5-year age groups, 1960-1985

YEAR	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+	Total
1960	—	0.5	3.1	3.8	5.7	4.3	3.1	6.9	8.8	15.1	10.2	8.7	4.0	4.3
1961	—	0.9	4.1	4.3	5.8	3.8	4.6	4.5	7.9	8.6	3.6	11.7	3.8	3.8
1962	—	1.7	4.0	5.8	8.1	5.9	6.9	10.0	9.0	9.2	7.1	7.3	3.7	4.9
1963	—	2.0	4.9	5.4	5.0	6.8	6.6	9.9	13.8	8.9	6.1	5.0	6.2	5.0
1964	0.3	2.6	4.2	4.3	10.5	9.4	7.7	9.7	10.3	13.0	7.6	11.8	5.5	5.9
1965	—	2.1	3.5	3.3	7.3	6.4	9.6	12.2	15.9	9.8	14.0	4.8	5.9	5.7
1966	0.3	1.7	2.4	6.9	7.2	11.2	8.0	11.8	13.2	15.7	10.4	4.7	5.2	6.0
1967	0.3	1.6	5.7	6.6	9.9	7.8	12.5	12.8	12.9	12.5	10.1	12.9	7.3	6.8
1968	0.6	1.2	5.4	6.3	8.1	12.2	15.4	13.7	19.3	8.9	9.8	11.7	6.2	7.2
1969	—	3.0	6.0	8.0	7.1	8.8	13.1	20.3	12.0	16.6	19.2	11.3	5.2	7.7
1970	0.3	3.8	4.1	8.4	12.2	10.6	16.5	16.7	20.5	20.2	13.6	14.6	8.3	8.2
1971	0.5	2.8	6.8	6.1	12.7	10.5	13.8	18.5	22.4	17.9	17.4	12.3	6.1	8.1
1972	0.3	4.2	6.0	14.1	11.1	13.5	20.8	16.3	19.5	17.0	10.8	11.3	10.6	8.9
1973	0.3	2.4	5.0	11.4	9.3	13.1	11.2	17.3	12.1	16.0	17.7	13.3	8.4	7.7
1974	0.5	2.9	6.5	9.6	10.7	15.8	15.5	18.3	20.4	15.9	15.8	15.2	5.9	8.6
1975	—	4.4	6.8	11.2	7.0	12.6	14.2	15.4	18.5	12.7	13.4	19.5	3.6	7.9
1976	0.8	3.5	8.0	8.3	8.6	14.0	14.5	10.7	12.6	17.3	15.4	10.7	9.0	8.1
1977	1.1	5.7	5.4	8.6	7.0	10.0	12.4	20.2	16.5	15.3	15.8	17.9	8.7	8.3
1978	0.6	3.4	7.6	9.4	9.2	7.3	13.7	14.6	13.6	13.0	12.3	15.3	7.8	7.6
1979	0.6	4.6	8.3	9.3	5.9	10.4	9.8	9.4	14.2	13.7	11.6	10.4	7.2	7.1
1980	0.9	4.4	7.0	6.7	6.3	11.1	13.1	12.5	14.2	13.0	15.8	10.6	7.9	7.4
1981	0.6	2.5	4.5	5.9	6.0	7.6	13.5	13.4	13.7	15.4	8.5	14.0	7.9	6.7
1982	0.3	2.6	6.0	6.8	7.2	9.3	10.7	10.4	9.4	12.0	11.1	13.8	4.8	6.3
1983	0.6	2.7	4.2	6.4	5.2	10.0	7.6	15.1	10.3	12.8	12.4	13.8	7.1	6.5
1984	0.6	2.6	6.0	6.8	5.7	8.1	10.6	7.2	13.7	12.4	12.2	13.8	8.9	6.7
1985	0.3	2.0	5.3	5.2	7.1	5.3	7.1	10.4	7.7	11.1	7.5	8.1	7.8	5.4

COUNCIL ON SUICIDE PREVENTION
(HAMILTON & DISTRICT) INC.

HAMILTON/WENTWORTH STATISTICS

YEAR	OVER 30	UNDER 30	TOTAL
1979	53	10	63
1980	43	9	52
1981	39	19	58
1982	44	19	63
1983	31	18	49
1984	40	19	59
1985	35	8	43
1986	32	14	46
1987	32	16	48
1988	42	20	62
1989	25	13	48
1990	38	15	53
1991	35	17	52
1992	9	28	37
1993	41	6	47

HAMILTON/WENTWORTH REGIONAL POLICE

Speaker's Bureau
Council On Suicide Prevention,
(Hamilton And District) Inc.

SUICIDE PREVENTION COALITION

c/o Council On Suicide Prevention (Hamilton & District) Inc.
205 Queensdale Ave. E., Hamilton, Ontario. L9A 1L1
(905) 388-0933

Councils On Suicide Prevention
(Hamilton & District) Inc
London-Middlesex
Peel
Toronto

Crisis & Distress Centres
Ontario Association
Telecare/Hamilton
Suicide Prevention Bureau/Hamilton

Community Health Departments
Waterloo community Health

Individual Agencies
Hamilton Wentworth Dept Social Services
Hamilton Trauma Prevention
Nexus Youth Services

Task Force
Haldimand Norfolk

Churches
The Salvation Army
Church Of Christ Grand Valley, Ont

Member Makeup
Clergy
Interested Individuals
Lay persons
Nursing
Mental Health Professionals
Social Workers

FACT SHEET

1) *SUICIDE is still a word people do not want to talk about. Twenty-five years ago people never wanted to talk about "cancer". Nobody wanted to say the "C" word. Suicide is that "S" word that nobody wants us to say.*

2) *SUICIDE PREVENTION IS EVERYBODY'S BUSINESS because suicide can happen in any family. The rich, the poor, the education or under-educated, the old, the young, and all cultures can be affected by a suicide. It does not always happen to "the other person" it might happen to us. It even happens in families where there is a lot of communication. We must eliminate the stigma and people must know suicide can be prevented if more people are aware. They must ask for the necessary help or they must offer their help.*

3) *Suicidal thoughts, behaviour and attempts are cries for help.*

4) *One in seven Canadians has seriously considered suicide.*

5) *Many productive years of life are lost in our communities each year because of suicide.*

6) *Because of the number of family and friends involved with each of us, the Canadian Mental Health Association estimated that with each completed, and attempted suicide, "8% of our Canadian population is affected by suicide" .*

7) *"For every completed suicide, there are on average 100 attempts", Sharon Barnes, the National President for the Canadian Mental Health Assoc.*

8) *"Because of the stigma surrounding suicide, as many as 30% of suicides are not reported", Sharon Barnes, the National President for the Canadian Mental Health Association.*

9) *If someone continually threatens suicide it is important that each time is taken seriously. If a person continually says they want to die then they must be in some kind of pain. They want to get rid of that pain. They really are asking for, and do need help.*

10) *ANYONE can become depressed but because of the stigma still attached to mental health issues, many people with depression do not seek treatment as quickly as they should. Without treatment there is a substantial risk of suicide.*

11) *Suicide is the SECOND LEADING CAUSE of death in our Canadian young people.*

12) *Canada has a HIGHER RATE of suicide than the United States.*

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SUICIDE PREVENTION COALITION

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Community Health Departments
Waterloo Community Health

Individual Agencies
Hamilton-Wentworth Dept. Social Services
Hamilton Trauma Prevention
Nexus Youth Services

Task Force
Haldimand Norfolk

Churches
The Salvation Army
Church Of Christ, Grand Valley, Ontario

Member Makeup
Clergy
Interested Individuals
Lay persons
Nursing
Mental Health Professionals
Social Workers

SUICIDE IS EVERYBODY'S BUSINESS!

Individuals and organizations committed to the prevention of suicide in their own communities have joined together to focus on suicide prevention awareness throughout Ontario.

This Suicide Prevention Coalition wants to present a unified message. It wants to educate, encourage community sharing and caring, and develop community awareness to change public perception and to increase suicide prevention opportunities.

Suicide is not a comfortable topic for most people therefore it is not widely communicated that there are prevention centres, suicide crisis lines or other helping agencies available. They do not know that suicide can be prevented if people are aware of the signs, symptoms, causes and where to go for help if someone is suicidal.

The Coalition is encouraging all churches, businesses, agencies, groups, educational facilities, etc. to join with them to promote Suicide Prevention Week, May 14th - 20th, 1995. The theme being: "SUICIDE IS NOT A JOKE; IT IS EVERYBODY'S BUSINESS".

Suicide can happen to anyone, therefore, the friends and families left behind are the victims. SUICIDE IS EVERYBODY'S BUSINESS!

WE CAN HELP SOMEONE WHO IS SUICIDAL BY:

LISTENING - This might be all we need to do.

TALKING ABOUT IT - If you think someone is suicidal then talk about it. This gives the opportunity for the person to really think about what they are saying. Many people do not want to end their lives but they do want to get rid of their problem.

BELIEVING THE PERSON - If a person is talking about suicide, he, or she, is in some sort of pain and needs help.

ENCOURAGING THE PERSON TO SEEK PROFESSIONAL HELP - All of us can give support and caring but the person will need more help than this.

STAYING WITH THE PERSON UNTIL HELP IS AVAILABLE - This person has come to you and trusts you. If the person will not let someone else come to help them, try to convince the person to go with you for professional help.

COLLECTING PHONE NUMBERS OF HELPING AGENCIES If you cannot convince the person to go for professional help then make sure numbers are available to the person. You can only do what the person will let you do.

TALKING TO SOMEONE YOURSELF - You cannot handle this burden by yourself.

FINDING EMERGENCY NUMBERS AND PLACING THEM ON THE BULLETIN BOARD - NOW!

If you are thinking about suicide, talk to someone about it. If someone is talking about suicide, listen!

For further information: *Council On Suicide Prevention (Hamilton & District) Inc. (905) 388 0933*

Suicide Prevention Coalition, 1995

Here is the table of suicides in terms of the Telecare system for all Centres.

	1993	1994
Suicide 1	626	685
Suicide 2	739	868
Suicide 3	150	165
Total Suicide	1,515	1,718
Total Classifiable (Crisis)	57,396	56,457
% Tot Suicide / Total classifiable	2.6	3.0

TELECARE TELEMINISTRIES OF CANADA INC.

ANALYSIS OF PROBLEMS RELATED TO SUICIDE FOR 1993 & 1994

1993 NEW AND PREVIOUS CALLERS ONLY (REGULAR CALLERS EXCLUDED)

	MARITAL STATUS					AGE						GENDER		ALONE	
SUICIDE PROBLEM CATEGORY	SINGLE	SEPARATED	WIDOWED	MARRIED	DIVORCED	UNDER 20	20 - 29	30 - 39	40 - 49	50 - 59	60 AND OVE	MALE	FEMALE	YES	NO
SIGNIFICANT OTHER	37	9	0	10	6	18	17	23	29	14	0	46	55	31	33
ATTEMPT	13	4	1	17	6	4	3	8	19	9	0	18	25	17	22
THREAT/IDEATION	223	46	17	94	50	31	136	100	124	53	22	203	263	228	212
PREVIOUS ATTEMPT	6	2	0	2	2	1	2	1	6	2	0	5	7	5	6
TOTAL	279	61	18	123	64	54	158	132	178	78	22	272	350	281	273
ALL NEW AND PREVIOUS CALLS	10,546	1,290	632	3,658	2,184	3,071	5,143	5,359	4,400	2,267	1,793	10,131	11,880	9,998	7,935
%AGE OF ALL NEW AND PREVIOUS CALLS	2.6	4.7	2.8	3.4	2.9	1.8	3.1	2.5	4.0	3.4	1.2	2.7	2.9	2.8	3.4

1994 NEW AND PREVIOUS CALLERS ONLY (REGULAR CALLERS EXCLUDED)

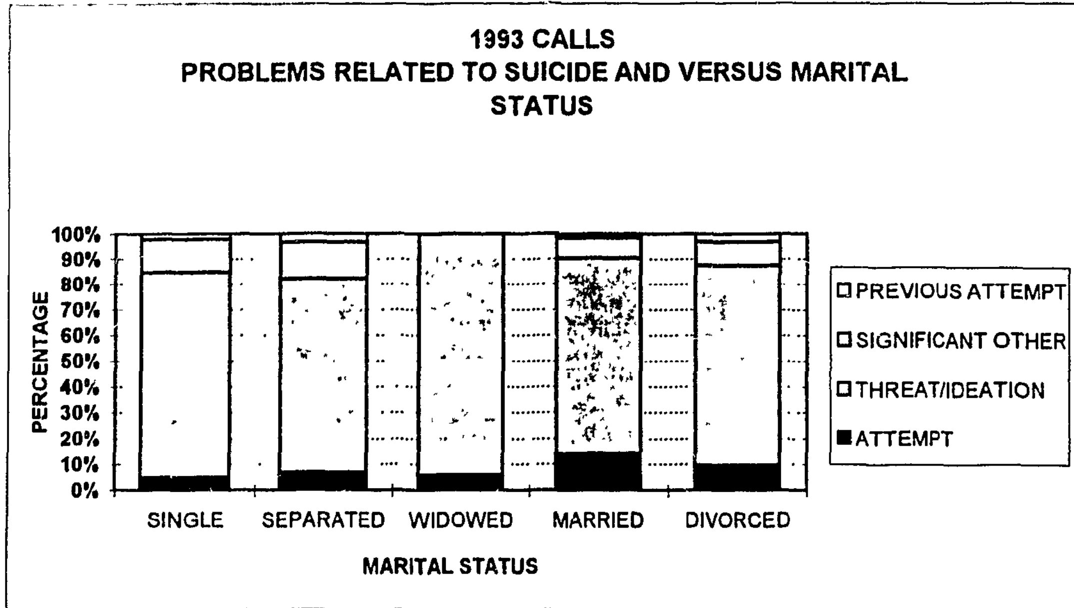
	MARITAL STATUS					AGE						GENDER		ALONE	
SUICIDE PROBLEM CATEGORY	SINGLE	SEPARATED	WIDOWED	MARRIED	DIVORCED	UNDER 20	20 - 29	30 - 39	40 - 49	50 - 59	60 AND OVE	MALE	FEMALE	YES	NO
SIGNIFICANT OTHER	22	0	5	33	3	13	20	24	27	11	0	32	63	12	47
ATTEMPT	26	13	3	21	0	35	25	18	14	0	6	20	48	28	35
THREAT/IDEATION	309	49	12	96	33	56	154	191	91	36	17	213	329	274	229
PREVIOUS ATTEMPT	3	1	0	6	1	0	7	1	2	1	2	9	4	7	6
TOTAL	360	63	20	156	37	104	206	234	134	48	25	274	444	321	317
ALL NEW AND PREVIOUS CALLS	11,215	1,411	696	3,736	2,188	3,055	4,541	5,860	5,706	2,651	1,452	10,035	13,192	11,115	7,927
%AGE OF ALL NEW AND PREVIOUS CALLS	3.2	4.5	2.9	4.2	1.7	3.4	4.5	4.0	2.3	1.8	1.7	2.7	3.4	2.9	4.0

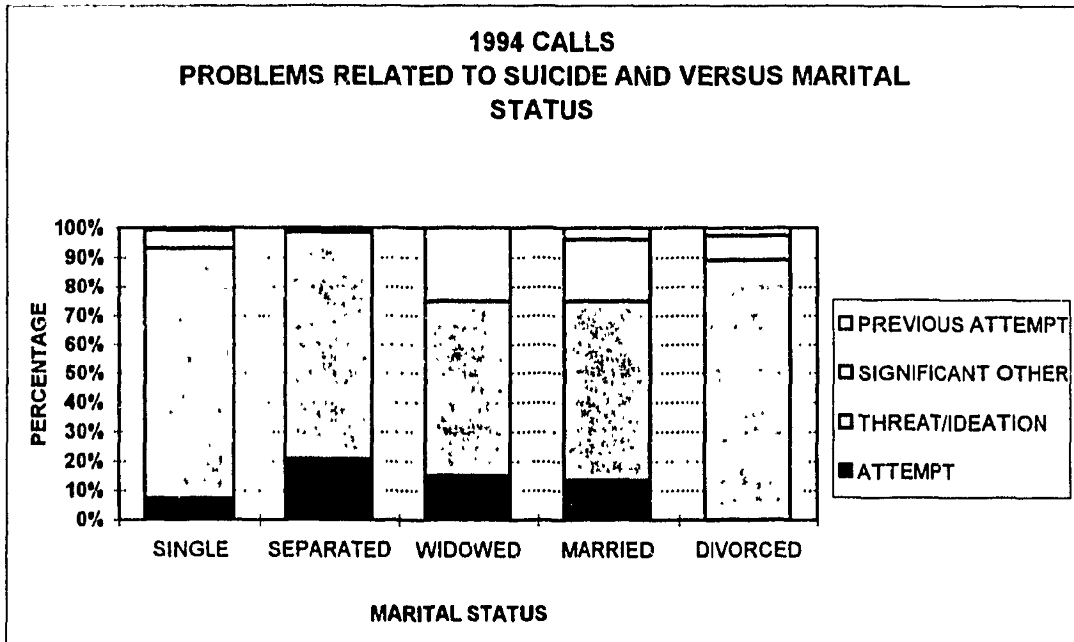
TOTAL NEW AND REPEAT CALLS FOR 1993 = 22,033

TOTAL NEW AND REPEAT CALLS FOR 1994 = 23,265

15/04/95

TELECARE TELEMINISTRIES OF CANADA INC.





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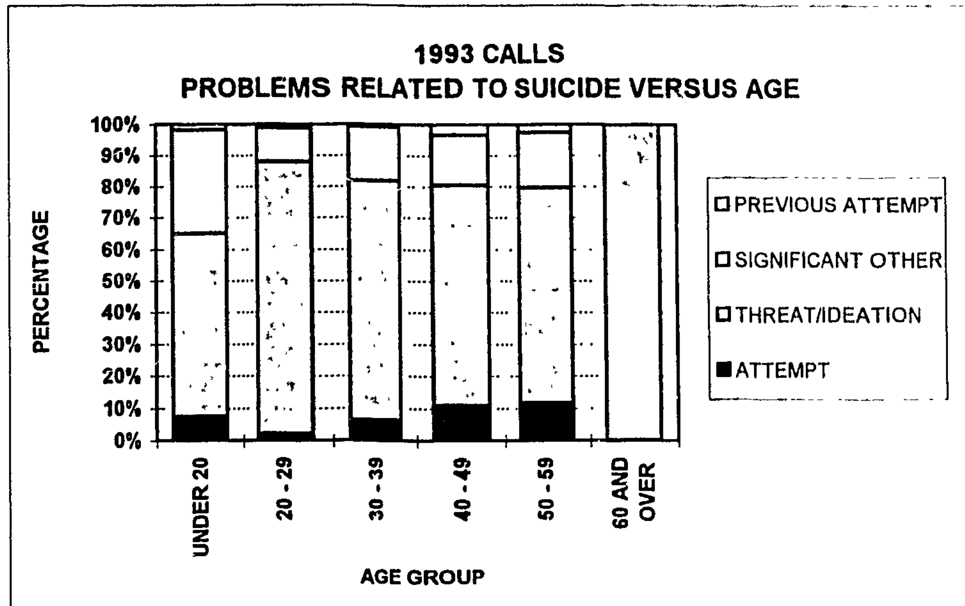

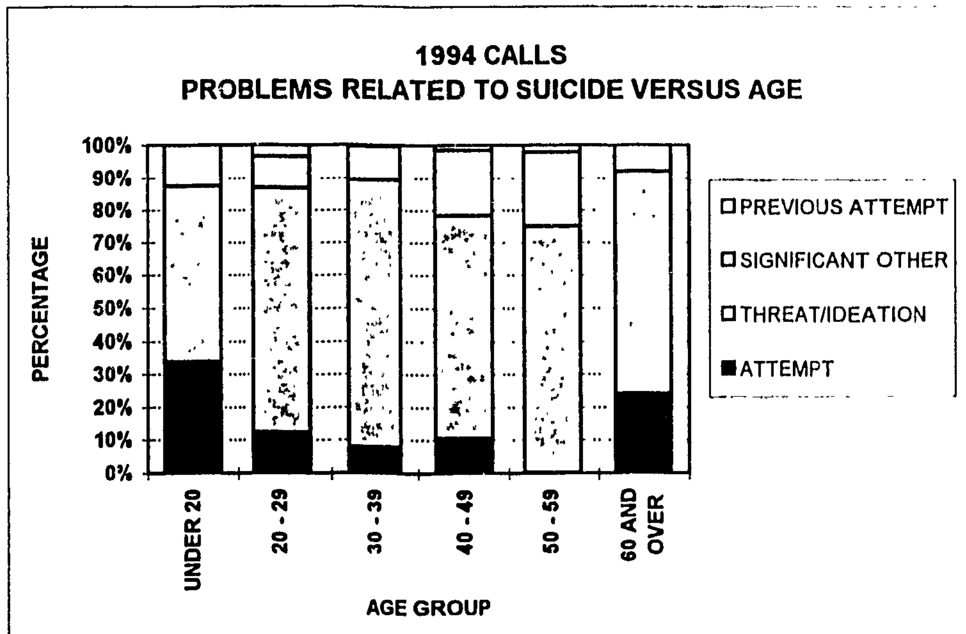

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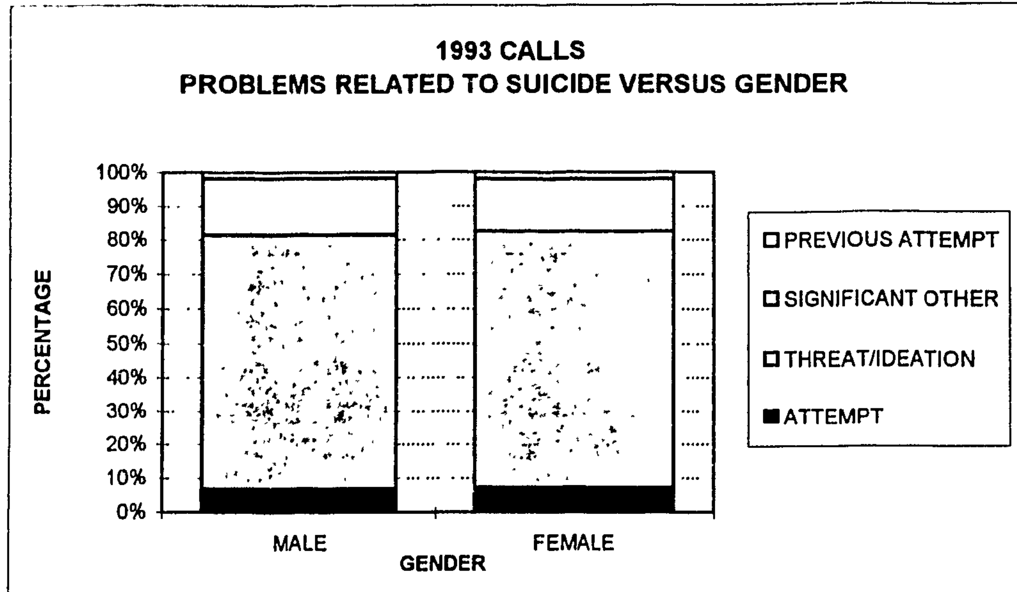
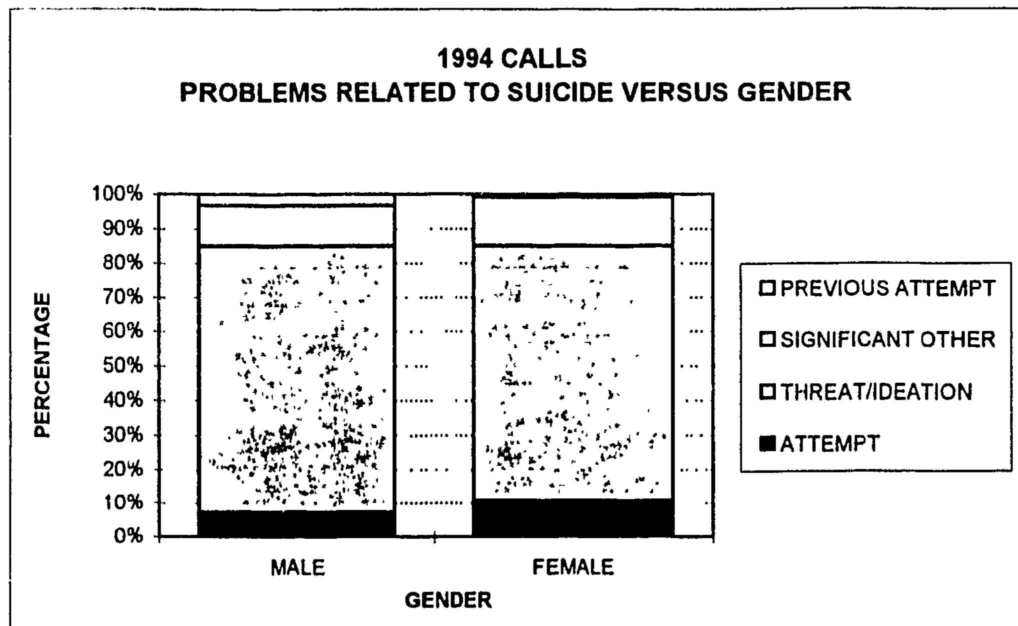
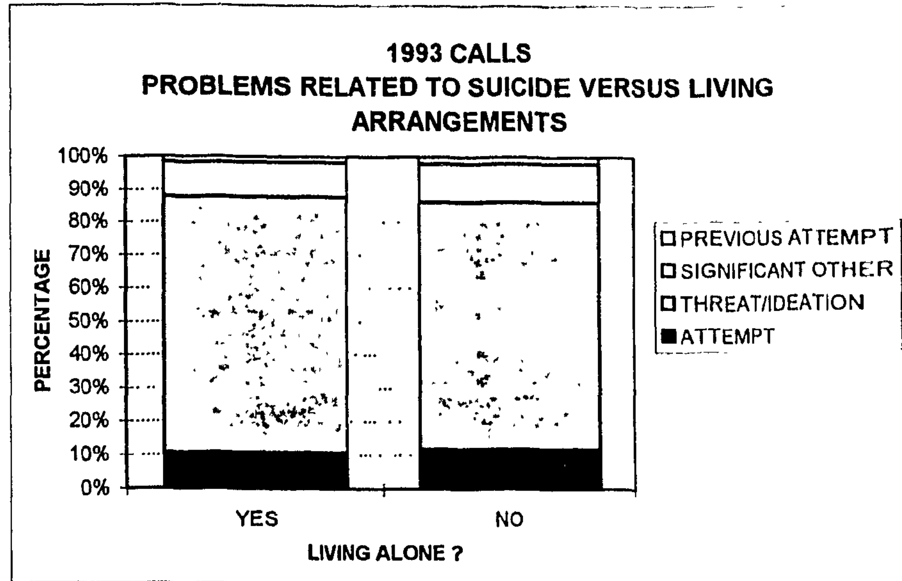
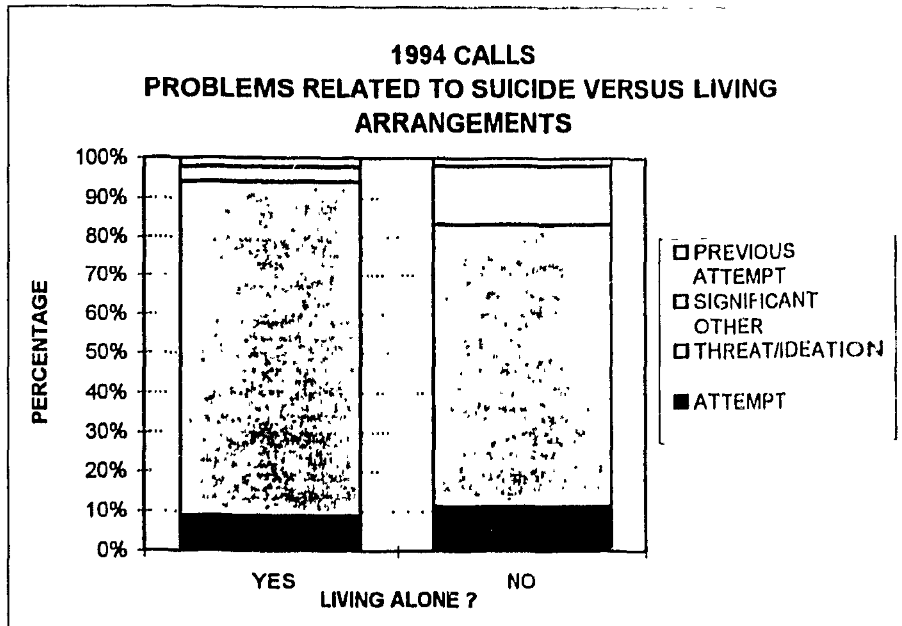




TELECARE TELEMINISTRIES OF CANADA INC.





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