Dealing with Suicide

the needs of clergy in providing pastoral care

Funded by
Protect Life - A Shared Vision:
The Northern Ireland Suicide Prevention Strategy and Action Plan

March 2009

FOREWORD

In 2006, ***Protect Life. A Shared Vision: The Northern Ireland Suicide Prevention Strategy and Action Plan*** was published by the Department of Health, Social Services and Public Safety. The aim of this strategy was '*To reduce the suicide rate in Northern Ireland'* and it identified a number of key objectives through which this aim would be addressed.

Within the Southern area, an extensive consultation exercise was facilitated by the Southern Investing for Health Partnership (SIHP) to develop the first Action Plan to address the recommendations and target groups within the Protect Life strategy.

During that consultation process, the role of Churches, Faith Based Organisations and Religious Bodies in relation to suicide and self harm was raised many times. In order to explore these concerns, a focus group discussion was held for representatives of Churches in the Southern area to further consider these issues.

The Southern Health and Social Services Board (SHSSB) commissioned a study to assess the specific needs of Churches, Religious Bodies and Faith Based Organisations in relation to the Protect Life: Northern Ireland Suicide Prevention Strategy. We are delighted to present this report of that work.

This is the first study of its kind in Northern Ireland and as such will make a significant contribution to the understanding of role and needs of this sector in relation to suicide and self harm. The report makes a number of recommendations for Churches, Religious Bodies, Faith Based Organisations and other sectors and provides direction for all sectors in taking forward and supporting work in this sensitive area.

We would wish to commend the staff of the Research Department of the Northern Ireland Association for Mental Health and within Carecall, in particular Dr Gerard Leavey, lead researcher for the undertaking this work and developing this report.

We would like to acknowledge the considerable work of the Protect Life Commissioning Team in commissioning and overseeing this study, namely Dr Stephen Bergin and Mrs Breda Teahan, SHSSB and Mrs Lyn Donnelly, SIHP and in addition Mrs Clare

Quigley, Mental Health Programme Commissioning Group, SHSSB. However, we would particularly wish to thank the clergy for their time, insights, openness and honesty in to what is a challenging and humbling aspect of their ministry.

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March 2009

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1. EXECUTIVE SUMMARY

This study proceeds from work undertaken by the Southern Health and Social Services Board (SHSSB) in relation to the Northern Ireland Suicide Prevention Strategy and Action Plan which provided within its short to medium-term actions (91-101) detailed and wide ranging targets for statutory agencies engaged in health promotion. The report allocated space to the needs of churches and other faith-based organisations in Northern Ireland (NI), commonly regarded as maintaining an influential position in community life in NI. Thus, the strategy and action plan detailed the following aims:

- By 2007 to ensure that, churches/religious bodies are aware of, and have access to, the local community support networks in their area.
- By 2008 to ensure that, all church/religious leaders are offered the opportunity to avail themselves of suicide awareness training.
- To liaise with religious bodies and local support networks to increase mutual awareness and understanding of their potential support roles during crisis periods.
- To encourage the development of enhanced links between churches/ religious bodies and the local community support networks.
- To make appropriate suicide awareness/mental health and well-being training available for all church/ religious leaders.
- To acknowledge and enhance the significant role that churches and religious bodies play in dealing with those in crisis and those bereaved by suicide.

As part of their Protect Life Strategy the SHSSB undertook consultation with families bereaved through suicide. The pastoral response of clergy to suicide was a common source of dissatisfaction for many families. This generally related, not to insensitivity or rejection on the part of the clergy but rather a ‘sense of awkwardness’ or embarrassment. Families were often left feeling unsupported by clergy at a time when spiritual help and guidance was most needed. In our view, many families may experience an acute sense of guilt in the days and months following the death of a family member; whatever

must be done to ameliorate, or better still, eradicate, the burden of negative emotions should be provided.

Communities can be a valuable source of support, both in practical terms and morally. People need to feel that their neighbours and their religious community are not judging them. In NI, communities exist, which remain relatively rural, tight and sometimes closed; importantly, clergy may have considerable influence on the attitudes within such communities and the way that people behave. It matters therefore, that the response from clergy is positive, caring and non-judgemental. However, the literature suggests that clergy may not be well prepared for pastoral care in matters related to mental health, emotional suffering and suicide. Thus, the issue of mental health literacy and competency may be seen as potentially detrimental to troubled individuals, families and the clergy themselves. Moreover, a potentially valuable community resource in dealing with the aftershock of suicide is under-resourced and in danger of being squandered.

In association with Carecall Ltd, the Research Department of the Northern Ireland Association of Mental Health (NIAMH) was commissioned by the SHSSB to undertake a needs assessment of clergy as part of a community based anti-suicide initiative. Broadly, the aim of the research was to explore the problems and barriers faced by clergy in the delivery of pastoral care to families bereaved by suicide. More specifically, we aimed to look at the needs of clergy in their pastoral role following suicide. The intention was to catalyse positive change for families, clergy and services. By better understanding the impact of suicide on clergy and the complexities involved in supporting families we hoped that such information might be useful to health and social care agencies as well as faith based organisations.

Anyone offering to provide a description of a typical religious minister working in NI would be wise to enter a considerable number of caveats and qualifying remarks. However, in an attempt to convey something of the problems of ministers as they deal with the painful realities of suicide in their communities, it might be useful to provide a composite picture of the clergy who participated in this study.

The clergy in question are compassionate and caring individuals, people who are closely involved with the lives and problems of the community, often they have formed deep affectionate friendships with people who have been affected by suicide. They work alone, putting in long, unpredictable hours dealing with concerns and anxieties related to life and death. Prone to stress and fatigue, there is seldom cover when it is most needed. They worry about their role and their capacity to give. When the focus of their pastoral care is someone with mental illness or perhaps more distressing, dealing with the aftermath of suicide, the minister is nervous, terrified of saying or doing the wrong thing, sometimes perhaps to the point of 'paralysis' when not even religious and spiritual advice seems useful. The pain and loss of confidence evoked by these encounters leave a legacy of stress with clergy for years. There are few resources available to the typical minister in these circumstances – certainly, the skills and knowledge that might have been helpful were not provided during training for the ministry. Similarly, they are not on hand from professional health and social care professionals.

However, even if these training resources, skills workshops and advice sessions were available, our clergy worry that they simply do not have the time to utilise them.

However, the clergy who participated in this study have an enormous depth of experience as ministers working in deeply deprived communities and environments; they have witnessed and managed as part of their work, distressing events that have flowed from many years of sectarian conflict in NI. Most of the clergy who offered their understanding and views about suicide and providing pastoral care to families bereaved by such events have first-hand experience in dealing with these problems; sometimes on several occasions.

The experiences revealed and the knowledge gathered in this study provides a unique and invaluable source for clergy and professionals working in the health and social care sectors. The report will hopefully provide a starting point for dialogue between clergy and services, not just in NI but elsewhere.

Training in almost any aspect of suicide or mental health, as

part of theological training, is probably the most basic and often mentioned request for helping clergy feel up to the tasks and duties required of them. They currently feel at a loss, and are hungry for more information – on counselling skills; signs and symptoms; understanding thought patterns of suicidal people; risk assessment and when to seek outside help; understanding the grieving process; awareness and understanding of mental health problems; availability of resources; prevention strategies and more.

2. KEY FINDINGS

This study identified the following key findings, based on the contribution of all the participants who took part, hereafter known as the Clergy.

- Most Clergy have had personal knowledge or contact with someone who has taken his or her own life. Many have first-hand experience of providing pastoral care to families and close friends bereaved through suicide.
- Clergy feel that tackling suicide is a major issue and feel that faith based organisations should be involved in tackling it.
- Clergy generally lack any training as part of ministry for dealing with mental illness and suicide and have little awareness of advice and support services for mental health problems experienced by congregation members and others.
- Clergy's explanatory models of mental illness are usually encompassed within a social or personal stress construction – however, despite acknowledgement of specific trigger events, clergy often consider the reason behind a suicide as mysterious and unexpected.
- Clergy consider mental illness to be a major precipitant for suicide and this understanding has permitted a more compassionate pastoral response.
- Theological perspectives on suicide and the sanctity of life, while still crucially important to clergy, are not a deterrent to offering compassionate pastoral care.
- There is considerable variation in the causes, circumstances and consequences of suicide. Clergy feel that there is no single appropriate approach to pastoral care.
- Clergy experience a considerable degree of uncertainty and stress in dealing with the aftermath of suicide. The death of someone through suicide provokes considerably more anxiety than 'usual' mortality.
- Clergy are often unsure about how to approach a family following suicide. The importance of careful and sensitive choice of

language was stressed; the fear of upsetting or offending families through a misjudged remark is particularly worrying.

- Most clergy feel that the best response they can offer to families is 'to be there' and offer a 'passive' response. The views, attitudes and needs of families bereaved by suicide are likely to be very different and this requires a pastoral response that is determined by personal knowledge and experience of the family.
- Although religion and spirituality can be comforting, a religion-couched message to families bereaved through suicide was regarded as sometimes unwanted and unhelpful.
- Clergy indicated that they would benefit by attending training on mental illness and suicide but are concerned about peer-perceptions of inadequacy, perceived hostility from secular organisations and lack of time for these activities.
- An inter-faith dialogue and response to dialogue is both desirable and possible. Much interfaith connection currently exists and was thought useful but for some clergy there must be recognition that the beliefs and value systems within different faith groups preclude a straightforward, homogenous response to suicide.

Recommendations

Within Faith Based Organisations:

- Faith based organisations need to recognise the huge demands on their clergy in their pastoral care, from dealing with emotional distress through mental health problems to bereavement by suicide. Stress awareness and management would be a useful part of training for ministry.
- Clergy across some denominations, where such structures exist, would benefit from clear, unambiguous policy and guidance on theological aspects of suicide and

approaches to pastoral care for bereaved families and communities.

- More specifically, clergy would appreciate clear, formal guidelines on the pastoral approach to suicide which would include all the problematic areas for clergy – everything from how to respond to that first phone call to how to conduct a funeral in such circumstances and almost anything that would give them direction beyond common sense approaches upon which they usually rely.
- Clergy could be better supported throughout the years of their ministry by creating formal structures of peer-support *(pastor pastorum*).
- Some clergy may benefit from professional counselling support particularly following suicide by a member of the congregation.
- Clergy need to be offered the time and support to train in mental health awareness and suicide prevention.

Training:

- Clergy should be provided with education and awareness raising regarding mental health problems, symptom recognition and the appropriate response and referral as part of the theological college curriculum.
- The delivery of advice, support, education and training on mental health and suicide must be available to clergy in a range of formats that are easily understood and accessible.

Collaborative:

- Health and social care agencies should recognise the pivotal community role of clergy. There is an urgent need for dialogue between clergy and mental health professionals.
- The provision of seminars and workshops that would be of greatest benefit to clergy would cover a complete programme on suicide awareness and bereavement by suicide.
- A set of guidelines for clergy on how to respond to people bereaved through suicide need to be drawn up collaboratively.

3. LITERATURE REVIEW

3.1 Background

Suicide is reported to be the second most common cause of death among young people, male and female, in Britain after motor vehicle accidents.

The World Health Organisation (2000)(WHO) estimates that around one million people die from suicide each year – a global mortality rate of 16 per 100,000. In the last 45 years suicide rates have increased by 60% with young people being the group at highest risk in a third of all countries.

In NI and in the Republic of Ireland (RoI) suicide is now one of the major causes of death among young males and various studies indicate that the rates for suicide and self-harm are on the increase. In 2006, there were 291 such deaths in NI, 227 were male suicides and 64 were female suicides. This is a marked rise on the number registered in 2005 when 213 suicides were recorded (167 males and 46 females). It is therefore, a major public health concern and one that challenges health and welfare agencies.

In England, mental health is one of the priorities for action set out in *Saving Lives: Our Healthier Nation (Department of Health, 1999)*. This sets a target to reduce the death rate from suicide by at least a fifth by 2020. The second annual report outlining progress with implementation of England's first national suicide prevention strategy shows a fall of nearly 30% in the suicide rate among young men since 1998. The *Our Healthier Nation* (Department of Health, 1999) target is to reduce the overall death rate from the baseline of 9.2 deaths per 100,000 in 1995-97 to 7.4 per 100,000 in 2009-11. A range of actions and progress are outlined in the report.

Importantly, there has been a marked decline in the suicide rate in England and Wales over the past 10 years, indicating that targeted anti-suicide policies on high risk groups such as prisoners, farmers, young men and those who self-harm, may be effective. For instance, about 27% of those who take their own lives in England and Wales have been in receipt of mental health services, about 1300 per year. Forty-nine percent had been in contact with services in the previous week, and 19% in the previous 24 hours (University of Manchester, 2006).

> "The causes of suicide are multi-faceted, and entail an interaction of biological, psychological, social and environmental risk factors occurring in an individual who may have various socio-demographic vulnerabilities interfacing with life-long susceptibilities that are usually subject to a precipitating event, with catastrophic consequences" (Joint Committee on Health and Children, 2006, p2).

Thus, suicide has provoked research from a plurality of disciplines – sociological, psychological, social-psychological and epidemiological. Most of these studies deal with the interaction between the individual, social groups and wider social processes in the attempt to identify causal linkages or risk factors, raising the possibility of lowering the suicide rate by lessening the responsible exposures to the risk factors and limiting access to the means of suicide. Thus there is a need for considerable resources in public health education, early recognition and intervention as well as particular legislation around access to lethal agents. The sociological literature emphasises social determinants of suicide rather than individualistic or psychological reasons. In the RoI, for example, the rapid speed of economic growth and urbanisation has been accompanied by a similarly rapid secularisation and challenges to traditional authority. Likewise, NI, which is also undergoing change through the 'peace process' and economic growth, has witnessed a considerable increase in suicide. However, our understanding about the macro-determinants and processes associated with local, regional and national suicide rates remains limited (Tomlinson, 2007).

3.2 Religion and suicide

In his seminal work on suicide, Durkheim concluded that the act was primarily a social phenomenon – best understood as sociological events rather than the characteristics or psychologies of individuals. Thus, societies with high levels of solidarity and integration would produce less suicidal behaviour than societies that are characterised as individualistic. Although highly critiqued in subsequent years, his data seemed to bear out this hypothesis. His argument pursued the line that religious association with suicide was less

to do with the degree of doctrinal injunction against the act of suicide but rather the strength of the collective. That is “details of dogmas and rites are secondary” (Durkheim, 1897: 169-170). However, as Koenig points out, despite decades of research on the issue we are unable to show robust, consistent evidence that people with particular religious affiliations are more or less at risk of suicide although conservative Protestant sects and Muslims tend to have lower rates than other groups (Koenig, 1988: 142) and some denominations tend to be relatively more hostile to suicide (Bagley & Ramsay, 1989).

Nevertheless, Durkheim’s work has spawned a large volume of research on the connection between religious beliefs, affiliation, denomination membership and suicidal ideation and behaviour. However, more recently research has predominantly focussed on specific religious-cultural beliefs and their influence on suicide. Thus, Stack has suggested a variety of religion-oriented mechanisms that may deter suicide. Religion may promote: (a) belief in an afterlife and the existence of a responsive, loving God; (b) a sense of purpose and self-esteem; (c) resources for reframing adversity; (d) an alternative social framework where socio-economic position is not the key marker of status. In addition to the positive cognitive aspects of religion, the potential benefits accruing to membership of a wider ‘family’ should be considered – a sense of identity, reciprocity, support, sustenance, engagement – key elements of ‘social capital’ (Putnam, 2000).

More negatively, in many religions, suicide is vigorously censured and the compensatory aspects of a benign afterlife are withdrawn from those who kill themselves. In Christianity the sin of despair, of which suicide is the ultimate act, was traditionally viewed as the rejection of God’s love, a rejection of salvation. In other words, people who died by their own hand were considered to have deliberately chosen corporal and spiritual excommunication.

The evidence suggests that strength of religious adherence (attendance, prayer, degree of religious salience) in a wide range of cultural settings is negatively associated with suicide, suicidal behaviour and ideation.

3.3 Faith based organisations

The public service role:

It has been suggested that churches and other faith groups (Faith Based Organisations) and the communities served by them have the potential to be useful partners in dealing with mental illness and suicide (An Roinn Slainte, 2005; Friedli, 1999). For instance, one objective within the recent Irish strategy on suicide was to support the role of churches and religious groups in providing pastoral care to the community and in promoting positive mental health, especially after a death by suicide. However, as desirable as such aims are, there has been scant research on just how such a partnership might be developed nor any consideration of the barriers that may arise. This gap in our knowledge provides the broad rationale for this Needs Assessment with Churches, Religious Bodies and Faith Based Organisations in relation to the Protect Life Strategy.

As part of interest in strengthening communities and the voluntary sector, there is an increasing acknowledgement among policy makers that there are considerable untapped resources and unexplored opportunities related to partnerships with faith communities. A recent research report for the Scottish Executive on faith communities indicated interaction with local government on issues such as social action on poverty, disadvantage, drugs, or asylum needs; educational matters including schools and diversity education for school groups, bereavement services and health and community care services (Maddox, 2001). Faith Based Organisations (FBOs) were keen to demonstrate their willingness and capacity to cooperate with government bodies and offered their substantial resources of personnel with which to do it. The research seems to confirm the Home Office (2004) contention that the “skills, capacity, and willingness to contribute to public life” of faith communities are under-utilised. However, the potential contribution on offer from FBOs and how these fit with existing statutory provision has not been examined. Nonetheless, a recent report commissioned by the Church of England (Davis, Paulhus, & Bradstock, 2008) argues that although the church provides a large proportion of

the welfare services, there is a considerable lack of reciprocity from Government, a poor appreciation "of the 'civic value' to the life, identity and health of the nation by Christian institutions".

3.4 Clergy, mental health and help-seeking

There is evidence that 90% of all cases of suicide / self harm, are associated with some form of mental disorder at the time of the episode, particularly depression and substance abuse. Thus there is likely to be some degree of overlap between these areas and clergy confidence, ability and attitudes towards these aspects of pastoral care in the events surrounding suicide. As the *Our Healthier Nation* strategy indicates a public health strategy on suicide should necessarily incorporate a wider base of community organisations for improved understanding of mental health problems and issues. In many communities, particularly among recently arrived and minority ethnic groups (Jarvis, Kirmayer, Weinfeld, & Lasry, 2005), clergy play a pivotal role as gatekeepers for services, community advisers and mediators between government and people. In the context of an increasing ethnic and cultural pluralism in NI, faith leaders will be an important conduit for information and advice.

As part of their welfare and pastoral role, community based clergy have significant contact with people who suffer from psychological and emotional health problems (Wang, Berglund, & Kessler, 2003); indeed many people experiencing what appears to be psychiatric illness are likely to seek out the help of clergy rather than psychiatric professionals (Mayers, Leavey, Vallianatou, & Barker, 2007). Some of the reasons for the seminal position of religion in help-seeking stems from the religious or spiritual conceptualisation of illness and suffering and the perceived need for religious resolution among groups and individuals. Thus, for some people symptoms of anxiety and depression may arise from a spiritual conflict, moral transgression and guilt, a damning spiritual self-evaluation; they have sinned or have weak faith. When these occur clergy may be sought for expiation, spiritual guidance and healing. Alternatively, other people rely on their faith as a means of coping with suffering (Pargament, 1997).

Despite growing secularisation, NI is still nominally a strongly religious country with high rates of church attendance (Brierly, 2005). Moreover, regardless of church attendance, churches are still called upon to provide the rituals associated with major life events (birth, marriage, death, etc.). This has considerable significance in the context of suicide and the ability or willingness of clergy to provide pastoral care to the bereaved. However, various studies in the USA have suggested clergy across all faith communities generally lack training, confidence and competence in dealing with such problems.

A recent qualitative study undertaken in England provided an account of the problems faced by clergy in various faith communities in the recognition and management of mental health in their respective congregations (Leavey, 2008; Leavey, Loewenthal, & King, 2007). Several major themes emerged including poor understanding about mental illness, lack of training in ministry or otherwise. Cultural and theological beliefs are important determinants of explanatory models of mental illness and also the degree and type of collaboration with mental health services. Other research in the USA indicates that clergy are reluctant to refer to psychiatric services (Wang, Berglund, & Kessler, 2003) or have problems in discriminating between various psychopathologies (Domino, 1990). However, it should be recognised that many clergy simply do not see the provision of mental health services as part of their role in ministry, and importantly, it is both inappropriate and unfair to assess their work on this kind of expertise. That said, many clergy understand the limits of their skills in counselling and welcome the opportunity to benefit from training in this field (Rupert & Rogers, 1985).

Of importance to this study, dealing with suicidal behaviour, self-harm and suicide may sit uneasily with many faith traditions, whereby the sanctity of life as God-given obliges a theological perspective of suicide as a sinful act, putting the person beyond God's forgiveness. Within such worldviews the act of suicide remains heavily stigmatised. Thus, among clergy in some faith traditions suicide may still have implications for the burial of the deceased person and the manner in which the family is treated by

clergy, the manner in which clergy provide (or withhold) services for the deceased and pastoral care for family and friends. As respected and influential community leaders, clergy may have direct and indirect influences in the way that congregations and communities respond to such events. We need also to bear in mind that the work of clergy is stressful and there is good evidence to suggest that clergy are highly susceptible to burnout (Lewis, Turton, & Francis, 2007; Louden & Francis, 2003).

Also of importance, we need to consider the likelihood that clergy from all faith groups will be affected by the emotional impact of suicide. This may arise from a lack of confidence or inadequacy in dealing with such exceptionally distressing circumstances. Clergy may also be challenged by a possible disjunction between traditional theological strictures, which demand an unequivocal approach to suicide as a 'sinful' act, and the need to offer a more compassionate consideration of human frailty. However, there are differences between and within religions. Thus, the way in which clergy react to suicide is likely to be predicated on several interrelated factors such as cultural background, mental health knowledge and training for mission, 'church' theology and adherence to doctrinal orthodoxy and rejection of bio-medical models of illness (Leavey, Loewenthal, & King, 2007). Issues such as the relationship between clergy and psychiatric services are likely to be important, as are problems of confidentiality between clergy and families (Leavey & King, 2007).

The construction of a partnership strategy that provides a single, all-faith perspective, while desirable, may be more complicated within NI but we suggest that there is a need to accommodate alternative and differential worldviews.

4. AIMS & OBJECTIVES

The overall aim of the study is to provide a better understanding of the issues and needs of clergy in response to suicide and suicidal behaviour among a range of faith communities in the Southern area of NI. The findings will serve as the basis for building a public health partnership with faith based organisations. The specific aims of the project were to examine the following:

(a) The views and experiences of clergy with regard to suicide in their communities;

(b) The barriers to pastoral care of people bereaved through suicide; and

(c) The resources needed to enhance the pastoral response to suicide.

5. METHOD

5.1 Steering committee

Building on the considerable work already undertaken by Carecall as part of the *Journey Towards Healing* project we were able to draw on the support of senior and influential religious leaders from across the faith spectrum. The aims of setting up this group were: (a) to notify the faith groups that such a project was being planned in NI; (b) to elicit their acceptance that such a study was necessary and to obtain approval; (c) to obtain their support in order to recruit other clergy. Thus we needed contact details of clergy in their organisations and a letter of recommendation; (d) to provide a conduit for feedback and for further assistance in promoting faith-based initiatives related to suicide prevention and support. To this end, the faith representatives helped in outlining and clarifying the broad principles of their respective tenets towards suicide-related issues and directing the researchers towards any key church religious and policy documents. An inaugural meeting of the steering group was held with attendance from all the main denominations. There was universal support for the project and a willingness to provide assistance for recruitment.

5.2 Key messages

- The clergy felt that there was much needed religious response to the suicide 'epidemic'.
- There was a deep concern that churches and other faith groups were increasingly seen as irrelevant to the lives of young people.
- Concerns were expressed that clergy were insufficiently trained and that the impact of suicide on individual clergy is detrimental to their own mental health.
- There was a willingness of those present to be involved in a cross-faith initiative on suicide.

5.3 Sample and recruitment

As per the research specification we tried to obtain, as far as possible, a sample of clergy from the main Churches and other denominational faith groups within the Southern area of NI. Thus we interviewed clergy within Presbyterian, Free Presbyterian, Roman Catholic, Church of Ireland, Methodist, and Baptist

Christian communities. While acknowledging that minority ethnic and faith communities are very small in NI (for example, compared to the UK and even the RoI) – in the last census 1.1% of people in the Southern area were born outside the Island of Ireland – we also interviewed representatives from the Muslim, Hindu and Jewish faiths.

It is generally difficult to anticipate clergy willingness to participate in projects of this kind. Previous research in the UK suggests the likelihood of a poor response rate. To deal with this difficulty we decided to approach recruitment through a two-pronged strategy. In the first stage, we identified a stratified random sample of community-based clergy. This was achieved by using lists of contact details for clergy in the region provided by senior clergy involved with the steering committee. Clergy from minority faith groups not represented on the committee were added to the sample. They were identified through community organisations and then approached to take part. Generally, clergy were sent a brief letter to explain the project. We stressed our regard for confidentiality and anonymity.

5.4 Survey questions

On an attached questionnaire, we asked clergy if they:

(a) ever had to deal with suicide among their congregation;

(b) provided pastoral care to someone who expressed suicidal intent;

(c) had an interest or strong concerns about this issue;

(d) would be interested in participating in the study; and

(e) would be interested in participating in a faith-based programme aimed at suicide prevention.

We enclosed a stamped addressed envelope for reply. This was followed three weeks later with a follow-up letter (a copy of the questionnaire used can be found in Appendix I).

5.5 Purposive sampling

The potential participants for the main qualitative study were selected from the responses to the survey. An integral aspect

of the project was to illuminate the experiences of clergy who have been confronted by suicide as part of their pastoral duties. Thus, we wanted to obtain rich phenomenological data that would provide an understanding of the specific experiences and worldviews of the participants (Denzin & Lincoln, 1994). For this reason, from the completed survey data we purposively selected those clergy who reported contact with people bereaved through suicide. We intended that a range of views would include both consensual and contradictory perspectives. We wanted to cover those clergy who may hold more marginal or punitive views about suicide in order to understand how these might be accommodated or managed. Thus, we asked clergy if they knew of other ministers within their own denomination who hold rather different views on suicide to their own.

5.6 Topic guide

We developed a topic-guide that covered the following areas:

(a) personal views of mental health, suicide and suicidal behaviour;

(b) actual and ideal responses to suicide in the community;

(c) dealing with family members following suicide including burial and post-burial pastoral care and support;

(d) community and congregational responses to suicide;

(e) FBO perspectives on supporting suicide prevention work such as the pastoral care of depression and other serious mental illness;

(f) an exploration of building relationships with statutory services; and

(g) shared or dissonant perspectives with other faith groups.

In keeping with qualitative research values, we were open to pursue other issues as they emerged in the interviews. Importantly, we attempted a detailed exploration of related issues through actual clergy experiences of suicide within their own and other congregations. We undertook all interviews at a time

and a place convenient to the participants. In the introductory letter and again at the interview, we stressed that the interviews were completely confidential and that they were free to terminate the interview at any time. We recorded the interviews using an audio digital recorder (a copy of the topic guide can be found in Appendix II).

5.7 Analysis

Quantitative: We entered the survey results into MS Excel and then transported to SPSS version 11 by which we performed simple descriptive statistics.

Qualitative: Interviews were transcribed verbatim and analysed using Interpretative Phenomenological Analysis (IPA) (Smith, Jarman, & Osborn, 1999; Smith & Osborn, 2003), an approach which attempts to understand lived experience and with how participants themselves comprehend their experiences; it is now widely used by researchers in health, clinical and social psychology. The analysis proceeds from a systematic search for themes in the first case through to an examination of connections between themes and across subsequent cases with the aim of establishing super-ordinate themes.

We have supported the thematic concepts with verbatim extracts from participants. In the first instance, the transcripts were read and then re-read by the researchers who made observations about the interview data. A more detailed coding and thematic development by members of the research team followed this. We achieved consensus by working back and forth through the major themes and sub-themes. The analysis followed the parameters and issues set out in the topic-guide. However, we were alert to new avenues of enquiry introduced by the clergy themselves. Thus, we anticipated that the qualitative analysis would assist in developing hypotheses on the personal and social responses to suicide, the role of clergy, community impact, training needs and contact with services. It is important to stress that this report was not commissioned or undertaken with the intention of taking a critical stance on the role of clergy; the analysis and the presentation of results, therefore, are predominantly framed within a *realist* perspective in that we

have not attempted to challenge or interpret the views of the participants. A deeper exposition of the complexity of these issues, such as the dissonance between theological and pastoral approaches, has, to some extent, been attempted in the interview process and in some sense may be considered as a construction between the interviewer and the interviewee. However, in doing so, we have been careful not to *represent* the experiences and views of the clergy.

6. QUANTITATIVE FINDINGS

Survey

Three hundred and ninety questionnaires were sent out and 164 were returned completed (response rate 42%). The respondents were predominantly male and aged between 30 and 75 years (mean age 52.3).

Professional experience of suicide

Eighty percent of the respondents have had to deal with suicide bereavement as part of their pastoral ministry.

Level of training for bereavement in suicide

We asked about the level of training in mental health and suicide.

Only 10 clergy (6%) felt that the training for bereavement in suicide was sufficient. The majority of clergy (n=98, 58%) reported that they had received none.

Thirty-six percent of clergy (n=60, 36%) felt that their training in mental health was sufficient.

Clergy involvement in anti-suicide strategies

The overwhelming majority of respondents (80%) felt that clergy involvement in anti-suicide strategies was *extremely important*; the rest (20%) thought this was *somewhat important*.

7. BACKGROUND: an outline of the clergy and their communities

7.1 Background of clergy

The total sample of 42 clergy interviewed represented the most common faith-based groups in NI. This included: Presbyterian (10); Free Presbyterian (2); Baptist (1); Methodist (3); Catholic (8); Church of Ireland (13); Jewish (1), Muslim (1) and Hindu (1). Other faith-based organisations included in the study were The Society of Friends-Quakers (1) and the Salvation Army (1). In line with qualitative methodologies, it is important to stress that the numbers of clergy interviewed within each of the denominations does not signify proportionate representation in the Southern area or in NI and should not be interpreted as such. We were not intending to make cross-denominational comparisons, although at times specifically denominational views may be apparent. Again on the issue of representativeness, only two participants were women. Although five female clergy responded to the questionnaire, of these, two requested not to be contacted; the three remaining were contacted and two of them gave interviews – Methodist and Church of Ireland ministers. The age range of the clergy interviewed was between 30 and 75 years old; their years in ministry ranged from one to 51. The length of time the clergy have been in their current posts varied from a few months to 23 years.

A few clergy came into ministry as a career move having previously held positions in different organisations or institutions in the secular world. Some of the clergy were not originally from NI, being born in England or the RoI and having the experience of serving in their ministries initially in those areas before moving to NI. Likewise, some of the local interviewees had previously worked in England or other countries. In some instances, they were established in larger communities than the ones they have been serving here, mainly in inner city areas where they were involved in a variety of community projects; such as programmes that dealt with alcohol and drug rehabilitation or reintegration of ex-prisoners into society.

The majority of non-Catholic clergy were married with families. In a few instances, their spouses were also involved in Church work in an informal capacity and in one instance a minister's wife was also a minister. The support and understanding of the

immediate family was mentioned on numerous instances as the best coping mechanism used by clergy to maintain their mental health and well-being, in particular, under the tremendous stressful circumstances faced when a suicide occurs. This aspect is explained in detail in the section entitled *Impact of Suicide on Clergy.*

7.2 Their congregations and communities

The interviewees' parishes or places of meeting were located in rural and urban communities within the catchment area. In some instances, due to the particular geographical distribution of population or the specific geo-political organisation of the churches, some of the clergy shared their duties between rural and urban communities.

Overall half of the interviews were conducted with clergy who served rural communities and the other half with clergy based in larger urban settlements, similar to the other faith-based organisations involved in the study – The Society of Friends-Quakers and Salvation Army.

In relation to the challenges found in ministering in rural or urban congregations, many of the issues were related to socio-economic and environmental factors that have impacted upon the communities. The most affluent rural communities, on occasions, were described as '*traditional and private'* or as having '*the typical concerns of modern life: financial, family, and work, etc.*', and with '*…spiritual needs* [as being] *the biggest problem*.'

Commonly, clergy in the more affluent congregations described parishioners as 'private', stoical people who were deeply reticent about sharing their worries and concerns. In these communities the congregations are well established and tend to have a wide spectrum of the population actively involved in church activities, in particular young people. In some areas there are private businesses that provide employment and in other areas people work in neighbouring towns in businesses or the civil service. In general, clergy suggest that people seem to maintain a connection with the church and have a strong community sense.

In the more socio-economically deprived rural communities,

congregations were declining in numbers, sometimes due to a shift in population either through sectarian processes or the migration of young people. Congregants were usually the elderly; younger people appear to have a diminishing interest in the church. Among socio-economically deprived urban areas, the participants served in large housing estate congregations or working class areas. Among the issues affecting these communities described by the clergy were chronic unemployment, sectarianism and paramilitary activity, alcohol and substance abuse; broken families and large numbers of single-parent families, domestic violence and low academic achievement in schools.

8. CAUSAL EXPLANATIONS OF SUICIDE

The following sections reveal clergy explanations for suicide – or attempted suicide. They are grouped into three sections: Mental Health Problems, Family and Personal Factors, and Community and Cultural Factors. These are not mutually exclusive categories, and other organisations of the material would have done just as well, as each case of suicide is unique and complex:

> *"It's the confluence of so many terrible things … I couldn't say it any other way than that. Never one specific thing, but certainly it's the straw and the camel's back mentality. You can have all that imagery, but when you have a confluence of terrible stresses and they come together in one person, who knows what the outcome is going to be?" (Catholic -ID02)*

8.1 Mental health problems

By far the most frequently mentioned mental health problem referred to by the interviewees was depression. A few clergy even had some first-hand knowledge of what the experience is like:

> *"During that time of depression I did have myself, I went through a time, a particular evening actually, when I suppose the only way that you could describe it was that fear of death was gone and there was a kind of blackness descended over you and if I hadn't …lifted the phone to speak to someone I mightn't be here today."* (Presbyterian-ID18)

> *"Strange enough, in the last year we have had two relatively young people have taken their own lives, young men. One of them had been depressed and had been receiving medication."* (Catholic-ID03)

But many other descriptions were also given, of various states of being that don't fit any official diagnostic criteria, such as: *mentally deranged, of unsound mind, having a chemical imbalance, not in their right mind, or having a nervous breakdown*. The use of these terms seems to reflect the inability to understand how someone can do such a thing:

> *"I came to the conclusion that the person wasn't in their right mind at that moment … for if*

they were in their right mind they wouldn't do it. I don't think anybody in their right mind … would commit suicide." (Presbyterian-ID21)

"Does one go so far as reason goes completely? Thinking about it, I would see it maybe as a brainstorm: somebody gets a stroke in the brain and there's no – well it's not rational anyway … It's not rational and reason is overcome by emotion." (Catholic-ID05)

"I remember … realising he meant to do this. You know, he didn't want to save himself. It was …so definite, final, purposeful." (Free Presbyterian-ID32)

8.2 Family and personal factors

Family or personal problems were seen as a factor in many suicides or attempts. Personal problems ranged from facing a prison sentence to bereavement to being diagnosed with a terminal illness to just believing that there's no other way out:

"I think (he) was facing a prison sentence and I think this [suicide] was maybe a way out. I don't know." (Catholic-ID04)

"Some people's lives are a real mess and they see no way out and the clouds come in, their thought processes go AWOL and the only way they see out …" (Presbyterian-ID36)

Broken relationships, bullying in school and marital difficulties were frequently mentioned:

"They were a couple that had no children and I always felt that they were extremely unhappy. They were poles apart." (Catholic-ID04)

"It was a combination of bullying in school and a broken relationship with a girlfriend. But at that particular age on that particular day obviously spelt the end of the world for the young chap. That's really all we know about it." (Methodist-ID35)

"Their child was being bullied in school … But it's so bad the mother said to me, she says, 'Do you know, there's times I think that if he would take his own life all of the pain would be over.' There was total silence. And the father turned to me and

said, 'Father, I have never said it but I thought that at one stage too.' That, I found the hardest of all." (Catholic-ID03)

Loneliness, debt, unemployment and bad financial decisions:

"I think she was isolated anyway, you know with the home life and she was an only child and isolation would have been a big key in her life, I think. And then shortly afterwards when she left school, within maybe months of that, because she was the age to leave school … she was removed from home because of the arguments between her and her mother and the Health Board or whatever had stated in a letter that due to unhealthy relations that she was not allowed back home." (Catholic-ID04)

"I think he felt his pride hurt because his wife would have been a lady of means in her own right, through business. He just had a reputation of very astute, very aware of business and his acumen was very obvious, but this was the first time that he had ever sold himself short, big style. None of us could have foreseen the price of property." (Presbyterian-ID36)

The breakdown of traditional family structure and values:

"When the comparatively solid guidelines of an earlier generation are replaced by more flexible and fluid ones that are not fully embraced … I think deprives young people of security, stability and unambiguous expectations." (Methodist-ID35)

"And that's why, you see in times past I mean when there was all sorts of suicide … there was this talk about the sacramental confession, this ability to say you're sorry and to move on. But if that had been the case, certainly in today's world, people don't use confession anymore. They don't even, many of them don't see a value in it I suspect and they see it as coming to talk to another human being and 'Why the hell do you want me to talk to him and tell him I did this, that and other?' So if it had been a help, I don't think it's much of a help anymore." (Catholic-ID06)

In one case, a man took his own life apparently wanting to alleviate

a burden on the family. He felt that, in that way, he was actually making a contribution to the family:

> *"I spent a lot of time with [this man] and … his general view to me [was] that I am a burden to my family because they would live better if I wasn't here and, eventually, he hung himself."* (Free Presbyterian-ID32)

8.3 Community and cultural factors

Suicides were seen by many as just a symptom of deeper societal issues. The interviewees spoke of an "awful instability" in children's lives, of social and family "brokenness", and widespread pain and suffering. Individual cases were seen as reflecting the overall mental health of the community:

> *"The circumstances that … lead someone to take their own life seem … to be so individual and often hidden. I wonder how much can be achieved in terms of prevention other than by measures that address the general social and mental health of the community."* (Church of Ireland-ID22)

> *"Circumstances surrounding his particular death, as it unfolded afterwards, were terrible. While he committed, to my mind, the ultimate act of, I suppose, a terrible choice, he was also terribly tortured by outside experiences."* (Catholic-ID02)

8.4 Alienation, secularism and modern culture

Alienation, especially among young people, was seen as a major factor. Despite young people having access to all sorts of communication (e-mail, mobiles, ordinary phones, text messages, etc.), they seem to be more alone than they ever were before:

> *"They're more in touch … but they're less in touch."* (Baptist-ID10)

According to the clergy, technology-aided relationships are much less valuable than real, face-to-face encounters; they lack intimacy, and lead to isolation. Especially for young people, in the world of real relationships – family, school, and church – they have nowhere to turn:

> *"These were people who had nowhere to go …*

they actually….. mentally, emotionally and physically, intellectually, rationally and every sense, had nowhere. They were totally in despair." (Catholic-ID02)

And related, secularisation was seen as a problem. The church and its teachings were one of the areas to which people have become detached. And, as one interviewee opined, *"when spiritual values are at a low ebb, then society is at a low ebb"* (Baptist-ID10). Most importantly, the guidance and structure that faith offers seems to be increasingly rejected. From the clergy perspective, society has lost its way, leading to a breakdown of the traditional family structure and values. A common perception among participants was that suicide itself became part of the cultural shift towards permissiveness and away from absolutes and imperatives:

"The clear, clean cut thinking of … earlier generations has been replaced by a relaxed approach … therefore in times of stress or trouble, suicide … can be in the thought pattern." (Methodist-ID35)

"… when suicide rates were supposed to be really heavy in Scandinavian countries they put it down to the fact that they didn't have sacraments. In Catholic countries and in Southern Europe it wasn't as high … And there was this talk about the sacramental confession, this ability to say you're sorry and to move on. But if that had been the case, certainly in today's world, people don't use confession anymore. They don't even, many of them don't see a value in it I suspect and they see it as coming to talk to another human being and 'Why the hell do you want me to talk to him and tell him I did this, that and other?' So if it had been a help, I don't think it's much of a help anymore." (Catholic-ID06)

Faith organisations were not exempted from blame. Thus, while it was argued that religion was anchoring and sustaining, some clergy expressed a failure of the church in reaching out to people - retaining relevance in contemporary society.

Other institutions, including schools and the liberal media were seen as part of the problem through teaching young people to "radically question faith of any sort." Moreover, other clergy worried that evolution was being taught "as a fact", part of a general erosion which made suicide more acceptable or at least, less daunting:

"if we come from nothing, and we're going to nothing, then what's the point of life?" (Presbyterian-ID24).

Moreover, young people, increasingly individualistic, have come under considerable pressure to reject social norms and values, with computers and the internet playing a major part in this. Not only do people spend lots of time at the computer, alone, playing games or visiting social networking sites like YouTube, but there was concern about sites on the computer that actively encourage suicide and offer instructions on how to do it. Similarly, deviant peer groups (as described by some clergy) were also mentioned as a bad influence on young people's behaviour and thinking.

One interviewee mentioned a "very dark side to much of the entertainment" (Presbyterian-ID36) young people take in – from horror movies, to computer sites, to song lyrics and the Goth movement. The glorification of suicide by both the media and the larger culture also gets some blame, encouraging suicide to be seen as cool, and leading to "a big day out." And for males, the fact that talking is not seen as a macho thing was mentioned, as heart-to-heart talk with a trusted individual is seen as a way to avert suicide.

The Troubles and its legacy were also seen as contributing to suicides in NI, as it has led to an "unwillingness to come forward and speak". This allows problems such as violence, abuse, addictions and mental health issues not to be dealt with openly. And overall, due to 30 or 40 years of conflict, including indiscriminate murder and suicide, life itself has been devalued:

"Just being able to go out there and take life, cheapened life." (Baptist-ID10)

The use of alcohol and drugs is also seen as a contributing factor, at the same time that it is seen as a symptom of larger social and/or personal problems. Lastly, the materialism of modern society received some of the blame, with its emphasis on monetary gain, financial success, and acquisition of goods:

"So many unrealistic expectations and demands placed upon the family unit. When one or other partner can't measure up sometimes it's an easy way out ...." (Methodist-ID35)

9. THEOLOGICAL VIEWS ON SUICIDE

> *"So it's important … to bring to people's attention that even if their loved ones have contributed to their own death, it is not some unpardonable sin that excludes them from Heaven."* (Free Presbyterian-ID32)

Suicide has been considered as anathema within most faith traditions. However, such views lacked the benefit of psychological or psychiatric insights into human suffering and behaviour gained over the past century. Anecdotal or media evidence on clergy response to suicide among community members suggests that more punitive attitudes to suicide have been replaced by compassionate concern. However, a strong theological position on the sanctity of life, which remains constant among most faith groups, may add considerable complexity to the position of individual clergy as they attempt to offer condemnation on one hand and compassion on the other. Thus we wanted to examine the ways in which theological tenets about suicide might be accommodated by clergy.

Clergy across the range of denominations, universally and vigorously reiterated their belief that life is sacred. However, without exception, the participants stressed that suicide is predominantly the product of a mental illness – in which case, the previously assumed voluntary nature of suicide, a sin of despair, has been reframed as an involuntary act of a mentally ill individual, perhaps driven by stress beyond his or her 'natural' or usual state by the confluence of various factors.

While some clergy suggested that other faith groups may hold punitive perceptions about suicide, the participants in the current study were clear that 'hardline' views within the Christian tradition have shifted in the past 50 years and suicides are generally treated like any other death. Thus, they support (and are supported by) the fact that suicide has been decriminalised. Moreover, the traditions of not allowing the burial of a suicide on consecrated ground have been abolished. However, from these interviews it appears that, with one exception, there have not been any formal statements by any Christian denomination in which a softer view on suicidal behaviour has been outlined. Of course, several of the faith groups

are non-hierarchical and as such lack central control or policy. Nevertheless, across all groups of whatever structure type, the approach to cases of suicide is left to the discretion of individual clergy. Significantly, clergy tend to distance themselves from a punitive view of suicide as sinful or use a sympathetic reconstruction of events which permits a reframing of the act as something other than suicide:

> *"[until recently most Churches viewed suicide as a] sin beyond forgiveness… That attitude changed in most churches 40 or 50 years ago."* (Church of Ireland-ID29)

> *"Because you see, many years ago, 40 years ago, you know the Church would have taken a very harsh line on anyone who committed suicide. They would have said they would not get into Heaven. And I think the Church was playing God there - they're not. They don't have the giving and the taking … I couldn't see of a God who would say to [anyone], 'You are banished forever."* (Catholic-ID03)

> *"… over the last two years there has been a Bill going through Synod [of the CoI] to encourage clergy in their ministry to suicides and suicide families and not to refuse burial of a suicide … I think the Bill is to make it impossible for clergy to do that … I think the Bill is just to formalise that suicides should be dealt with sensitively and the family should be ministered to carefully."* (Church of Ireland-ID29)

> *"Well I think in my time, you know I was ordained in 1962, that the number of cases of suicide would have been small enough. And then you had the old attitude, you know, was it sinful? … it was a hangover from older times, you know that the sacredness of human life and the dignity of it and the humanity of it and sort of an idea that you were responsible in your own will of doing the thing and doing a wrong thing, etc. But I think with the whole development of psychiatry and mental understanding, etc., that all that changed."* (Catholic-ID08)

> *"[Within the Methodist Church] there would be a very compassionate understanding of suicide … So it's not the sort of approach which would*

say, because you commit suicide you're a terrible sinner and you'll go to hell, which is what you sometimes get from people." (Methodist-ID26)

"That's the other thing you need to understand about Baptists … is that there isn't a position [about suicide]. You know, that each Church is independent. We associate but we're independently governed and autonomous and so what I tell you, … it's not necessarily the rule of thumb for Baptists in Ireland or NI even." (Baptist-ID10)

"Okay, you can say 'Thou shalt not kill' and you've killed yourself but having said that, God still loves them. I don't care who or what they are, God still loves them. I just could not do that. I couldn't bring myself to condemn them. I don't understand what is in those people's minds, so if I don't understand that, how can I say those people have committed a sin?" (Church of Ireland-ID36)

"… ultimately each minister [within the Presbyterian Church] has his own conscience on matters. So I may interpret the Scriptures to say that God in his grace and in his mercy will receive this person who has committed a life to Christ but has committed suicide. Somebody else may say that that isn't possible. So again, that's a matter of interpretation and their own viewpoint. And that covers a whole range, I mean there is a whole range of areas there that people would be divided on, has their own way of interpreting the Scriptures." (Presbyterian-ID21)

Throughout the interviews, clergy stressed an explanatory model of mental illness in suicide, generally provoked by social and personal stressors and the use of drugs and alcohol. They noted that the stigma surrounding mental illness among faith communities has somewhat lessened - in tandem, a theological discourse of suicide has diminished; it has been replaced among clergy by a more psychological understanding of the phenomena. Thus, an emphasis on psychiatric intervention is seen as more immediately appropriate than religious or spiritual remedy:

"I would say that in the past when a person was put into a mental institution, it was a big thing. Even going in for medication to help to get off the

drink. They were considered [to have] a weakness. But that's lessening now – although there's far too much tolerance for over abuse of drugs and alcohol. At the same time it's not regarded as a crime and it is not a crime because, I suppose, it's innate in the person's make-up." (Catholic-ID05)

"I think in the past… people tended to talk less about this [mental health problems] and almost there was a stigma attached to this that people were ashamed of. In the Church of Ireland or our Diocesan Youth Council we had an event recently thinking about this and a doctor, a psychiatrist … spoke to young people about the need to observe their mental health and to think about this and watch out for their friends as well." (Church of Ireland-ID28)

"I think if we were being strictly theological, yes, it [suicide] would be regarded as a sin in that… theologically … God is the giver of life. But is suicide wrong? …if someone is terminally ill and in great pain causing ongoing great distress to loved ones who are dealing with them, I mean that certainly for me would come into it. And I don't think there is a blanket answer … I think there is a wealth of difference between suicide, if that's the word, in terminal illness and in following peer pressure…" (Methodist-ID35)

Finally, within The Society of Friends (SOF), or Quakers as they are commonly known, there is no official document in existence in relation to suicide. Central to the SOF ethos, there is no written doctrine governing the community; the Bible is open to interpretations and its contents are adapted to the different contexts within the parameters of human development (continuous revelation):

"The Friends would say is that it's down to, I suppose, continuous revelation and what we mean by that is how we live out our lives and how we are open to the workings of the Holy Spirit and how that manifests itself … So I suppose, from the time when the Bible was written until now, a lot of things in society have changed and … maybe some of the issues were the same at the time when the Bible was written

… even within this [suicide], take, in the Bible you have a lot of people using arguments for and against."

The SOF participant indicated that an enduring and key element of the organisation is that all members are encouraged to share their beliefs, feelings and burdens with openness. These are usually managed in an honest and sensitive manner. We were informed of the forthcoming publication of a set of guidelines for The Society in Ireland in which the topic of suicide is tackled:

"I suppose, what we have done through that is really to give some guidance, not just to those who are possibly feeling sort of, feeling depression or poor mental health but as well as that, giving guidance to those in the aftermath of a suicide as well ..."

However, consistent with the relative absence of structure and dogma with the Society, it was assumed that there would be differing views of suicide among members:

"... there is that wide variation within The Society of Friends. Some people would probably say that suicide is wrong and should never ever happen and others would say while we would not want suicide to happen, obviously it's one of the sort of modern occurrences within everyday life … accepting that the occurrence happens and that we should do our utmost to prevent that and I suppose, coming from the other end of sort of saying well all life is precious and sacred and that we should be doing more to make sure that individuals understand that."

10. THE EXPERIENCE OF DEALING WITH SUICIDE

All clergy reported that the issue of suicide was of personal importance. Most have had to deal with suicide and its aftermath, called upon to offer pastoral care to those bereaved as part of their ministry. In other cases, clergy had neighbourly or community connections with individuals and families affected by suicide. Additionally, some clergy had been more personally affected by the suicide of someone close (a relative, friend or colleague).

The instances of direct suicide experience among the clergy interviewed were varied – all participants had the experience of dealing at least with one suicide; exceptionally, one interviewee had experienced 20 cases. Some of their experiences were related to suicide clusters which have recently occurred in NI. In parallel with the research evidence, most of the cases experienced by the interviewees were clustered within particular groups, such as young males between 15 to 25 years of age and adults (male or female) in their middle adulthood (40-60 years) or people in late late-adulthood (75+ years). The clergy also referred to suicides linked to depression, again consistent with evidence which confirms that psychiatric disorders (usually mood disorders and depression) account for 90% of suicides.

Among the methods used, some of the most common and accessible ones were also described by the sample: hanging, overdose, poisoning (for example, carbon monoxide, fertilizers, gas inhalation), shooting and drowning. The cases related by the clergy included individuals who irrespective of faith or immediate trigger factors ended their own lives:

- *A woman who was very much involved with the Church but who suffered from depression for several years.* (Church of Ireland-ID31)
- *An elder of the Church took his own life ingesting a fertiliser. Suffered from depression for quite a long time. Left behind a wife and two children.* (Free Presbyterian-ID32)
- *A married woman with two grown up children. Suffered from terminal illness for some time; confirmed brain tumour shortly before suicide (overdose).* (Methodist-ID17)
- *A teenage male. His mother came home and found him in his loft conversion hanging*

from the rafters. Broken relationship and bullying at school. (Methodist-ID35)

- *Twenty cases: from overdoses to inhaling gas to hanging.* (Catholic-ID03)

In many cases, particularly among young people, the suicide was inexplicable to the clergy. That is there did not appear to be any significant problems in the lives of these people and news of the action came with a considerable shock. In other cases, suicide happens in the midst of apparent banal normality. Thus, as one clergy remarked:

> *"[He was a] …loving husband, father – devoted to the children and his wife. He had gone to work, left home as normal, kissed his wife goodbye and was found in the local car park just that morning on the way to work where he had shot himself."* (Presbyterian-ID21)

Other similar experiences:

> *"I mean I have known priests who took their own lives. And people just could not believe it! And none of us, when all the talking was going on, even those who professed to know him said 'We didn't know anything that might have led to…' I mean and they would have known him … the underlying thing was none of us knew anything that might have provoked this."* (Catholic-ID06)

> *"No, … they [the family] had no indication, they tell me. And certainly within the Church we had no indication he was, if he was clinically depressed we would have known there were problems in the relationship with the girl, we would have known that he was with a rough year group in school but there was no warning, no signal that he was going to take such a serious step."* (Methodist-ID35)

> *"And I don't subscribe fully to this idea that certainly it's a voice that I've heard from many people, 'What the hell makes a person do that?' I would have to say, in my experience, it's a confluence of so many terrible things. I couldn't say it any other way than that. Never one specific thing but certainly it's the straw and the camel's back mentality. You can have all that imagery but when you have a confluence of terrible stresses and they come together in one person, who knows what the outcome is going to be."* (Catholic-ID02)

11. THE IMPACT OF SUICIDE

Inevitably death by suicide has a more profound impact on survivors and all those involved in dealing with its aftermath, particularly the clergy. The next two sections include findings on the impact of suicide on the clergy involved in the study and the communities they minister to.

11.1 Impact of suicide on clergy

Clergy sometimes find themselves at the forefront in dealing with the aftermath of a death by suicide. They are generally called immediately by the families after they learn of the death of a loved one. Hence, the clergy become, on most occasions under these circumstances, the first recipient of the news and the first respondent to the family's grief. It is worth pointing out that what emerges from the interviews is that clergy are often long-standing members of a community, particularly those in rural areas. As friends and neighbours, the relationship between many parishioners and clergy may be close. Thus, over the years, attachments and bonds are formed which exceed pastor-parishioner association:

> *"… when a minister's been in the congregation for a number of years, you become more than a minister. You become a friend, a close friend to people and they will open up, especially when they know it's going to be in absolute confidence and when they know that it's somebody who's not, in a sense, in the medical profession…"* (Presbyterian-ID24)

As a result, in many cases the impact on clergy can be profound. In one case a Presbyterian minister described finding his close neighbour immediately after he killed himself. The minister stated that this event has had a lasting effect. He thinks about it often:

> *"I got a call from a niece to go over; she thought her uncle had taken a coronary but he had shot himself through the heart with a shotgun. He had left a note. The man was clinically depressed and we didn't know it. They had no family, didn't speak much to anyone. More than parishioners, they were friends."* (Presbyterian-ID36)

Throughout the study phrases like '*Total shock*', '*It was shocking*', '*Utter shock*' and '*Totally shocked*' became a leitmotif in the description of how the clergy felt initially when they were informed of a suicide death. Other words used by the interviewees to describe their prime feelings to the news of a death by suicide included: *horror, trepidation, disbelief, foreboding, distress, anxiety, devastation, consternation, bewilderment, sadness*. Often, these feelings are tinged with regret and guilt:

"…inside sometimes I'm churning and I'm nervous and I'm anxious and I just don't know what to say at times." (Church of Ireland-ID37)

"It's a tough one. How it affected me? Okay, candidly, there would be moments you would wake up, so certainly, the modern phrase is post-traumatic. I had that and I would recognise that. It also made me aware, even at that time, that there was more to life than the institutional world that I was born and reared in, even to the politics of the world around me. What was most important was the person you were dealing with and that life was so tough for some people as opposed to others." (Catholic-ID02)

"… devastating, very hard to cope with … I was horrified at what happened and at the devastation for the family." (Church of Ireland-ID29)

"Shock, wondering again what I could have done to prevent it… There is no doubt about it that I lost sleep over it." (Presbyterian-ID30)

"… it does scar you … I suppose, to be honest, it brings – fear wouldn't be the right word – but maybe a more heightened anxiousness in situations." (Presbyterian-ID21)

"Well, I suppose on a personal level you know it was a shock to me and I had been with some family members … celebrating, … and I came right back into this." (Catholic-ID01)

"… it just makes a profound impact on one and sometimes it is really hard to articulate, even for the person who pastors." (Church of Ireland-ID22)

"… the body was on the floor. So then the sudden impact of everything hit me at once, you know the police and so on…" (Methodist-ID17)

"I think you see, the first thing you have to deal with yourself is the initial shock, that this is a suicide. Because as a priest, you know, you are sort of always sort of half alert in expecting emergency calls for people dying suddenly and you don't think for one moment, 'Is this a suicide?' It's only when you get to the scene that you realise, when you get there and the whole thing changes. This wasn't what I expected, in a sense, you know." (Catholic-ID04)

Clergy are no strangers to death; it is at the heart of much religious belief and ritual. Thus, clergy are involved with family bereavement on a regular basis. However, a view reinforced throughout the study was that suicide, more so than with any other death, triggered in clergy, quite profound feelings. They revealed that they were deeply touched, becoming emotionally involved with the grief-stricken family, acknowledging their hurt in an honest and genuine manner. The following quotations suggest some of the emotional and professional turmoil. They also illustrate the difficulty in maintaining a balance between their emotional connection and an element of professional distance:

"I can see the aspect of grief and all that, the steps of grief ... I have been through grief so I get to see that, but though this other thing [suicide] was more painful ... I think perhaps again I should be able to, how do I help people like this? I did follow-ups for quite a while but I wasn't sure I was doing the right thing or saying the right thing or understanding the right thing of what they were telling me. I was doing my best." (Church of Ireland-ID33)

"You live with the person to a degree. You journey with the person to a degree. Now you don't feel the pain that they feel. You don't feel the guilt that they feel, - nor the helplessness. But you feel for them, feeling those things and physically and emotionally it does have its demands because I don't know that you'd ever come away from a conversation in that context thinking, 'I helped that person.'" (Presbyterian-ID34)

"How did I feel? I was frightened, frightened of and I suppose I feel when people are, when there is a death, people need to be cared for. They're very fragile. In this situation they were even more fragile - at least I felt that. I was heart scared of saying or doing anything that would cause them any further grief. I was trying to be – and I suppose from a minister's point of view, I could be just clinical – but I found that I couldn't be clinical. I really felt empathy with them. It's like you want to reach out and touch them and make things better but I can't do that." (Church of Ireland-ID33)

"… this young man's parents would be most beloved by me I suppose and that probably unfolded through the year afterwards and the days afterward [the suicide]." (Catholic-ID02)

"I was very devastated by it. It was my first ever experience of anybody having committed suicide. I felt very sad for the family. I felt, 'What a terrible thing for them!'" (Church of Ireland-ID29)

"No, I would have changed [my views on suicide]. The last body I came across was a young man that had hung himself - knew him very well - He had been cut down. Nobody else was there. The police were standing a 100 yards and he said, 'He's up there.' So, I went up and I said to him, I said, 'L….., what did you do this for?' I mean he was dead. He was dead." (Catholic-ID03)

However, it is also important to state that this heightened sense of empathy is often calibrated, measured according to the closeness of the relationship with the deceased or their families. Paradoxically, for some of the clergy, who had not had a previous relationship with the deceased or their families, feelings of anxiety and uncertainty were exacerbated, concerned about the appropriate language – verbal and non-verbal – and even of the appropriate member of the family to approach:

"I remember nearly sort of jumping a little, you know and realising I didn't know him and there was almost nearly a sense of relief that it wasn't some of the young fellas I did know ... And I don't mean that disrespectfully." (Catholic-ID04)

"I was frightened … I feel when there is a death, people need to be cared for. They're very fragile. In this situation they were even more fragile – at least I felt that. I was heart scared of saying or doing anything that would cause them any further grief." (Church of Ireland-ID37)

"I think for any minister, there is that initial shock, particularly if you have known the person for any length of time. There is also a sense in which you wonder how you didn't see more or how you missed it, how you couldn't have been involved in some way." (Presbyterian-ID21)

The impact of a death by suicide on the clergy after the initial shock was also intimately linked to extreme feelings of *inadequacy* and *uncertainty*. Although the interviewees felt that any death, whatever the circumstance, could be difficult, suicide posed somewhat different challenges.

Families are expressing their deepest feelings of pain and at the same time they often feel more angry and guilty; they are in shock themselves, particularly if a member of the family has found the body. Clergy may then become a conduit through which family members can channel their pain, or seek answers to the questions of 'why?' or even, in some cases, address their anger. The majority of the interviewees referred to their feelings of lack of confidence and inadequacy in dealing with this and their uncertainty, not in all cases, about how effective their support had been:

"… [when] the person has taken their own life, how to actually speak to a family in that situation is a tremendously difficult thing… I don't know if anybody can be prepared for this, in truth. I don't know what you can do to be prepared for something like this." (Church of Ireland-ID28)

"And the father said to me, 'Did my son suffer?' And I said, 'Pardon?' And he said, 'Did my son suffer? And I said, 'No, no, no, he didn't.' And then he said to me, 'How do you know?' and I thought, 'What am I going to say now?' And I looked at the guy behind him who actually was an uncle of the wee fella that had killed himself, … and he sort of just sort of, 'I don't know what you're going to say.' So in the end I said, 'No, your son didn't suffer because he had his hands in his pockets" (Catholic-ID04)

"God's help was very evident but I felt so inadequate … I'll never forget that day. I can tell you exactly the day." (Presbyterian-ID36)

"I think, basically the family, obviously when a suicide happens they ask this question 'why' and I, myself, would certainly, with hands up would say, 'Look, we honestly do not know.' And there's times, I wonder, are the people asking a question that they expect an answer for or are they just voicing, really a feeling of bewilderment as to why this should happen?" (Catholic-ID03)

"That was quite traumatic for them [the family] ... I often say it's hard. Like what do you do? There is no map, there is no easy set of – here are 10 ready answers to your questions and that will make everything all right for everybody – because it's not. Every individual's thing is different. Every circumstance is different. Every person that you deal with is different. So what do you do? At times you feel very, very inadequate." (Church of Ireland-ID31)

"Everybody was feeling for them as a young family without a daddy and a husband. The questions, the endless questions of 'why?', 'why?', 'why?', 'why?' which no-one could answer … How do you answer that? If you were ministering to me now and I was saying, 'why?' How do you respond or does that depend on whom you're talking to?" (Catholic-ID06)

11.2 Clergy stress

Finally, some of the interviewees expressed their views in relation to a more systematic, long-term form of support to help them cope with the huge demands of their work. It is recognised that clergy serve numerous social functions which makes ministry a very stressful career. Time demands often are seen as a problem which usually interferes with family time, such as evenings and weekends (Lee, 2007).

At times of crises such as bereavement by suicide, clergy expressed that they were not only confronted with their day-to-day ministry demands, but also with more specific demands in terms

of their response and pastoral care to the immediate family and the affected community. Hence, there appears to be a ratcheting upwards of clergy stress:

"It's a tough one. How it affected me? Okay, candidly, there would be moments you would wake up, so certainly, the modern phrase is post-traumatic. I had that and I would recognise that. It also made me aware, even at that time, that there was more to life than the institutional world that I was born and reared in, even to the politics of the world around me. What was most important was the person you were dealing with and that life was so tough for some people as opposed to others." (Catholic-ID02)

"... is my biggest worry in ministry that I make some sort of a [mess of it]. Is that just from a lack of confidence? Could that be addressed by proper support and supervision or is that a process of the difficulty of this particular work?" (Church of Ireland-ID31)

"I haven't been looking after myself well enough recently. I need time off. I haven't had a Sunday off since August. I keep in contact with friends, college days, we still share and that's good. But there are times when it can be quite lonely...I'm very fortunate that I've a good family that keep me sane and keep me busy." (Presbyterian-ID36)

"And I remember at that moment realising he meant to do this [take his own life] … You know he didn't want to save himself. It was that realisation that it was so definite, final, purposeful … And I remember being so taken aback by that, so taken aback by that, that he really meant to do this." (Catholic-ID04)

11.3 The response to suicide

11.3.1 Balancing the needs of families with those of the community

The treatment of suicide in a sensitive, empathic and non-judgemental manner became a recurrent theme during all the interviews. Needless to say, compassionate pastoral care retained, to some degree, core theological values. In order to

reconcile the beliefs and values of their particular religious faith with the 'irreversible consequences of choosing suicide as an option', the majority of the interviewees appealed to the *sanctity of life*, the *preciousness of life*, and the *mercy of God*. Furthermore, being in a position of faith community leaders, the clergy had the opportunity to help de-stigmatise death by suicide and by default mental health as well. This aspect became paramount for some of the clergy who were faced with suicide clusters and in their pastoral role were indirectly conducting a suicide prevention campaign. In this regard the approach of the interviewees was very personal.

The use of language was an important issue. Some preferred to 'soften the language' and refer to the suicide as a *tragic loss/ death*. One participant, a free Presbyterian, never used the word suicide, consciously preferring to use the term 'contributed to his/her own death' which he stated encompassed the reality of the event and circumstances more honestly and less brutally. Similarly, this catholic priest.

> *"You know, mentioning the word suicide – I would never hardly use that word … But certainly I would talk about the sanctity of life"* (Catholic-ID01)

The need to keep an open mind and to be non-judgemental was stressed by many clergy:

> *"…you need to look at the situation holistically and not be coming to it with a predetermined [mind]… it has certainly given me a far warmer heart towards my people."* (Presbyterian-ID36)

> *"… well the last one [suicide] that I officiated at, I talked about the man. I mean he was a very good fella. … I said, 'Look, the manner of his death, the manner of his going is no longer relevant. We have come to pray for his family, to commend his soul to Almighty God.' And that's basically what we would say. We certainly would not condone nor would we set up, get up and judge this person."* (Catholic-ID03)

> *"I went through this experience of suicide with the bereaved and now I...know that you can't judge the person who took their life … I think, at the end of the day, it shows us just the frailty of our own selves and our*

own weaknesses and there's a sense in which, it's only by the grace of God that you're here yourself in many ways. So I think once you see it up close and first hand it brings again an awareness of just all of that. It isn't as black and white as you would like to think it would be." (Presbyterian-ID21)

"But I think that's so important [listening], that when people do want to express things, especially young people who are struggling and battling with various issues, whether it's faith or sexuality or drink or drugs, that you're there and that you're not there to condemn; that you are there to accept and also to help them through these struggles and maybe even to get help for them. And I think that is so, so important; to reassure them." (Church of Ireland-ID37)

"I think there's something about the reality, that it's known. We're speaking of something in a way that's not judgement of the person, not glorifying what they have done but actually dealing with the trauma and then maybe encouraging people who have maybe a similar thought to say, 'There may be help if you seek it.' That's what I am trying to do and to help the family not to go down a road of self blame on themselves for not picking up on a particular sign." (Catholic-ID07)

"One would tend to underline that God alone is the judge of all of us and that He alone understands the pathway we've taken through life … So, one would refrain from any kind of condemnation of course … one would always try to look for the positives in a person's life and be thankful for those … and would try to address those particular types of issues." (Presbyterian-ID19)

Others declared themselves to be more direct and assertive, on occasion addressing this issue from the pulpit. In doing so, the clergy felt that they, as spiritual leaders, had responsibilities towards society, not solely to bereaved families. Thus, they felt that the problem of suicide should not be perpetuated either through censorship, a pretence that it wasn't an issue, or that suicide should not be allowed to be glorified or romanticised in any way. Nevertheless, such clergy were concerned about the feelings

that this provoked among the family and broader community:

"...you're living with the dilemma of I know theologically … that some people go to Heaven, some people do not. So therefore I don't know where this person stands. But I do know that there is a loving God. I do know that there is a God who judges rightly and fairly... it would be irresponsible for me to say your loved one is, therefore, safe in the arms of Jesus or home in Heaven or whatever. Those words have to be chosen guardedly to be true to Biblical teaching without sounding like a cold arrogant pompous so and so." (Presbyterian-ID34)

"I have to say I could not avoid the issue [of suicide] and I say that to the parents. I say, now you know I really can't avoid the issue here and I would say I'm not out to ridicule your child or your son or your daughter but at the end of the day, I have to address it in some shape or form … I wouldn't go down the road of preaching, as it were, against suicide in the word that you mean against suicide but at terrible traumatic times like that I go down the road of offering another way." (Catholic-ID04)

"… there are many, many aspects involved here… what about the individuals who have been coming to terms with the suicide in their own families, schools perhaps, … business, you know, the community, what about that? And that, to me, is, I think, vitally important, that we don't just focus at the funeral but we focus at the overall picture in what will be a very, very long period of time." (Church of Ireland-ID12)

In one instance only suicide was viewed as a sin and as such it should be preached about:

"I have to say, first of all, that suicide is sin. 'Thou shalt not kill.' And that has to be recognised. I think if that were more fully recognised, there might be fewer suicides. I know that suicide is no longer a crime. We're living in a secular society where people are saying to themselves, 'Well if it's not a crime then it's all right.' I sometimes wonder if it were put very clearly to people, 'Here is something that is wrong.' Would they think twice about it? Or are we saying to people, 'Look if you do this, we will have nothing but pity for you.' Are we encouraging people to

– what's the word I'm looking for? - caress their own self-pity? I don't know." (Presbyterian-ID30)

And as the same minister suggests, the clear moral injunction against suicide is important in the midst of an increasingly permissive society; it has a purpose and should not be downplayed:

"I don't see what's so wise about 21st century thought that says, 'Well, we'll just remove the taboo from suicide.' ….there was a reason why people had a taboo in and the Catholic Church didn't bury people inside graveyards. I don't think that was a good thing but the reason behind it is probably a lot more significant than we have given credit for. They were trying to communicate to the people who were alive that life is precious… the real challenge [now] is to find some sort of ways of saying that life is so precious, 'this isn't a good idea.' And I haven't come up with it but there's got to be some way to do that." (Presbyterian-ID30)

11.3.2 Blaming God

The act of suicide is also interpreted, perhaps unconsciously, by some clergy as an almost personal breach of trust between clergy and the church member. The inability of the person to make contact and reveal their pain challenges clergy sense of mission. It also clearly provokes a sense of failure among the clergy. In the following extracts various clergy articulate this failure and the challenges to their religious beliefs and values, most particularly when suicides have been religious people:

"Thinking of F, for instance, … the lady who had the hope of the Gospel, who knew that she had that hope in her heart. She had that conviction but yet felt that she had no other hope but to take her own life. Why should someone who has that assurance and that eternal hope … feel that they cannot talk, first of all to their Lord but also to their Church family? Why can't they seek help in that way? And that's a very hard thing to take, from a faith perspective … a tremendous challenge." (Church of Ireland-ID28)

"… many, many people consciously and deliberately and even wilfully say God's

stuffed… I personally do believe that at that point, in theological terms, Satan steps in and therefore I cannot lie to people. And if someone is dying in whatever way without having consciously asked God's forgiveness and sought his mercy, then I can't say you're going home to glory and all will be sweetness and light…" (Methodist-ID35)

"… but the ironic thing for me is that if, again those that have committed suicide in our Church wouldn't have always been, apart from one woman, ... regular at Church, which is strange in a way ... You know, we have had ministers who have committed suicide and that's the thing, that's the frightening thing." (Presbyterian-ID36)

" … the mother … just apologised profusely for what her son had done to me [to the priest] … And I said, 'Not at all. Don't be thinking like that.' It was awful, you know, that she could only think of me and yet her son was dead." (Catholic-ID04)

"I think long-term, it's the area of trust and faith again and slowly rebuilding their faith in a God who is there and was there and I think that takes time … I think the [surviving spouse] felt enormously and immensely let down and I think that then affected every area in terms of trust." (Presbyterian-ID21)

11.4 Impact of suicide on the family

Bereaved families face particular dilemmas related to public revelation, the funeral arrangements, content of obituaries, handling the media, the intrusion of legal processes, and invariably the questioning of their value system. Finding answers to the question of 'why?' become an interminable quest and the bereaved may also experience intense feelings of guilt, shame and rejection. Friends and neighbours may also feel and act in similar ways; they can feel embarrassed, unable to discuss the death with the immediate family or feel unable to comfort or support the bereaved (Clark, 2001). The views of clergy chime with findings in previous studies of family and community responses to suicide.

Guilt, shame and blame:

"… the families, the close relatives, the friends and so on all seem to share this common thing of… guilt where there is a lot of blame … The ensuing aftermath seems to be a catalogue of guilt where the family [is] punishing themselves for not recognising the signs and seeing that something was going to happen." (Presbyterian-ID34)

"That was very difficult to go to the brother and try and console [him] and assure [him] that nothing he had done or said had contributed to [the suicide.]" (Presbyterian-ID30)

"First of all, I think the family knew it was a suicide … And they wouldn't have wanted any outside involvement." (Catholic-ID04)

"That's one of the devastating things about suicide because if it's been successful, you can't ask the person who has done it 'why?' and, of course, everybody looks back on everything that's happened and thought, 'Why didn't I notice there was a depression? Why didn't I notice something was going wrong?' What could you have done differently? What could you have done better? Suicide raises all those questions for people and obviously much more intensely for the family." (Church of Ireland-ID29)

Shame:

"… there was no Church service. There was, simply at the family's request, there was simply a funeral parlour brief. Funeral parlour and on to a grave." (Baptist-ID10)

"… and there seems to be an underlying fear that suicide therefore is an unpardonable and people struggle with that …" (Presbyterian-ID34)

"I think in some situations, if I were to talk to her [the mother of the suicide] the way I'm talking to you now, I think she would probably say that he took his own life, but I think if she were in a group of people she would still tend to refer to it as "his accident." (Presbyterian-ID24)

"Everybody was feeling for them as a young family without a daddy and a husband.

The questions, the endless questions of, 'why', 'why', 'why', 'why' which no-one could answer … How do you answer that? If you were ministering to me now and I was saying, 'why?' How do you respond or does that depend on whom you're talking to?" (Catholic-ID06)

11.5 Community response

One significant remark from one of the interviewees perhaps summarises the overall effect of suicide on the community: '*intense emotional trauma.*' Notwithstanding the adverse effect of suicide on a whole community, the clergy in this research also pointed out the supportive attitude toward the bereaved families shown by members of the community and its positive effects. According to the clergy, communities were helpful to the grieving families in a number of ways. Predominantly, it was the sense of solidarity, turning up for the funeral and offering practical and emotional support:

"If someone dies, if someone committed suicide, probably they would be kept at home for three days and, you know, the coffin would generally be open. People would come, come really in support and the vast majority of them would say to the parents, 'Look, we have no answers and we're just here to say to you that we care and if there is anything that we can do'. And I think there lies the core: 'If there is anything we can do." (Catholic-ID03)

"… it's the solidarity and the knowledge that you're not on your own in your grief and that people are there to support you and they want you to know that they care. I think words sometimes can seem so shallow, so ineffective." (Church of Ireland-ID23)

"I think people had a different perspective on it [the suicide] and people were terribly and deeply hurt by that experience." (Catholic-ID02)

11.6 Pastoral involvement with the community

In this respect, it was also pointed out that being open about the event created awareness of suicide in communities by an increased awareness of risk factors mainly emotional concerns and worries, relationship problems, isolation or lack of

communication, and to a certain extent, mental health problems:

"But I stress this; we can't help if we don't know there's a problem. It's getting people to talk. I would often, in the course of my preaching, say to people, 'look the door is open. The phone is there. Come and see me.' We would be very, very open to that now." (Presbyterian-ID36)

"Well I would visit my congregation very frequently. And I would very often find that people would confide in me and especially when it comes to things like depression." (Presbyterian-ID24)

"The expertise we're supposed to have is to tell people you have a value: 'I want to give and nurture your life to make it better but I want you to travel this road of faith with me because that's where you're going to find the best experiences. That's not to say we don't all fall and I mean I'm your pal because I fall on a regular basis. But you get up, dust yourself off, start again.' That's the only way it makes sense." (Catholic-ID06)

A few of the clergy experienced a cluster of suicides in the community, from which there was a collective outpouring of grief, in particular at funeral services. The impact on the community in these cases was thought to be more profound and some clergy felt that while this required a more stringent message from the church, it had to be coupled with greater pastoral support with respect to immediate and long-term needs.

The clergy were fully aware of the possibility of ' so-called copy-cat' suicide and made a point to avoid glorifying or sensationalising the death of the persons, they also enlisted professional help:

"Looking back, we didn't realise we were heading down into a pit: the initial suicide in the cluster ... So yes, then it was dealing with family and a massive outpouring of grief and sympathy, shock and terrible pain and amongst this young man's colleagues and the extended family and the girlfriend and so on and so forth … the pastoral need was looked at where we started to talk about getting professionals … So then we started to bring into play other

things and we started to talk about it and we dealt with it at Sunday masses and weekend masses, specifically dealing with this whole thing … I suppose without much learning and without much instruction, began to realise that we had to be way more conscious now of the hardest thing we were going to do, which was to cut to the chase a bit and start talking about ... the glamour of what was out there ... changing certainly even the level of sympathy, even the level of empathy, even the level of sensitivity, not for the families but for the wider public so that we became more careful." (Catholic-ID02)

12. PASTORAL CARE TO BEREAVED FAMILIES

We were interested in the delivery of pastoral care to families and friends and sought to explore the difficulties that this might pose. Bearing in mind that most clergy regarded themselves as somewhat inadequate to the task, much of their pastoral role in this context was presented as maintaining low-key support, simply 'being there' and being guided by the situation. Thus, the provision of pastoral care for the most part was taken to mean a flexible, non-intrusive offer of support (spiritual or otherwise). In this way the clergy viewed themselves as a resource that could be used in various ways and to varying degrees by the bereaved families.

The following quotes illustrate the different dimensions of pastoral care advocated by the clergy:

Being present and unobtrusive

"I really felt empathy with them. It's like you want to reach out and touch them and make things better but I can't do that. You have to sit and just be there for them." (Church of Ireland-ID33)

"You don't have to say an awful lot but to be there and of course there's usually a fair number of other people around and supporting…" (Catholic-ID08)

Giving comfort

"My concern would be to bring them as much comfort as I could … There would be no way I would be condemning the deceased, I could do that at every funeral if I wanted. But no, no, no! For those who are left behind, this is something where they need a lot of help." (Presbyterian-ID30)

"[The Mass] has a real value … It brings the private into the public and back into the private again. Again, that's a language I don't often use. It allows you to be distracted from the pain, it allows you to be comforted in a community, it allows you then to plumb your own depths of faith and look for your own consolation…" (Catholic-ID02)

Listening sensitively

"… suicides should be dealt with sensitively and the family should be ministered to carefully." (Church of Ireland-ID29)

"I will sit and listen and occasionally maybe a word to try but for me, it's often just listening." (Methodist-ID35)

"I mean, we as priests would go along and visit the home on a number of occasions and listen to the family and talk to them." (Catholic-ID03)

…and dealing with guilt

"Essentially the role, which is common to other pastoral situations, is the listening ear. … Most of the time there is little more than that needed. Just to be the ear for someone to unburden, to voice, to tell the story. But also, you know, where advice is given or where thought or counsel is given is to point to the things which alleviate some of the guilt, particularly in relation to eternal matters." (Presbyterian-ID34)

"Rightly or wrongly, I sat in quietness with them and wept as they wept. For me, it was a matter of sitting, making a cup of tea … trying to talk through the endless scenarios of "What ifs" and "Maybes", "Whys" and eventually weeks later, maybe into months, trying to help them see the whys and the wherefores of what they felt was their error in having missed signs that I don't think were there." (Methodist-ID35)

A low profile for religion

Interestingly, various clergy suggested that although religion could be comforting to some people, for others it might be seen as clumsy and perhaps opportunistic. It was not clear when (or how) a spiritual/ theological approach could or should be made. It seems likely that this was viewed as a matter of experience and judgement, generally initiated by the bereaved rather than by the clergy:

"… I don't think people necessarily expect you to have all the answers. I think maybe what helps is your own sense of vulnerability. You know, this is a situation that you are finding hard to deal with just as much as them. But what you try to do is you're bringing, I suppose, a different perspective from the point of view of Christian faith…" (Church of Ireland-ID37)

"… I would not enter into a theological discussion of suicide unless they [families] initiated

that aspect of a discussion … because I feel that they are so mixed, they are so hurt, … that they're not really in the frame of mind to understand and appreciate maybe what I would try to explain to them, maybe on another occasion." (Presbyterian-ID24)

"Sometimes the person will not be ready to receive that and I think you've got to be discerning as to how and when you'll apply what the Bible tells us." (Free Presbyterian-ID32)

"In many cases like this people really sometimes don't want to know about God ... So you've got to allow people to vent those questions and frustrations and I don't believe we have the answers to those and I would never … suggest that … I think it is a time for listening and a time for support, a time for being there and a time for just reassuring them that God is in it somewhere and not to be too direct or heavy with that." (Presbyterian-ID21)

Following up after the event

" … I don't think anyone who has loved someone will ever stop missing them for the rest of their days. So you have to be sort of kind of sensitive. I think it's always good to remember things like anniversaries if you're a minister. Remember when someone passed on and pay the family a wee visit." (Presbyterian-ID18)

"… if I'm involved in a funeral [the process] is reflecting on the words. The homily, but not simply the homily; there is the time you visited the house before and afterwards. We would be very good at trying to do that in this parish. You keep in contact with families. It's not simply a matter of doing a funeral, 'Bye, bye.' Irrespective of what contact there's been beforehand, it's reflecting on the words. Reflecting on the words that are coming up for the people as well." (Catholic-ID07)

"I follow up people who are bereaved for years and years because again, people handle grief in very different ways. But there are some people who don't handle it well at all and I would be visiting every week in homes for years." (Presbyterian-ID24)

Finally, one clergy pointed out the more challenging situation that arises when the suicide occurs in nonreligious families:

> *"Those who have no faith, then it is just really a point blank anger and it really is a real intense emotional time, so they aren't prepared to move on that journey … This is the point where it brings people to an awareness of God, now that happens occasionally. And I suppose those with faith, their anger can be channelled through God. Those who don't, the anger is channelled at God in that sense and you are a representative of God at the end of the day. So you just have to take it and keep returning to visit the people until they possibly say enough is enough and you know that yourself with experience anyway."* (Presbyterian-ID21)

13. PASTORAL CARE IN THE COMMUNITY; the discussion of suicide

Stressed throughout the interviews was the need to be open with the community. The degree of 'openness' to some extent depended on the needs expressed by the family – the level of privacy and reference to suicide they wanted:

"I spoke, obviously, to the family and asked their permission at the funeral service and so on, to speak openly about it because you have to be sensitive to a family's needs and concerns. And with their permission I addressed the whole issue from what I see as a Biblical perspective…" (Presbyterian-ID36)

"I have to say I could not avoid the issue [of suicide] and I say that to the parents. I say, now you know I really can't avoid the issue here and I would say I'm not out to ridicule your child or your son or your daughter but at the end of the day, I have to address it in some shape or form … I wouldn't go down the road of preaching, as it were, against suicide in the word that you mean against suicide but at terrible traumatic times like that I go down the road of offering another way." (Catholic-ID04)

"All I did, which I would do at any funeral anyhow, is take a portion of God's word and do a short sermon on it. And if there is something in the person's life that is relevant I bring that in as an illustration. In this case, I just simply had to say, 'Look we don't know what goes through people's minds'…" (Presbyterian-ID30)

"Well, particularly in our prayer meetings, Church prayer meetings … we do that without being, without having to have all the detail, just simply… seeking to be a support to the families who are obviously going through the trauma of the situation." (Baptist-ID10)

"In that sense I see it [suicide] as another tragic death … You have to be ready for all sorts of other things that come at you. So it might seem heartless – and I don't want it to mean that – it's kind of, it's just another sad, sad death and that's the way I have approached it, tried to talk about it, helped if I could have helped with the young family involved and you know, moved on. I still see them. I still see the wife and the children every week or nearly every week." (Catholic-ID06)

"… each Church must take a responsibility for their congregation … the old fashioned ministerial visit to the family … just to go on a regular basis to be in touch with the family, to even ascertain if there is any difficulty. I think the Church must get back to its roots." (Free Presbyterian-ID32)

The following quote reveals a degree of ambivalence that may be present in the views of clergy, particularly in the absence of unequivocal guidance within training for ministry:

"In college there was no talk of suicide or anything like that, so I got no help there. On the one hand, 'Yes, real pity' but on the other hand, maybe a firm hand is needed … I suppose [suicide] has coloured my approach in pastoral situations." (Presbyterian-ID30)

14. TRAINING NEEDS

As described in greater detail in previous sections, many clergy exposed low confidence in managing the impact of suicide on families, communities and themselves. They described being ill-equipped or out of their depth, and holding enduring feelings of inadequacy.

Most clergy have had little or no training in mental health issues generally, or in suicide specifically and appeared grateful for any help that might be available. Training was seen as vital in helping them avoid various blunders. Uncertain as to how to respond – what to say and do – they report feeling unconfident about the effectiveness of the support they offer. Often, they are left with just their instincts and common sense to make the best of a difficult situation. One spoke of "the importance that clergy should not be left on their own to deal with this" (Church of Ireland-ID12). Another described the situation of a colleague: "the minister didn't have a clue what to do, poor man … it was just beyond his experience" (Methodist-ID26).

Commonly, clergy reported the need for training and support in pastoral care for suicide, whether from secular organisations or in collaboration with other faith organisations:

> *"I don't see anyone … in any Church rejecting training and help in this area. I think many people would welcome help and guidance, and … the pooling of resources."* (Presbyterian-ID36)

> *"I mean you want to stop people from hurting. But how do you do it - I would appreciate more guidance on that because I don't know."* (Church of Ireland-ID29)

Again,

> *"I don't think the Church really tells you very much what to do. Yeah, yeah, you know, there's no sort of, well really there are no guidelines really about how you deal with it. I suppose as well maybe different suicides maybe different circumstances…"* (Catholic-ID01)

Practical, relevant guidelines would be of "immense benefit". Some kind of "core training" is needed, and the best training, at least for some, is deemed to

come from those with the most experience, which are bodies external to faith organisations – those that are most "in tune with" the latest thinking and assistance. Also, information and feedback from this very research project would be welcome.

14.1 Professional assistance

As noted previously, clergy contend that suicide often comes as a shock, lacking any clear warning signals. However, they also recognise that suicide needs to be seen in the wider context of mental illness and, occasionally, there are people whose actions or affect give cause for concern. Dealing with these situations requires a degree of knowledge and skills that they consider to be absent among faith based organisations. As one minister states:

> *"… we live in a more secular society, and … not everybody is going to necessarily be sort of looking for a spiritual approach to their issues."* (Presbyterian-ID18)

> *"Well, I was aware that he was badly depressed but what's the difference between that and suicidal? But this morning I was thinking to myself and saying like you know, that situation, 'Is there a psychiatrist around that I could contact and ask him what are those symptoms indicating as far as your experience tells you?"* (Catholic-ID05)

In general, the clergy said that they would value being able to undertake training alongside other professionals such as, health and mental health care practitioners and nurses, social workers, counsellors, therapists and any other experts on the subject. Because of this, they are very open to training from any source that can offer something useful for them:

> *"It's not so much the agency that I would be interested in, as whether the individual has the experience and the competence and the capability to actually tell me things that will be useful, and what label they have, or whatever else, doesn't matter to me."* (Presbyterian-ID19)

> *"I think the better impact would be someone who is well aware of dealing with suicide and*

mental health problems, if we try to put it all together in some way. You know, come into a body of priests and saying, 'Look guys, this is on your doorstep and here are signs.' Like that's something, we wouldn't even be aware, whereas a trained professional would say, 'Well, like one of the things is … people who live on their own and who drink on their own', wee pointers." (Catholic-ID06)

Interdisciplinary training was seen by the clergy as an opportunity to enhance their skills and knowledge in this area. Additionally, this was seen as useful networking and information sharing that could encourage the build up of channels of communication among the different disciplines which would allow a more co-ordinated response to people at risk and to the bereaved by suicide.

The major concerns about a knowledge and skills deficit relate to: (a) the presence of mental illness and risk assessment of suicidal intent; (b) local professional help resources; (c) pastoral counselling of depressed and suicidal people; (d) dealing with families following suicide. These needs are illustrated by the following quotes:

"We would want to be at the preventative stage…where we're probably struggling the most is missing those warning signs, it's identifying. I think we need to be able to identify clearly, 'Is there a particular pattern? Is it only the introverts, extroverts?' People say, 'I'm going to commit suicide.' Does that mean they will or they won't? How early on should we call in particular help?" (Presbyterian-ID21)

"Well I think it should be talked about [the topic of suicide] in general priests' training as students or whatever. I mean it shouldn't be avoided. It shouldn't be avoided. And also that understanding of – which I think comes naturally to priests and ministers – of sympathy towards the people that are involved and I haven't met any religious people, I must say now, whatever about what it might have been like in the old days, before my time, who would have adopted a condemnatory kind of attitude. I never met them." (Catholic-ID08)

"But I think that must include the prevention, the dealing with prevention of the situation rather than just dealing with the aftermath." (Methodist-ID17)

"I think a formal… training is good even from a point of view of the very basic of things to look for and to deal with. That would be invaluable …" (Presbyterian-ID36)

"Well I was aware that he was badly depressed but what's the difference between that and suicidal?" (Catholic-ID05)

"… you want to stop people from hurting, but how you do it. I would appreciate more guidance on that because I don't know … I suppose all you can try to do is give people enough time and space to help to build their feeling of worth and allow them to start from that kind of a basis. But certainly, I mean nobody has ever taught me how to do this." (Church of Ireland-ID29)

"What would one do in a situation like that? [in which the individual is reluctant to accept that something is wrong] … It's often said that prevention's far better than the cure. When do you step in and when do you stay out?" (Catholic-ID05)

"Having something in place, a strategy in place whereby if a suicide happens that you know where to turn for help; that certainly would be something that would be so helpful." (Church of Ireland-ID28)

"Why do people commit suicide? What sorts of people? Speak with the professionals to try to get a bit of understanding behind the person who has committed suicide." (Church of Ireland-ID31)

"I think you need to have some kind of understanding of what's happening within a person's mind who is contemplating suicide … So whether or not anyone can come along, whether a psychologist or psychiatrist can come along and say, 'If someone commits suicide, this is really what's going on in their mind." (Presbyterian-ID13)

"… [when] the person has taken their own life, how to actually speak to a family in that situation is a tremendously difficult thing … I don't know if anybody can be prepared for

this, in truth. I don't know what you can do to be prepared for something like this." (Church of Ireland-ID28)

"And then the next thing is to inform the family. How do you inform them? Do you go or do you ring up, ring the phone, which is so impersonal. How do you and who do you tell?" (Catholic-ID05)

14.2 Inter-faith/ inter-denominational initiatives

The idea of designing a training programme to be delivered in an inter-faith format was well received by the clergy:

"I think doing the training together … would be excellent … because … I think you can gain insights from each other which would be very, very useful." (Methodist-ID26)

"… I don't see anyone that I know in any Church rejecting training and help in this area." (Presbyterian-ID36)

"I think discussion helps me and somebody speaking of their story is something that I can learn and process … I can see what they're, you know in terms of what they're trying to do. I think it is, there's something of the sharing of stories and experience of what has worked and what hasn't worked or just there is no one way." (Catholic-ID07)

The benefits of inter-denominational training initiatives were identified as:

- **an opportunity to reach the larger community regardless of religious background:**

  "I think the inter-church situation would be inevitable just to be able to get people, you know this is not something that is restricted to a denomination." (Methodist-ID17)

  "Within the inter-faith or inter-church area we would need to look at ways in which we can perhaps work together within the community to say to people, 'We believe that there is hope for you,' and perhaps approaching them on a united front." (Presbyterian-ID13)

"I think those options are open [interdenominational training]. I think there was something a couple of years ago between the Church of Ireland and the Catholic Church … I think we are more and more open to those ... should just be more open into the impact of it [suicide] … the human experience. And even just being updated in terms of like compare to what's been going on in the North Belfast area … Portadown area…" (Catholic-ID07)

- **an opportunity to learn from one another:**

  "If it is run on the basis that this is the Board [Health Board] doing something and that people of various faith backgrounds are there in their own capacity simply learning, I don't see where the problem would lie." (Baptist-ID10)

  "But, I mean from colleagues, ministers of other denominations who will have just as many experiences and how to support people, all of that is good and while I can see – how would I put it? – there's benefits both ways. I mean you're comfortable with your own colleagues, from that point of view but I mean, as one who is part of a fraternity group of ministers, I mean they're fine men. I never get to meet them that you don't learn something." (Catholic-ID06)

  "Well, it would do no harm [ecumenical training]. I mean life and death cuts right across. You know what I mean? Absolutely!" (Catholic-ID06)

- **the best way to maximise resources:**

  "I think many people would welcome help and guidance and, for want of a better word, the pooling of resources." (Presbyterian-ID36)

14.3 Intra-organisational training

Overall it was recognised by the clergy that they lacked training in mental health and suicide awareness/prevention. This gap related mainly to their formal education in theological college:

"I had probably four lectures 20 years ago and that was basically the height of it." (Presbyterian-ID36)

"I don't think the Church really tells you very much what to do. Yeah, yeah, you know, there's no sort of, well really there are no guidelines really about how you deal with it. I suppose as well maybe different suicides maybe different circumstances …" (Catholic-ID01)

"I got no help in college. In college there was no talk of suicide or anything like that, so I got no help there." (Presbyterian-ID30)

Under these circumstances the clergy who deal directly with vulnerable people – as hospital chaplains, for example – undergo training on their own initiative or educate themselves on the subject through reading:

"I was a hospital chaplain in [psychiatric hospital named] for five years and did about three courses on it [mental health issues]." (Church of Ireland-ID27)

"... any understanding that I have of bereavement – and it is a very limited understanding I'd have to say – would be from reading books, which I did of course on my own initiative to try and develop skills in that area." (Presbyterian-ID19)

With the above in consideration, the need to include the topics of suicide awareness or bereavement in the theological college curriculum was voiced:

"So it probably would be useful to raise bereavement counselling or suicide awareness counselling at some sort of training stage … There probably should be something in the core training, a module or whatever." (Presbyterian-ID34)

This was considered as important because faith-based organisations were seen as reactive to social crises and lacking in adequate structures and mechanisms to assist clergy in providing good pastoral care. Some considered that a more professionalised approach was expected by their communities:

"… in November at our Presbytery, as a follow up to what had happened [a suicide cluster in a neighbouring area], I led a seminar on suicide for

the Presbytery, which would be the ministers and one elder from each Church. It's the first time we have actually set aside business to look at a current situation, break up into small groups and try to come to terms with what was going on." (Presbyterian-ID20)

"Well, I think it should be talked about [the topic of suicide] in general priests' training as students or whatever. I mean it shouldn't be avoided. It shouldn't be avoided." (Catholic-ID08)

"I think that the Church also needs to provide some kind of training for those of us who are involved in meeting people and counselling people and dealing with problems that individuals and families face up to." (Presbyterian-ID13)

"It's because of circumstances; once a suicide has happened only then conversations follow. But, having said that, because of the unfortunate rise in our knowledge of suicide – it's one of the apparent increases in our communities – more dialogue is coming forward. People are starting to question why and look at the provision to see whether or not we are being appropriately trained, even to spot signs, to spot areas of doubt and difficulty." (Presbyterian-ID34)

Although limited, this deficiency is increasingly recognised by clergy within their respective denominations and, in some, efforts are being made to address this issue through structural change. For instance, some clergy being specifically trained in suicide awareness:

"Now that the ministry and the service of ministry is changed, you find that there is certainly more contact and more structured contact between priests and the cluster." (Catholic-ID02)

"… there's been an increasing awareness [within the Church] of the need for pastoral training… I think the pastoral side, in terms of bereavement counselling in whatever direction you go in with that, is greater than it has been in years gone by." (Methodist-17)

"… there are different Churches that actually have now got officers who are actually trying to do in-service training … the

Methodist Church in Ireland is one of those Churches and as part of their college in Belfast now one of the staff is available to do various things and different day training courses."
(Methodist-ID26)

15. BARRIERS TO TRAINING AND/OR COLLABORATIVE INITIATIVES

The barriers to training identified by the interviewed clergy will be discussed in two sections. The first (General) will deal with barriers that would apply to any type of training. The second (Collaborative) deals specifically with barriers involving collaboration with other professionals or inter-faith (and interdenominational) groups.

15.1 General

Time

By far the most referred to problem in attending any kind of training was lack of time. The work of the clergy, superficially at least, had a degree of predictability but very often it is not – as they respond to the crises and difficulties in the lives of their parishioners. Work may be scheduled but then has to be dropped because a person has died or been brought to hospital. As one minister put it:

> *"Invariably, something else comes along. I mean there could be another situation, another crisis, another illness … that becomes top of your priority list."* (Presbyterian-ID34)

And in most instances, the Church provides no cover at times of crisis – someone who could take over responsibilities for a time. This is particularly difficult when it conflicts with family life. Any extra evening activities, or residential training that requires them to be away from home, would pose a special problem. Commonly, clergy felt that they were considerably overstretched.

Role conflict

The second barrier is a conceptual one. It relates to clergy concerns about the extension of their role into a secular domain. For some, dealing with suicide prevention is not part of the vocation:

> *"Most ministers maybe don't see that as the priority of their ministry."* (Free Presbyterian-ID32)

> *"We're not trained for counselling. I mean we are not officially trained for counselling. I mean that is a specialist task. Any disaster you have these days, you know counsellors in schools, counsellors are there and we're not trained to counsel."* (Catholic-ID06)

For other clergy, there was a concern that training of this nature might be unnecessarily demanding or that they would end up just being managers of other people – "salaried managers managing our volunteers" (Church of Ireland-ID22). Time is an issue here too and though social action on suicide was needed, it may conflict with their main pastoral and spiritual remit and take clergy into a social care or community worker role:

> *"I am not ever going to be an expert in suicide or suicide prevention … I see my task as pastoring those under my care."* (Baptist-ID10)

Competence

The third general barrier, not frequently mentioned, but possibly felt more widely, was the possible negative perceptions by one's peers; that training in this issue might be regarded by other clergy as an admission of low competency in pastoral care:

> *"I think there's also a culture of … once you finish training and you're out there, you've broken away from the system and you then have got your independence to get on and do the job that you felt the calling to do and I think sometimes people view … going back into school in a negative way rather than a positive way."* (Methodist-ID26)

Utility of training – the uniqueness of suicide

The last general barrier to training, again not widely voiced, is that there is some doubt about the ability to train effectively in areas of such complexity. If each case of suicide is unique, can useful generalisations be determined?

> *"You don't know what you're going to hear [from those left behind after suicide] … that's why I'm saying I don't believe there's any formal training you can receive … every suicide is so individualistic ..."* (Catholic-ID04)

A blueprint that covers suicide in a general way was considered unlikely.

15.2 Collaborative

Collaboration with professionals

The main barrier to collaborative training with professional and secular organisations relates to

fears that the spiritual role of the Church might be undermined. It was widely felt that the relationship between doctors or consultants and clergy could be much improved. For instance, some clergy feel that they are seen as not important by health care professionals, though they believe that the health service is interested in the health of the whole person, including spiritual aspects of health and well-being. Importantly, it was felt that clergy often played a useful part in helping a person recover or come to terms with illness and dying. However, they perceived themselves to be sidelined or disregarded by the caring professionals. This was occasionally expressed rather strongly:

> *"[They] look down their noses at you as though you're just some religious freak that is coming along from outside."* (Methodist-ID26)

> *"I think that people forget, or organisations forget, that there is a spiritual dimension to every person, you know? That there is a God dimension, whatever you want to – term it what way you wish – that they can't reach."* (Catholic-ID04)

> *"I know some … nurses and people and I know they have very full and exhausting lives and they're probably dealing with things without having to think about, 'Oh God, could we draw somebody else in?' You know it's just maybe not on the radar … In an ideal world we would be seen as part of that support, network of supporting."* (Catholic-ID06)

Collaboration with other faith groups

In a limited way, there was a view that a few clergy might be resistant to working with other faith groups. In the words of two clergy:

> *"The very word ecumenical rings alarm bells."* (Baptist-ID10)

> *"I can't see it [inter faith collaboration] because there's no contact. I don't know what it's like in the bigger areas but my experience is that collaboration or ecumenical movements … don't take off. They just haven't taken off. People are more friendly and people are more cooperative and people are more accepting but I don't know, the clergy don't seem to want it. That's factual now."* (Catholic-ID05)

However, most clergy expressed openness to being involved with secular organisations and Churches of other denominations, as long as that can be done *"without questioning deeply held religious views."* (Free Presbyterian-ID32)

Simply learning about suicide or other mental health issues would be fine, but praying together would, for some, not be acceptable. Learning from each other, and then *"doing in their own context what needs to be done"* (Baptist-ID10) would seem to be the acceptable formula for all. A certain dovetailing is both required and desired:

> *"I think the spiritual needs need to be addressed by the Church, but the practical needs … could easily come from a secular organisation."* (Church of Irealnd-ID28)

> *"I think there's a great benefit in sharing. You know sharing our experiences and our darknesses or whatever in relation to it [suicide]. But I can't see how you can formalise a programme because every case is so different. The only thing that they have in common is that somebody took their life. Somebody died."* (Catholic-ID04)

> *"I have no, operating or working with Christians, Muslims, Hindu, any difficulty whatsoever."* (Church of Ireland-ID15)

> *"I think in the context here [in NI] it would be ideal if it [training] could be done ecumenically because I think that the issue of suicide is something that affects everybody. It's not particular to their religious background or whatever – if they've got a religious background or none. So in that way, a lot of the issues I'm sure overlap and dovetail into each other."* (Methodist-ID26)

For some, a barrier to ecumenical or professional collaboration lies in the continuing problems of sectarianism in NI. There was recognition that some ministers might not attend a conference on suicide, even if held in a neutral venue, because of the possibility of the presence of different faith communities. Though the differences may not be as strong as they once were, there probably are still "difficulties on theological grounds" of how suicide is viewed.

According to one interviewee:

> *"Northern Ireland can be naïve about the fact that there's always been that divide, and I think there always will be on issues of faith."* (Presbyterian-ID21)

Confidentiality

A third and somewhat more complex barrier to collaborative initiatives is confidentiality. Very often, when a Church member is receiving a service in the community – whether medical, mental health, or some kind of social service – there is a disconnection between those services and the pastoral care that the clergy can offer. It is felt that it would be more beneficial to the receiver of services if there could be some collaboration between the two types of services:

> *"It would be really, really helpful to have a conversation with this particular person's social worker … but I don't feel that I can instigate that because … it puts the social worker in a very difficult position because of breaking confidentiality."* (Methodist-ID26)

Moreover, although not specifically related to suicide, a particularly sad and frustrating situation for clergy surrounds the end of life care of parishioners in hospital:

> *"We're trying to minister to our own parishioners and the person … is shortly going to be deceased … very often the hospital staff just refuse to discuss at all with clergy … the staff are more worried about the confidentiality, and we're excluded."* (Church of Ireland-ID31)

Due to fear of impinging on an individual's right to confidentiality, "there's no liaison, there's no dialogue between, effectively what are two carers, two counsellors, two listeners" (Presbyterian-ID34). They never cross paths in any useful, productive way:

> *"[… this man attempted suicide and the priest spoke to him] he did go in and seek some care in [a psychiatric unit] … So, I think the professionals were involved … I wouldn't be, unless I happen to have been in the house when some of those were there, that's the only time you get to know the professionals … I think I would be open to [get involved]*

if someone you know said: 'Can we meet you?' Because the person has, just in today's world, you know some people might not want, you know, it's so formal. But if the person has said, 'Well I'd like a visit from my local Church as well', if they're willing to have those joined up I would be content to be part of that." (Catholic-ID07)

16. SUMMARY OF FINDINGS

The findings of this study indicate that suicide is a major source of stress and anxiety to clergy. It is perceived and experienced by them as often bewildering, generally traumatic and deeply corrosive to their confidence and ability to provide pastoral care. What seems clear is that clergy from across the faith spectrum feel that the rise in suicide and suicidal behaviour is a significant concern and one that demands an improved and urgent response from everyone in the faith communities. It might be argued that there is an element of predictability in this assertion arising from a selection bias among the clergy who provided in-depth interviews. However, the findings from the quantitative survey suggest otherwise.

The findings indicate that the needs of clergy cannot be met solely within the faith organisations nor can they be met through provision from external professional mental health agencies. Importantly, a significant message delivered within these interviews was the need for dialogue and reciprocity in order to foster mutual understanding and respect, knowledge and information-sharing between the secular and religious agencies. More specifically, clergy would appreciate clear, formal guidelines on the pastoral approach to suicide which would include all the problematic areas for clergy: everything from how to respond to that first phone call, what to say and what *not* to say, how to conduct a funeral in such circumstances, helping with practical matters, minimising the pain of others, dealing with guilt; and almost anything that would give them direction beyond common sense approaches upon which they usually rely.

Along with such guidelines, several clergy suggested some kind of supervision or personal feedback on how well they are following those guidelines, or how effective their pastoral care seems to be. In a similar vein – still addressing the desire for more guidance within their own FBO – is the suggestion of a designated colleague who can be consulted for guidance when needed. In addition to being knowledgeable on Church stances toward social issues, and up-to-date on pastoral guidelines, this person would ideally be an expert on suicide and mental health matters. And, being internal to the Church, this colleague could also be seen as filling the role of mentor or trusted confidant.

Others outlined the need for an ongoing forum on suicide and other mental health issues. It was felt that this would permit a degree of preparation and proactive engagement with these and other problematic social issues as opposed to the current sense of a belated reaction.

Some version of a *pastor pastorum* had appeal to several interviewees. With all the stress, doubt, and anguish that the clergy must deal with in relation to suicide and the bereaved, they themselves are sometimes in need of pastoral care. Though there might be some overlap with the role of the designated expert discussed above, clergy stressed the need for dedicated personal help from someone who had experience and empathy. Both practical and emotional needs would be addressed. One interviewee suggested that counselling services be made available to clergy and their families, paid for by the Church.

With time constraints being such a big factor in the lives of clergy, several suggestions to make the best use of time are offered, in order to facilitate training. Training that is flexible, modularised and available at a choice of different times would be helpful; this might include accessible learning formats such as CDs, DVDs or videos that are capable of allowing for ever-changing schedules. Arranging some kind of cover within the FBO for attending training sessions was also mentioned. Clergy, are often torn between attending an interesting or useful training event and just continuing with their busy pastoral schedule. Also, the idea of combining training sessions on existing meetings was voiced.

Lastly, legal advice was mentioned. In this age of increasing litigation, clergy would like to know their vulnerabilities regarding legal action. Again, guidelines would be appreciated, especially regarding mental health, suicide and confidentiality.

Collaborative

For the most part, our interviewees are very open to the idea of training with those from other faith groups, and to being taught by secular professionals, as long as they are “just learning”, i.e., are free to implement what they learn within their Church in a theologically and pastorally appropriate and relevant manner. Moreover, training on suicide

and mental health topics would be welcome as long as it is focused, practical and time-limited and provided by experienced individuals.

Guidelines, again, would be appreciated on how to respond to the bereaved – provided from a professional perspective in the mental health field, as distinct from the 'within-FBO' guidelines mentioned above, as it is recognised that different people and groups have different areas of expertise, and therefore different views. What to do and not to do from a mental health practitioner perspective would be expected to cover different aspects than those offered within the Church.

People working in different fields (mental health, medical, social services, and clergy) have different roles and areas of expertise, so they tend to view the patient/person/parishioner compartmentally; each will focus on different aspects of care. However, it emerged from some of the interviews that informal liaison between clergy and clergy of other denominations, medical and mental health professionals, and social service representatives already exist. These tend to develop within social networks. Individuals come to know and trust each other, and even informally pass on referrals – successfully skirting the confidentiality issues. Thus, as one minister pointed out, his local general practitioner would sometimes hint that a particular person might benefit from a pastoral visit. There is no fear of reprimand or negative fallout, as each knows the other only has the best interests of the person at heart, and would not do anything inappropriate. There is a shared sensitivity to caring for the person. This type of informal referral may be of considerable benefit. Thus, setting up protocols to facilitate liaison was viewed as important. It was suggested that protocols be put in place to permit a degree of information sharing which would be necessarily patient-initiated and guided, confidential.

A referral system was also suggested, providing clergy with contact details of practitioners and protocols for engagement. Another suggestion, for training purposes and deeper understanding was to arrange liaisons with groups representing those bereaved or otherwise affected by suicide. It is important to hear first-hand about their experiences, and to involve them in planning for services at every

level. They have their own, very valuable, area of expertise and insight not available through training.

Community Wide

A substantial part of the cause of suicide, as reported by the clergy interviewed, stems from societal problems in the larger community. Addressing these concerns, over time, might reduce the burden on clergy by reducing the rate of suicide. Encouraging talk and openness about emotional problems was suggested as the single most important change that could promote healthier, happier lives, and therefore reduce the desperation and need for escape that suicide implies.

For some people, especially the young, training might be needed to enable them to talk openly about their feelings, or even to recognise that they have them, as this is not a culture known for its emotional openness. Self-esteem classes would help address this problem, since self-worth is often lacking in suicidal people. Similarly, coping strategies for dealing with life events would be beneficial. One interviewee, while recognising the huge problem – "the brokenness" – faced by some in his congregation, and the need for professional help in dealing with it, also wondered "how many of this community actually could begin to articulate their feelings in the way that a counselling relationship requires." (Church of Ireland-ID22).

Early intervention – in primary and secondary schools – to even begin to expose children to this aspect of life would be a big step in the right direction. The clergy themselves would like help in this area too.

17. CLERGY OF OTHER FAITH GROUPS

Islam

In Islamic traditions, suicide is strongly condemned. Thus, the Koran forbids suicide and the perpetrator cannot be forgiven and is doomed to perpetual hell. However, there is some evidence that relatives of the dead person may be treated sympathetically within most Islamic traditions (Ladha, Bhat, & D'Souza, 1996). Although suicide in no longer a criminal offence in developed nations, it continues to be in developing countries, especially in Islamic nations. The influence of religious and social factors on the registering of suicides coupled with the stigma of mental disease leads to under-reporting, which may be as high as 30-100%.

According to the Imam interviewed, in Islamic tradition suicide is considered a sin because all life belongs to God; the only excuse for suicide is having mental health problems for which a person has not received help, therefore, God will not condemn them:

> *"If you have psychological problems that drive you to suicide and you have no control over your action, then it wouldn't be a sin because God could not blame you for something you have no control of."*

The Imam felt that mental health problems are probably as common amongst the Muslim population in NI as in any other population. Likewise, there is a stigma attached to them. However, in Islamic tradition, mental health problems are associated with Jins (also known as Jinni – a spirit) and these may be dealt with through prayer and exorcism rituals. Muslims tend not to consult mental health professionals. However, the Imam would encourage help seeking from mental health professionals should religious intervention fail. In this way, religious or medical problems can be differentiated. He felt that training in mental health awareness for imams should be considered as helpful.

In Islam, families bereaved by suicide can sometimes be treated poorly by the community. In the past, it was not unusual for Imams to refuse to pray for the dead. However, he averred

that a person who took their own life and their families should not be judged because judgement is solely God's prerogative:

> "*We don't judge, only God can judge. We can't see in his heart, we can't see in his mind, we don't know what he was going through and it would be unfair for any person alive or dead to judge that person for committing suicide."*

An Imam will comfort the bereaved family before and after the funeral, but mainly families are supported through friends and relatives around them:

> "*In Islam, people lean a lot on their own family and they get the support they need from their own family. If they need more, they can come to and see the Imam and talk to him and call in any time."*

Judaism

In the Jewish tradition, suicide has been treated as a sinful act and as with other Abrahamic faiths, the usual privileges and rituals accorded to the dead and their families were sometimes withheld. Jewish Law (*Halakha*) assumes the existence of an omnipotent, omniscient and benevolent Creator and a relationship between the creator and all human beings; consequently there is purpose in every instant of life, for the individual and for the community.

A person is obligated to follow the Jewish law dictates which 'not only forbids killing any innocent person, but it affirmatively mandates steps to safeguard and to rescue human life' (Resnicoff, 1998). Sometimes, *Shiva* (a period of mourning) or *Kaddish* (prayers for the dead) could be denied. However, contemporary Jewish thought allows for the possibility that a person might kill themselves while suffering from mental illness and thus, death was not an entirely voluntary act. The rabbi interviewed indicated that in Jewish tradition suicide is:

> "*Definitely unwanted and a sin … One of the Commandments is to look after oneself and ending one's life is definitely against the Halakha and the Torah – not a question about that."*

Notwithstanding, the interviewee made a distinction in Jewish orthodoxy on suicide:

> *suicide* with regret of the act: when the person regrets the act before their death; they are saved and the suicide is treated like any other death;
>
> *total suicide* with no regret of the act: when the person does not regret the act before their death; they would probably be buried in a different part of the cemetery.

It was stated by the rabbi that suicide is very rare within the Jewish community:

> "*There is a school of thought that most suicides are not real suicides because they regret it at the last moment … To find a total suicide is very rare because most people believe that they've regretted it after*

… Therefore a lot of cases aren't taken up as suicides."

However, when suicide happens the bereaved are offered comfort and support in an empathetic manner:

"*They [the families] wouldn't have been outcasted, no. They would have been treated … with empathy and one would comfort them as much as possible*."

Mental health problems, on the other hand, are recognised as factors that have a negative impact of a person's well-being and people are encouraged to seek professional help if necessary:

"… to go to a psychologist nowadays you don't have to be somebody crazy. You can be a regular person on the street who happens to be going to a psychologist just to handle a certain scenario."

Hinduism

Hinduism is an all-encompassing or generic term associated with a wide range of religious practices in India but with their foundations in Vedic scripture. This provides a less consistent, often ambivalent attitude within Hindu tradition (Hassan, 1983), indeed there is evidence that suicide was permissible in the early Vedic period; in the later writings (the Upanishads) suicide is strongly opposed and salvation is denied to the suicide (Ineichen, 1998).

Latha et al (1996) suggests that while suicide attempts in India are no longer a punishable offence, they have become so common as to constitute a major public health problem. However, some surveys in the UK suggest that there are significantly higher rates of suicide and attempted suicide among Hindu migrants compared to their Muslim counterparts (people born in Pakistan and Bangladesh) (Neeleman, Jones, Van, & Murray, 1996; Raleigh & Balarajan, 1992).

The priest discussed how in Hinduism suicide is generally associated with societal and environmental factors to which people are exposed and these create 'tension' and worries in the lives of the sufferer to such an extent that they feel that death is the only solution. Essentially, 'suicide' means 'giving up.' The priest argued that suicide is definitely a sin. In Hinduism a person's life or body is not theirs to take, it belongs to God. A person is supposed to complete a life cycle – approximately 100 years – and reincarnate after death. If a person dies prematurely through suicide, they still reincarnate to complete their life cycle. When the suicide is reincarnated, other people and they will know that in a previous life they have taken their own life.

In Hindu culture mental health problems are believed to be caused by 'tension' in people's lives and this may be a factor contributing to suicide:

> *"… life tensions, family tensions, business tensions, all tensions … No-one is tension free...* [and this] *ends only through prayers to God."*

The only way to alleviate those 'tensions' is through prayers to God. People are guided by priests who are, through their religious education, fairly competent in counselling skills. The interviewee expressed that the only way to better support people in their crisis – relating to mental health problems or otherwise – is through guidance in a sensitive and sympathetic manner. Mental health awareness, however, is not a topic included in a priest's education:

> *"… you receive education on 16 different sectors of religion … through your education you should be able to give guidance to people to improve whatever they are going through … My help is only guiding."*

In Hinduism, in death by suicide, funeral arrangements and rituals are similar to those of any other death. In Hindu religion, everyone is treated the same. When a person takes their own life the grieving process is not different from that of any other death. In general, happiness and sorrow are shared by all human beings and when tragedy strikes people are supportive to one another. This ameliorates the 'sadness and depression' caused by adversity or death.

Finally, the interviewee expressed that the issue of suicide is sometimes discussed in a community when they have been affected by it.

18. CONCLUSIONS

Many people would argue that religious organisations should play no role in the care of people with mental health problems. Indeed, there are voices within faith groups who view clergy involvement in health and social care as an erosion of their spiritual leadership (Norman, 2002). Nevertheless, embedded as they are in local communities, they are often at the frontline of human suffering; it is simply implausible that they have the choice or the inclination to turn away from this suffering. They are in a unique position but one that is complex and fraught with anxiety.

Unlike professional groups, clergy are often in long-term contact with families, and as we have indicated, sometimes as neighbours and close friends. Although trained to provide advice and support from a spiritual perspective, the death of a congregation member through suicide requires skills and knowledge beyond that provided in training for ministry. Most clergy are open to training from secular professionals and in collaboration with other faith groups but such openness is not without caveats. Thus, each individual, group, agency or organization, whether faith-based or secular, must treat all other parties with respect. In order to create this respect, the information covered should, as far as possible, stick to shared principles and problems which don't encroach on each other's value systems.

What appeared to be accepted by the clergy was a common desire to help people in pain, and to prevent needless death; the deeper the knowledge and understanding about others' perspectives and approaches, then the more effective approaches would emerge. As stated very strongly by one interviewee:

> *"I find, speaking to people, that there's just a sense of wanting to be as open and caring and as loving and supportive as possible to those involved. And I find that right across the board … I think sharing each other's experiences can only be good. In our ordination vows, we say 'we refuse light from no quarter', and I would say Amen to that because we can all do with sharing."* (Presbyterian-ID36)

19. RECOMMENDATIONS

Within Faith Based Organisations (FBOs):

Faith based organisations need to recognise that a large part of pastoral care is taken up with the problems of people who are emotionally distressed or affected by more enduring social and psychological problems. They also need to recognise that this aspect of ministry and the pain of dealing with families and communities will contribute to the stress and possible burn-out among some clergy. Therefore:

- Clergy across most denominations would benefit from clear, unambiguous policy and guidance on suicide which allows a balance of theological positions on the sanctity of life but which accepts the existence of mitigating factors including mental illness;
- Clergy could be better supported in preparation and throughout the years of their ministry with continuing pastoral development in mental health and suicide awareness. They could also benefit by creating formal structures of peer-support (*pastor pastorum*) and pastoral supervision; when a minister is confronted by a suicide within his or her community and/or facing difficulties in offering pastoral care to families, some clergy may benefit from counselling support;
- Clergy are pivotal in their support to families and communities bereaved by suicide so they need the time to train in order to acquire the appropriate knowledge and skills. Replacement cover of pastoral duties for time off to train is necessary.

Training

- Clergy should be provided with education and training on mental health problems, symptom recognition and the appropriate response and referral. This should be provided as mandatory in training for ministry and with the assistance of skilled and experienced mental health professionals.
- Acknowledging the often pressured and unpredictable nature of ministry, the delivery of advice, support, education and training on mental health and suicide must be available to clergy in a range of formats. These might consist of information packs and internet-based materials, in addition to educational seminars and workshops which should be provided in relatively small, local groups.

Collaborative

- Health and social care agencies should recognise the significant contribution that FBOs provide to troubled people and the pivotal community role of clergy. There is, therefore, a need to explore ways in which dialogue between clergy and mental health professionals might be cultivated, with the establishment of frameworks and forums at both local and regional levels.
- The provision of seminar and workshops that would be of greatest benefit to clergy would cover the following: (a) the recognition of signs and symptoms in mental illness; (b) risk assessment of the suicidal person – understanding and recognising suicidal ideation; (c) management of the suicidal person; (d) guidelines on how to respond to bereavement by suicide; (e) understanding the grieving process of people bereaved by suicide; (f) information on resources and support for the bereaved by suicide.
- A set of guidelines for clergy on how to respond to people bereaved through suicide need to be drawn in collaboration with mental and health care professionals as well as groups representing those bereaved by suicide.

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APPENDICES

APPENDIX I - QUESTIONNAIRE

Religious Leaders and Pastoral Care in Suicide

1. What age are you? _____

2. Sex: Male ☐

   Female ☐

3. How many years have you been a minister of religion?

   _____

4. Have you ever, as part of your training for ministry, been provided with pastoral care following suicide?

   a) None ☐ b) Not enough ☐ c) All that I needed ☐

5. Have you ever undertaken training in counselling or psychotherapy?

   Yes ☐ No ☐

6. How confident do you feel dealing with people bereaved by suicide?

a) Not confident at all b) Somewhat confident c) Very confident

7. How important is it for Churches and faith-based organisations in Northern Ireland to be involved in suicide awareness programmes?

a) Extremely important b) Somewhat important c) Not important at all

8. Have you ever, as part of your ministry, had to respond to bereavement trough suicide?

   Yes ☐ No ☐

9. Would you be able to discuss the issue of suicide, faith communities and suicide further?*

Yes ☐ No ☐

(*The discussion we propose will be at a time and place convenient to you. The content of the discussion will be anonymised and confidential. If you are willing to participate in further discussion, please leave a telephone number where we will be able to contact you.)

Telephone number: _____

APPENDIX II - TOPIC GUIDE

Brief introduction to the study:

"I want to begin by reassuring you that the aims of the project are to support clergy in their pastoral role in dealing with suicide and its consequences (expand as you see fit). In order to do this we are trying to obtain as wide a range of views and experiences as possible from clergy on this issue. The interviews will be recorded but everything discussed will be confidential; all the transcripts and any other material from the project will be completely anonymised. "

We are looking for the *individual* views and experiences of clergy – so we would hope that you can be as frank about this subject as possible."

Brief Biographical details:

When they did the participant become a minister/ are they married, children/ how long they have lived and worked in the parish (community). What are the general difficulties of being a minister of religion today?

Background of the community in which they work:

Obtain something of the socio-economic mix of the community/ particular problems and difficulties (employment, deprivation, experience of violence) or whether fairly stable and solid.

Personal and working experience of suicide:

"We realise this is an extremely sensitive issue and we are alert to the possibility that someone close to the individual ministers that we are interviewing may have had a close personal bereavement due to suicide.

Can I ask if this has happened to you?

If yes – "can you say something about this?"

If no - "Has someone in your faith community or parish died through suicide?"

"Can you tell me about this? –

- Who was the person and
- When did it happen?

- What where the circumstances?

- How well did he/she know the person?

- was the person and/or the family very religious?

- Did the minister

- Realise that the person was feeling depressed or suicidal?

- Have much contact with the person before they died?

How does the minister feel about the circumstances of the person's suicide?

- Could it have been avoided?

- What should people done?

Explore –

- What impact did it have on the family and community?

- What are the long term effects?

- What would help prevent, or at least, reduce suicide?

Explore –

- How it effect the minister?
- Did he/she feel able to respond confidently to the family's needs?

Training Needs

Can you tell me about any training on suicide and pastoral care that you have received that you felt was useful in this situation?

How does your church/faith group advise you on suicide?

…what about mental health problems, more generally?

Explore –

- What would be helpful to clergy? (Counselling support, educational packages, expert advice…….)
- Who do they feel is best place to provide this? (the faith organisation, services, expert groups)

- Is there a need for greater collaboration between health & social services and the faith organisations?
- How should the faith organisations respond to this problem?
- What might be the possible barriers for prevention strategy that included the faith organisations?
- Do you feel that the faith groups in NI should work together on this issue?
- Do you feel that most people from your church feel much the same way as you do on these matters? – who might have very different views?

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