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Transcript of National Catholic Partnership on Disabilities Access to Suicide Prevention and Ministry Support

October 20, 2009

Participants

Dr. Thomas Welch - NCPD Council on Mental Illness, Adult and Forensic Psychiatrist
Fr. Ron Rolheiser, President, Oblate School of Theology
Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
Jan Benton, Executive Director - NCPD

Presentation

Operator
Greetings and welcome to the National Catholic Partnership on Disabilities, Access to Suicide Prevention and Ministry Support. [Operator Instructions].

It is now my pleasure to introduce your host Dr. Tom Welch who is a member of the NCPD Council on Mental Illness. Thank you, Dr. Welch you may begin.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Thank you. Once again, I am Tom Welch and I am a physician, psychiatrist in practice in Portland, Oregon and I am pleased to be your moderator today for NCPD's webinar Access to Tools in Addressing Suicide, Pastoral Support and Prevention Strategies. I will be serving as your moderator. I will have the opportunity to interview two very gifted individuals. First, I will be talking with Fr. Ron Rolheiser. He is a member of the Missionary Oblates of Mary Immaculate and is President of the Oblate School of Theology in San Antonio, Texas. He is a scholar, lecturer and writer. His weekly column is carried by dozens of newspapers worldwide and archived on his website. Once a year he focuses on the topic of suicide. He is joining us today from Portsmouth, Virginia where he is meeting with the priests of the Richmond Diocese. Then we will be able to have a conversation with Claire Woodruff who is the Coordinator of Religious Education for the Archdiocese of Portland in Oregon. She has been involved for several years in the Suicide Bereavement Support Group of Southwest Washington and Northwest Oregon.

Our webinar today is being presented by the National Catholic Partnership on Disability or the NCPD. And particularly the Council On Mental Illness in partnership with the National Conference for Catechetical Leadership and the National Federation for Catholic Youth Ministry. We also are collaborating with the National Apostolate for Inclusion Ministry and the National Catholic Office for the Deaf.

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At any point during our webinar today you can submit written questions that we will be screening and responding to during the question and answer portion toward the end of today's session. If you click on the question button, you will get a pop-up screen and can then type in your question and press submit. We will try to get to as many questions as we can depending on the time constraints.

So as we come together, I invite you all to join us in prayer:
Loving God, Healer of all, be with us today.
Open our hearts; let us hear the stories of our brothers and sisters whose lives have been affected by suicide.
Fill us with your Spirit, Lord, so that we might transform their pain into consolation and despair into hope.
We ask this in Jesus' name.
Amen.

We are gathered today from over 170 sites across North America and to get a sense of where everyone is, I invite you all to participate in this poll. If you could click the circle next to the time zone in which you are participating in the webinar and then press the vote button, we will be able to tabulate all of those sites and present the array and geographical distribution of our participants today. Please submit your responses and in just a few seconds, I will display the results.

Well it looks like we have a preponderance of people who are joining us in the afternoon where they are, as opposed to us out in the West who are still in the morning. Almost half are in the Eastern Time zone. The next largest in the central. Glad to see that we have an “other“ I am assuming that is probably someone from Alaska. Perhaps Hawaii. Thank you for participating in that poll. We will have another poll shortly as well.

What I would like to do now is just provide some background information on suicide. This is coming from my perspective as a psychiatrist in clinical practice treating adults with mental illness as well as having been informed by training in the Masters program in pastoral ministry.

To begin with I would like to define a few terms that will be used throughout today's webinar. The first is the basic definition of suicide, which is a self-inflicted death with evidence that the person intended to die. A suicide attempt is self-injurious behavior with a nonfatal outcome, but with evidence that the person intended to die. This is in distinction to self-injurious behavior like cutting or burning that is sometimes associated with other mental illnesses in which the person is acting as a way to relieve distress or to summon attention without the intention to die. A suicide attempt has the intention to die. And then, suicide ideation are the thoughts of serving as the agent of one's own death. Thinking about doing what it would take to bring about one's own death.

In the United States in 2006, which is the year that we have -- the most recent year that we have data, 33,300 deaths by suicide were reported. We also suspect that there were probably other deaths that were ultimately the result of suicide that were missed. Sometimes accidents, car accidents which appear to be random may

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actually have been suicide attempts. We know that more men die by suicide than women, but that women attempt suicide more often than men. We also know that suicidal ideation is very common. In the course of a year over 5% of the population has suicide ideation where as less than 1% of the population attempts suicide and only 1/10th of 1% will actually die by suicide.

Currently the highest rates of death by suicide in the United States are in teens and young adults, that age group as well as elderly white men. Age, gender and race all factor into rates of suicide with white people having a much higher rate of suicide than black people. Rates are increasing in recent years in middle-aged women, however. So the demographics of suicide are changing. Contrary to popular belief that depression or suicide increases around Thanksgiving and Christmas, the highest rates of death by suicide are actually in the months of April, June, and July.

We have our next poll and this is just to get a sense of your appreciation of the geographical variation in suicide rates. If you could click by the button next to the state that you believe has the highest suicide rate, which is number of suicides per state population and click the vote button, we will tabulate those results.

Alright, so let's take a look, see what people think. There seems to be strong support for New Jersey having the highest suicide rate. Actually, New Jersey and the District of Colombia have the lowest rates of suicide in the United States. The highest rates are in Wyoming and Montana. South Carolina is actually right in the middle in terms of suicide rate. There are many speculations about why this geographical variation exists. Some are that in the West Coast -- or in the Western United States we tend to have much lower population densities, it's easier for people to isolate, withdraw from social supports, we also tend to have more access to firearms in the West and lower church involvement, lower church affiliation which is different than say in New Jersey or the District of Colombia.

So when we talk about suicide, there are some identified risk factors. The biggest risk for suicide is a person experiencing depression or other mental illness and/or having an alcohol or substance use problems or intoxication. The vast majority of death by suicide are associated with depression or mental illness and a large majority of people who die by suicide test positive for alcohol or a substance. The statistics will say that about 90% of all deaths by suicide are the result of a mental illness. My own personal bias is that pretty much all deaths by suicide, if we were able to get the absolute perfect data, would show some evidence of a mental illness or substance use.

Having attempted suicide previously is a risk factor for attempting suicide in the future. So the past tends to predict the future. Having a family member who has died by suicide is also a risk factor for suicide and this may be due to sharing the same type of mental illness that may be more prevalent in one's family and also there's some evidence that there is an innate sense of impulsivity that may be transmitted through generations that predisposes someone to impulsively do something to take their own life.

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Other risk factors include having a major life stressor like a serious illness, losing a relationship or a job and having access to firearms. Firearms are the most common means with which people will die by suicide.

There also are some protective factors. Factors that will help either deter someone from committing suicide or prevent them from getting to that place in the first place. The first one is sometimes called resilience. The ability to cope with stress and tolerate frustration. Having responsibility for children, beloved pets, other significant personal obligations can serve to deter someone from dying by suicide. And religious beliefs. This can work in one of two ways. People who have deep faith who believe in hope and believe that things will get better with God's help can be deterred from suicide. The opposite is people that have belief that they will be condemned or that they will suffer eternal consequences by dying by suicide can also serve to deter them from attempting suicide. And then having social supports, a network of people around who are able to react, monitor, provide feedback to the individual who is experiencing their depression, for instance.

If someone is at risk of suicide and might be contemplating suicide, there are some warning signs that a death by suicide might be imminent. One is if the individual experiences intense anxiety or a sense of internal pain or recklessness. An overall feeling of discomfort. If they are feeling desperate or trapped, if they have intense anger, withdrawing socially, so people stop answering the phone, stop going to social events, stop seeing their families, that is a warning sign of an imminent suicide. And then talking about suicide or making plans, drawing up a will, giving away prized possessions can all be signs that someone is considering a suicide attempt.

So what do we do if we find that someone is contemplating suicide? The first thing is to take their comments seriously. Do not dismiss the comments that someone might make about wanting to be dead or wanting to die. A corollary there is not accepting offhand comments or jokes about suicide so that the topic of suicide is reserved for the most serious, real consequence of mental illness rather then it being kind of a joke. Supervising an individual if they are appearing to be at imminent risk of suicide. That may take the form of say in a religious education program, someone is talking -- or a child is talking about suicide, not letting the child walk home alone. Calling the parents and having direct person-to-person hand off from the class to the home. Providing the person with information, sometimes it may mean a family member at home just making sure there is someone there, having the person maybe there at a distance, have them call periodically to check in to make sure that they are not progressing down the line to actually dying by suicide.

Another response is to get the things that are potential means of suicide out of the person's domain. That includes getting guns, pills, knives away from the person so they don't have access to them. And of course, seeking professional help and even accessing emergency services if the threat is so imminent that you can't provide an adequate level of supervision or support or if the person is so committed to acting that they need that intervention.

There are some ways that we can prevent or potentially prevent a death by suicide. The most important is identifying and treating depression and other mental illnesses

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as well as alcohol and substance use problems. There are a variety of ways that these can be screened. There are screening tools that have been developed for specific settings including primary care medical provider offices, high schools, college campuses and we will have some links to those resources on our webpage.

Another way of identifying and treating depression is to make sure that people have access to mental-health services so that people who are experiencing mental health conditions will be able to get timely and appropriate evaluation and treatment. The other item to consider is the abolishing of stigma that when people feel stigmatized for having a mental illness or for thinking about suicide, that may prevent them from seeking help. That will again delay the treatment and potentially result in a bad outcome.

Also don't be afraid to ask. If you suspect someone may be contemplating suicide, it's okay to ask them. There is a myth that by talking about suicide someone will be more likely to act on it. That just isn't true. In fact it probably will make them less likely to act on it if they know that someone is caring enough about them. Providing education so all of you today have already made a step in the prevention of suicide by participating in the webinar. And then there are a variety of formal suicide prevention programs especially -- I am especially pleased with ones that are supported by the Substance Abuse and Mental Health Services Administration or SAMHSA. Their website is just full of a variety of resources for suicide and a variety of mental illnesses.

Some final considerations about suicide is that some people with mental illness, despite optimal care, will still die suddenly of their illness, not unlike people who have heart disease or cancer who may get state-of-the-art treatment. Some of them still unfortunately will die and that is the case with mental illness. Death by suicide is not predictable. We try to think that we can predict it based on the risk factors, but ultimately it is an unpredictable event, but it might be preventable. And in many cases, there may be ways that we can do things to prevent someone from dying by suicide. But it is not the case always, unfortunately.

Now when someone dies from suicide, the affects on the survivors can be enormous. We will be hearing today some particularly powerful stories that will point that out.

There are a couple of suicide support resources that I wanted to point out to you at this point. Places that you may turn to get the answers that you need in addressing this. One would be the local Catholic Charities, your pastor, if you have a parish nurse, school counselors, in grade school and high school and on college campuses, usually college campuses will have a Student Health Center and a Student Counseling Center that usually have very good resources and may even have suicide prevention plans already in place. Every community has a crisis number that can be found in the front of your phonebook. We have a National Suicide Prevention Lifeline. And your local mental health resources.

So we may not be able to get to all of your questions today, but we are hoping that you will draw upon these and other resources to get those questions answered.

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I would like to now turn to Fr. Ron Rolheiser and ask him a few questions that will address some of the pastoral concerns regarding suicide. So hello Fr. Ron Rolheiser.

Fr. Ron Rolheiser, President, Oblate School of Theology
Hello, hello.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Thank you for joining us today.

The first question I would like to ask you has to do with that there continues to be a lot of misunderstanding about suicide. Why do you think this is?

Fr. Ron Rolheiser, President, Oblate School of Theology
Well I think actually for a good number of reasons. One of them is because of the gravity of the issue itself. Suicide is -- really taking your own life is really the ultimate taboo not just in terms of morality, of church but in human life. The instinct for life is the most powerful instinct inside of us and when something goes wrong with that, we are left with a deep misunderstanding. But also I think in the past, both the Church and Society in trying precisely to protect life have put such a powerful taboo around suicide and necessarily so that we were left with the idea that to somehow take your own life is the ultimate act of despair, the ultimate violence against humanity and even today it leaves the survivors with just a devastation. I noticed in your slide it said it can reek havoc with survivors, it simply does. It might be one of the most powerful wounds that could happen to someone is to lose a really precious loved one by suicide. So there's a lot of misunderstanding and also we have been bereft of good literature. There isn't -- even today there is not a lot of good literature and understanding around the question of suicide.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
I know that you have written about suicide and that you have indicated that people who die by suicide die against their own will just as someone with terminal cancer might die. Can you expand upon that?

Fr. Ron Rolheiser, President, Oblate School of Theology
Yes, happily. I am sure that most of you who are tuned in today who have had the experience of losing a loved one by suicide that in virtually every case you know that this person is a deeply sensitive person. Sometimes hypersensitive. A deeply wounded person and that their suicide, the analogy I use and you used it as well in your slides, I use the equivalent to it is an emotional cancer or an emotional stroke or an emotional heart attack. Just as people get taken out of life against their will through a stroke, through cancer, through a heart attack. I really believe that most suicides, again most but not necessarily all, but most suicides, the person dies against his or her will. They die; they are taken out of life against their own wishes through whatever combination of illness, wound, hypersensitivity. An image I am fond of using in my writings where I say often times that you have known people who have committed suicide, the image I use is often they've been people who were too bruised to touch. That is kind of the image where you have a wound and because it is a wound, normally your skin has a resiliency and a capacity to touch hard and sometimes in even brittle surfaces but if you have been burnt, you can't really touch

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and everything makes you shriek in pain. I think that the psyche and the soul of the suicide person is they are too bruised to touch. One of the images I also use in my writing is it's akin to somebody who's clothing catches fire, so they jump out of a high-rise window to try to end that pain when in fact it ends their life. Certainly that has been my experience with people that I've been close to that have committed suicide. In every case, in my experience, it has been a very sensitive person, a goodhearted person who went out of life against his or her will.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Mhmm, Mhmm. That pain also accompanies those who are left behind after the death of a suicide. Would you mind talking about how those who are left behind often deal with a lot of guilt and second-guessing?

Fr. Ron Rolheiser, President, Oblate School of Theology
Yeah I think that -- it almost goes with the territory and in every case or virtually every case there is a lot of second-guessing by the survivors and all the common questions which we have asked -- we ask ourselves, if I'd only been there, I should have been more sensitive, why didn't I notice. But it is interesting, a lot of suicide victims or people that die by suicide, they pick their moment. They pick their moment and the suicide is programmed precisely so you are not there. As you yourself said in the introduction, a lot of the suicides are not predictable. Then we are left with the second-guessing. My experience has been that oftentimes they precisely pick a moment when you are not there. We can't be second guessing -- the analogy I use in my writings too, I have sat at the bedside of loved ones who are dying of cancer and heart attack and all the love and watch in the world couldn't keep that person alive. I think it's the same sometimes with suicide inside of a family. All the love and watching in the whole world can't prevent this person from dying. I always tell people to not second-guess themselves. If only I had known? If you have stopped it then, it might have happened 2 days later.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Right, yeah, very, very good points there. I am wondering Father if you could explain a little bit about what the church's current teaching on suicide is and what is the appropriate pastoral practice with regard to burial.

Fr. Ron Rolheiser, President, Oblate School of Theology
Okay, the church's teaching is actually it's quite clear and it is pretty nuanced. It would be interesting if we could turn back the clock and look at the church's teaching say a hundred years ago, but today it is expressed in the Catechism of the church which is kind of our official guidebook. First of all it affirms and very importantly it affirms that it is a grave wrong. Suicide [indiscernible] is a grave wrong. They will go on immediately or soon to say that many times there is diminished responsibility. In most cases we can assume there is diminished responsibility through illness, through whatever, but they affirm that it is a grave wrong, nobody may take his or her own life and they also affirm a subsidiary point which is very important that all cooperation in any kind of you know assisted suicide is wrong. So that the Church has never believed in euthanasia. I believe never will. All forms of assisted suicides are wrong. But then they go on very importantly to say about suicide that we should not -- they put literally should not despair about the eternal salvation. God has ways of reaching

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these people, even though we can't, and it interestingly says nothing about burial and that is a switch. Formerly in the church, and in many of the churches, suicide, people who died by suicide weren't allowed to be buried in sacred ground. The new code of Canon Law which came out in 1985, they put a list of people that should not be buried there and that is glaring by its omission. So it is very significant that it is not on there. I would think, other than maybe some rare, rare abusive cases, that today the question is not even asked anymore, that it is taken for granted that the person will be buried with a church funeral inside a church grounds.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Mhmm, yes and I'm sure you would agree, that would be the absolute best pastoral practice or the only acceptable pastoral practice.

Fr. Ron Rolheiser, President, Oblate School of Theology
Yes.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
I wonder now if we could turn to three kind of related questions and you can either answer these in parts or together. They have to do with the helpful pastoral practices to be used by those wishing to support people who might be contemplating suicide, the loved ones of people who might be contemplating suicide and the loved ones of someone who has died by suicide.

Fr. Ron Rolheiser, President, Oblate School of Theology
I will take them separately. The first question first. Supporting those people who have loved ones who are contemplating suicide. I would not have much further to say than what you said in your slide. I think you put that well. I know that Claire Woodruff will speak in a few minutes. In my own pastoral experience, most of the time, I am there after-the-fact. They call the priest in to deal with -- so I have not had a lot of experience dealing with people -- I have dealt with people who are depressively dangerous you know and you there give a lot of -- the major thing there is it's very important you try to get them some professional help. The first thing I do is take them to a medical doctor or take them to a psychiatrist. That is very important. But the second question where I've had more experience with and that is dealing with people who have lost loved ones to suicide. That is when they call the priest in. You go to the house or the hospital, wherever it is. A number of things, first of all, this does not sound like it is much, but maybe it is all we can do, I think the most important thing at a time like this is to share their helplessness. There is truly a powerful helplessness and there is not anything -- or there is not much you can say that will take that pain away or change the situation, but it is very, very important that somebody, like I want to use the expression, I'm a man of the cloth, so that somebody who is symbolically invested by the community, the clergy, a pastor, somebody comes and that this person shares and stands with them inside of their helplessness. That is very, very important. A lot of times, like in the days after, I have lots of experience with this with people who I have been writing to for some years after their spouse committed suicide, but one of the things I often tell them is I have good news and bad news. The good news is you will get better. The bad news is not for a while. Because there is a helplessness that has to be endured. I try to help them in terms of second-guessing. Take away the if only I had been there. It would not have mattered. To share their

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helplessness and I do everything from giving them poetry and scripture, but not even so much [indiscernible] resurrection which I will talk about later. For instance, the Book of Lamentations where the author says, "Sometimes all you can do is put your mouth to the dust and wait." Or I remember a poet, Rolky (ph) wrote to a friend who lost a loved one in death and he simply said to give the heaviness back to the earth itself. Mountains are heavy. The seas are heavy. There is a heaviness has to be lived and we need to be with the people in that heaviness. There is not any cheap consolation at a time like that, in that. But there is deep consolation. That is kind of like Schopenhauer (ph) once said, "All pain can be born if they can be shared." It's really important to be with people at a time like that and to share that helplessness.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Hmm. I think one particularly painful situation is the pain that comes from the loss of a child. And parents' pain is even more deeply felt when their child, regardless of their age, has died by suicide. Would you comment on this and perhaps share an example of how you have responded to a parent experiencing this pain?

Fr. Ron Rolheiser, President, Oblate School of Theology
Well it's interesting, that brings in a double pain. When a parent loses a child by sui -- not just by suicide, but even by ordinary death, it's interesting, I studied anthropology and anthropology has taught us that -- see nature -- as Christians believe in God, equips us, we have the for lack of a better word, we have the wiring inside of us to handle the deaths of our own parents. They are hard, but we are structured for it. But it is interesting; nature and God have not been structured to handle the death of a child, your own child. You simply don't have the internal wiring for it. First of all, that is brutally tough even when it is not by suicide. It's doubly tough when it is by suicide. Again, there, I try to stand with them in their helplessness and try to help them -- we do speak the words of consolation to say well you know, the child is in better hands than ours or hands that are more gentle than ours. And those words -- that kind of consolation I think it will actually really be helpful when down the line when some of the raw pain has been taken care of. But immediately at the time, like I said, there is no remedy other then to be with people and to help them through it. It's like if I get in a car accident or part of my body is burned, I just have to endure that pain until the skin regenerates. I don't want to sound stoic or pessimistic, but I don't want to offer cheap consolation either. The good news is we do get better. The bad news is it takes time, healing takes time.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Hmm. And that healing is associated with pain in and of itself.

I wonder Father, are there any images from scripture that you've found especially meaningful when addressing the pain and concerns that arise following a death by suicide?

Fr. Ron Rolheiser, President, Oblate School of Theology
Yes I do. My all-time favorite image of Scripture -- and it's not just death by suicide but I preach this and it is usually the Sunday after Easter, and it is John 20, Chapter 20. The text where Jesus goes through the locked doors inside this huddled circle of fear. I always tell people that is the most consoling image in all of religion. I have

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studied Buddhism and Hinduism and other religions and the most consoling image in Christianity. It's a - let me give you an image -- somebody who dies by suicide, this is my image. Oftentimes what happens is they get trapped inside of a private hell into which no psychiatry, medicine, human love or understanding can any longer penetrate. They are literally locked inside of themselves. They have locked the door and we can no longer get into it. Now the image in John's Gospel, this is exactly what happened. The Disciples because they were so afraid, they locked the doors and they were huddled in fear. Jesus went through the locked door, stood in the middle and he breathed out. That breath -- you have to have -- which you first met at the very first line of Scripture the beginning was the form of [indiscernible] and God breathed over the waters. So that quite simply the image is I believe that most suicide victims are sick, oversensitive, too bruised to be touched. They are locked inside of some kind of private shell that no human love or psychiatry or medicine can any longer penetrate. When they wake up on the other side, Jesus will be inside, goes through the locked doors, stands in the middle and breathes out peace. They will experience peace. It's interesting, I want to take that image a little further. If you ever go to the Anglican Cathedral in London, England. St. Paul's Cathedral, inside of there is a very famous painting that has a lot of knockoff paintings from around the world. [Indiscernible] famous painting about the Jesus who knocks. You are all familiar with the image of Jesus standing outside of a locked door and knocking with a lantern. And inside you have a man huddled in fear and the idea is that only the man can open the door to let Jesus in. That is a wonderful painting, but it is not good theology. [laughing] In John's Gospel, the exact -- they are inside and they can't open the door. In fact when I look at Holman Hunt's (ph) painting, I don't like the chances of this man opening the door. He is pretty far gone in depression. Jesus comes through the locked door and stands in the middle. That to me is the ultimate consoling image. Every couple of years I put it out again in my writings on suicide and this is incidentally -- those of us who are Christians, that is what we mean by the doctrine when we say he descended into hell. When we say Jesus descended into hell, it does not mean that he went to the place where the devil was or whatever. Our belief in the resurrection is that there is no hell that we can go into in, private shell, into which God's love can't penetrate. Sometimes we can go into hell from which no human love will no longer penetrate, but God's love can get into there. It's the most consoling doctrine in religion any place. I think it's particularly apt as an image for suicide.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Hmmm. Thank you so much for that. That is a very compelling image.

I just want to remind you that you can continue to submit questions and that all of the presenters today will be able to address your questions.

I would like to now turn both literally and figuratively to Claire Woodruff who is sitting next to me here in Portland. I have known Claire for several years and I have heard her story about the loss of her husband before. And need to warn you that it is a very powerful story and that to expect that you may have some very strong emotional reactions to this story. But her story I think ultimately is one of hope.

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Claire, thank you for joining our webinar today. I am just wondering would you be willing to share -- to share your story of being a survivor of someone who died by suicide?

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
Sure. I can do that. My first husband, Ken, died by suicide 14 years ago. It was two days before Thanksgiving and 3 days before our 23rd wedding anniversary. Our son was a freshman at the University of Oregon and our daughter, a junior at Jesuit High School here in Portland. Ken and I had a "fairy-tale" kind of marriage! After 23 years, we were still very much in love with each other. He was my soul mate, my best friend, we had such a great relationship, great kids, and we were at a point in life where we just kind of looking forward to growing old together. He was a machinist for a large company that required him to work 33 days with no time off. Because he'd never previously shown any signs or indications of depression, all of his doctors agreed that it was "work-related stress" that triggered his depression. Ken's battle with clinical depression was relatively short, but very, very intense. From the time he was first diagnosed until he took his own life, it was only about 3 months. During those three months, he was in therapy with a psychiatrist, he took several anti-depressants, he was hospitalized in a psych ward for 6 weeks, and he had electric shock therapy. And slowly, ever so slowly he began to get better; the depression seemed to be lifting and he began to show glimpses of his "old" self. But, one day in late November, he relapsed and why this happened, we'll just never know. He'd had one last shock treatment in the morning and when I brought him home at noon, he went straight to bed. These treatments always wore him out and he'd sleep for 12-14 hours. At 2 o'clock, I woke him up, gave him his meds, and he went right back to sleep. When I checked on him at 3:30, he was still sound asleep, so I left him to go pick up our daughter up from school. I was gone for 45 minutes, and when we got home, the bed was empty. We frantically raced all over the house looking for him and then we noticed that the back door was ajar. We found him in the garage, where he'd hung himself. I went into the garage and managed to get him down and began giving him CPR. My daughter ran into the house, called 911 and then began phoning family and friends. The police and paramedics got there very, very quickly but, we were all too late. Kenny was gone.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Thank you Claire. That is just an unimaginable situation. How did you and your family respond?

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
Well, you know, word spread quickly, the grapevine worked really fast and it wasn't long before people began coming to our house. Over the next few days, the house was always full of people. The refrigerator filled up with food and the house just seemed to fill up with pain. The prayer vigil for Ken was on our wedding anniversary, his funeral the next day. These were wonderful, wonderful celebrations of Ken's life, and they were very healing but they were also very, very painful. The response of friends, parishioners, and neighbors was absolutely overwhelming. So many people did so many things for us. The list of things that people did is so long. My kids and I

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were literally overwhelmed by this outpouring of love. It kinda felt like God's love was just pouring into our lives and hearts through these people, and it was over whelming. At first, it was hard to accept. I was used to being the "giver" and it was difficult to be on the "receiving" end of so much love, so much giving. But, honestly, I didn't have the energy or strength to argue so I learned to just sit back, let people do what they wanted and needed to do, and to say thank you. It was very humbling. By the end of the second year, I was still crying myself to sleep every night. Around that time, a couple of friends told me to "snap out of it," "get over it," "it's been two years". But, I couldn't make myself be happy anymore than I could make it go away. It was with hindsight that I realized that many of the people close to me were feeling very helpless and frustrated. They didn't feel there was anything they could do to help. There wasn't any medicine, they couldn't fix it, and it had to be really, really hard for them to see me so sad all the time. The suicide and its aftermath were changing me. They wanted the "old" Claire back, but she was long gone and I didn't know how to articulate that.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
So how did you and your children respond to Ken's death?

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
Well, you know, at home, I really didn't do very much. My daughter and I ate a whole lot of fast food that first year. And sometimes, our relationship was very, very strained. Our family, our entire world had been turned upside down and my kids and I needed to learn new ways of interacting and relating with each other. It was excruciatingly painful and, at times, very, very ugly. I was hurting so much myself, and running on empty so much of the time, that I couldn't be there for my kids. And this often made me feel like the world's worst Mom. Somehow, though, we muddled through it all and our relationships survived. I would even say, that going through all that horrendous, gut-wrenching stuff together made my kids and me even closer. You know, there's a saying that goes, "When you're hurting the most is when you're growing the most." That must mean that we've all earned at least a couple of PhDs.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Mhmm. I know at the time you were working at a Catholic parish, I'm wondering what it was like when you returned to work.

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
Well I went back to work two weeks after Ken died. It was early December and I was the DRE in a parish, which as you know, is a very, very busy time in a Catholic church. On my first day back to work, my boss, the pastor, walked into my office and said, "We all know it's going to be a long time before you're up to speed. So, if there's something on your plate that needs to be done, and for whatever reason, you can't do it, let me know. We'll try to find a staff member to do it and if none of them can do it, we'll look for a parishioner and if that doesn't work," he shrugged his shoulders and said, "I guess it just doesn't need to be done." He also told me, and this was really, really important for my healing, he also told me that if I just ever needed to get out of here, I had permission to leave. I should let the secretary know, but I didn't need to

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give her any reasons. This was incredibly freeing. It took away the pressure I was feeling because for the longest time, I really wasn't up to speed". Intense grief is very hard and exhausting work and I had little or no energy. It felt like I was in a fog. I couldn't think clearly or creatively and for about a year I just pulled out the letters, programs, and liturgies that I'd used before and repeated them. But, you know, my co-workers and volunteers in the parish and staff were just amazing, wonderfully helpful and understanding.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Well Claire, did Ken's death raise any spiritual questions for you?

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
(laughing) Oh God, a million all the time. Ken was the first person close to me to die. So I was faced with death for the first time, personally faced with death for the first time in my life. Death is so final. It's so harsh and so permanent. I found myself wondering "What is death?", "What is Kenny now?", "Where is he now?" Because of my faith I believed that Ken was in heaven, but I would ask myself, "What is heaven?", "Where is heaven?", "What does our soul become?", "What does it mean to be in the fullness of God?", or to "Be with God?" I asked these questions, wrote about them in my journal over and over and never really found any answers. Eventually, though I stopped asking the questions because I no longer needed to know the answers.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Hmm. Well Claire, can you tell us about your involvement in Suicide Bereavement Support?

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
Oh yeah. I've learned a lot about grief these past 14 years. One of the first things that I learned was that as a rule, Americans don't want to talk about death, and when you mention the word suicide, most people get out of the conversation very quickly. It makes them very, very uncomfortable and squirmy. I learned to read body language. If someone asked me how I was doing, I'd look closely at them to figure out what they really wanted to know. Are we on the right question?

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
I think I may have confused Claire. Go ahead. I think you're responding to about learning about your grieving process and then we'll get on to the bereavement.

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
Okay. I learned to read body language very quickly. If someone would ask me how I was doing, I'd look closely to see if they really wanted to know how I was doing, or if they just wanted to know or have an answer like "Ya know, all things considered, I'm doing fine." Because not everyone can be present for that kind of all-consuming pain and that's okay. I was consumed with grief. Grief that I just couldn't make go away. There is no delete or fast forward button for it. There is no medicine, band-aid, or blue print. We all grieve differently. Grief is as individual as our fingerprints and it simply

takes as long as it takes. And, in the emotional and psychological devastation that follows a suicide, grief usually takes much longer than most Americans think it should. Every single day in that first year, the associate pastor would walk into my office and say "How's it going? How're you doing? How ya feeling?" And not only would he ask but he also was able to be present to whatever space I was in. He had the gift of listening, which was good, because I needed to talk about it all the time. Over and over, I needed to tell my story. It was a blessing to have this priest, as well as a couple of friends, who were willing to just listen to me – without trying to fix it.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Mhmm. Now maybe you can go back to the question about your experience with bereavement support.

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
Yeah, I would certainly be happy to talk about suicide bereavement support because that was a huge part of my healing. Shortly after Ken died I began grief therapy with a psychologist. I saw him for nearly two years, and then began going to a Suicide Bereavement Support group. At my first support group meeting, I told them it had been two years and I was still crying myself to sleep every night. Someone in the room said, "Of course you are. It's only been two years." I simply can't describe what a relief it was to be with people who really understood what I was going through, to know that I wasn't alone, and to realize that I wasn't crazy, and wouldn't always be so consumed by grief. Since that time, I went to that support group for 2 years and then I went through some training to become a facilitator and I have been a facilitator in that support group for 10 years now and it meets once a month.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Good. Very important work. I suspect there are similar groups across the country.

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
Yes, there are. All over the country in most major cities there are suicide bereavement support groups or survivors of suicide they are sometimes called.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Okay, great. Well Claire, where are you today with the whole process of grieving Ken's death?

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
Well, I'm at a place where I realize grief is a journey. After about 4 ½ years, I'd healed enough to be able to write in my grief journal, "I don't know why Kenny and I didn't get to grow old together. But, somehow, he's where he's supposed to be on his journey and I'm where I'm supposed to be on mine. And I have a real deep peace about that." It was around that same time that I began dating, a very scary thing for me to do at that point in life. And I met and fell in love with another wonderful man. His name is Ron and in May we celebrated our 7th anniversary. And what I tell him is that, "I love you with all of my reconstructed heart". But, while I am at peace with Ken's

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suicide, his death still deeply affects our family. Our daughter is getting married this coming Sunday and at different times, we have all cried because her dad is not here to walk her down the aisle and to share in this wonderful celebration. Suicide causes huge, gaping wounds in our hearts and it takes a long time for the wound to heal. When it does heal, it leaves a scar that still hurts from time to time. Suicide isn't something that we ever get over. It changes us, it transforms us, and it becomes part of us. It is something that hopefully, we learn to live with.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Mhmm. What factor would you credit with helping you get from where you were to where you are now with your reconstructed heart?

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
There are several things -- I would say that one of them is that I just waded into the pain. I did not try to dodge it or bury it or get too busy to grieve. I went waded right into it and I faced it. Another -- a second thing is I think that honesty is something that we -- that helped us all. From the very beginning of this depression, we were always honest and upfront with what was going on with him. We told people that he is clinically depressed, he's in a psych ward in the hospital. We didn't lie about it or sugarcoat it. We were honest about it. And then when he died by suicide, that's what we said. When people asked how he died, because I was a young widow, how did he die? He died by suicide. There is no shame with this. There should -- there is in many circles but there should not be. He died from a physiological disease which was clinical depression. I think that our honesty helped us to grieve because we did not have to hide anything, we were honest about his depression and about the way that he died. The third thing that helped us and my family was the family itself. Ken was a member of a very large family. He is one of 7 kids. A very large close knit and extended family. Just they threw their arms literally and figuratively around us and held on tight. A couple of his brothers stepped in and became surrogate dads to my kids. One of my brothers in laws became my own personal 911 number. I've could call Rod to do anything, anytime of day or night and he would drop what he was doing and be there for me. The last thing, but certainly not the least thing that helped me get through this was my faith. I simply cannot imagine getting through the suicide of Ken without my faith. It was so comforting to know in my bones that Ken was no longer in pain, that he was with God, and that he was at peace. The hope and the certainty that I would see him again was instrumental and a huge part of my healing.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Thank you so much Claire for sharing your story. Very powerful and I think we will take just a tiny break from the discussion of suicide to hear from the Executive Director of the National Catholic Partnership on Disability, Jan Benton.

Jan Benton, Director, NCPD
Thank you very much Tom and thank you Claire so much for sharing your story. I know for myself how touched I am and I'm sure all of the listeners are today. We want to thank Fr. Ron too for being with us and sharing his valuable insights as well as yours Tom.

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The webinar today is being sponsored and brought to you by the National Catholic Partnership On Disability's Council On Mental Illness. We are happy at the NCPD to have this Council to be able to provide resources for all of us to address these type of issues that are so important pastorally. The mission of our Council is on your screen and it is that following Jesus who embraced all, we assist the Catholic community in reaching out to and accompanying our brothers and sisters with mental illness and their families, assuring their rightful place in the church and society.

Earlier Tom, in offering prevention strategies to suicide, you mentioned the need to abolish stigma and to educate ourselves about mental illness and suicide. This is the work that the council has undertaken since its beginning in May of 2006. We have been working diligently thanks to a grant from an anonymous source to prepare resources and training opportunities to assist everybody pastorally who is working in this area throughout the country in your own outreach and support efforts. We recently, in July and then again in September, completed a series of one-day awareness workshops and a three-day advanced training and we anticipate offering those again in the years to come. We have also produced a 27 minute video that is available and it is open captioned entitled "Welcomed and valued". It is people with mental illness sharing their own stories and the ways in which their faith has nourished them in their journey and in their illness. We also have a 94 page manual also called "Welcomed and valued" that has a variety of resources and documents in it including forming relationships, outreach to families and peer support. The manual is available for sale, but it is also available for free download on our website www.NCPD.org. Since October 2007 when we began our webinar series, our Council has devoted one webinar a year on this important topic of mental illness and support to people with mental illness and their families. I urge anybody who is interested in learning more about this topic to go to our website and to view the archived copies. They are available for people to view and we will be selling -- making them available soon on DVD for to people to be able to show them to groups as well. While you are on our website, we also encourage you to go to the page that the Mental Illness Council has resources -- a variety of resources, prayers, petitions, other resources that are available for free download.

One thing that we are very excited about and it is a very new part of our initiative is the establishment of the National Catholic Network On Mental Illness. That was an outcome of these trainings that we have recently had. The people who have been a part of those trainings have said we need to be able to keep in touch with one another, we need to share resources and that is what we are doing with this network. In the best sense of the word, network, that's what we want to do, keep in touch with one another so we can support each other. So if you are interested and want to learn more about the resources or about the network, we encourage you to contact our office and to go to our website at www.NCPD.org, there you will learn more about the work of the Council, be able to download our resources, view the archived webinars, as I mentioned.

In the future, we are still in the process of developing and establishing how we will be connected as a network, there will be a way in the future on line to be able to just click on it and join, but in the meantime, if you would like to be sure to get on the ground breaking time right now, just send us an e-mail at ncpd@ncpd.org and just indicate

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please add me to the network on mental illness. I want to thank you all for being here. Now I will turn it back to Tom.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Thank you very much Jan. Now we have a little under a half-hour to address your questions. So we have been gathering your questions that you submitted and what I would like to do is start with a question for Claire if I might. The question was, I heard you say die by suicide. In the media and more typically people say committed suicide. Could you explain?

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
Yes, I very carefully use the word die -- or the phrase die by suicide, took his own life, killed himself instead of the word committed suicide. To me the word -- the verb commit implies a criminal action or a sin. A person commits murder, commits adultery. To take their own life or to die by suicide, the person who dies by suicide is not engaged in any criminal activity and it is not a sin, so I don't use the word commit which implies a crime or a sin. If we use the word commit in conjunction with suicide, we continue to feed the image out there -- the National -- that is the -- that suicide is a sin and a crime. So I choose not to use that word in association with suicide.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Mhmm. Thank you Claire. Similar to the person first language that we use in talking about people with mental illness or people with depression, that really humanizes the person and the situation. My next question is for Fr. Ron. The question is in the image of Jesus you shared with us -- can Jesus touch a person through the locked door even while the person is living and struggling and provide support to that person when no one else can reach them?

Fr. Ron Rolheiser, President, Oblate School of Theology
That's a very good question and a very complex question. It's a good question because yes, Jesus can, but it is more complex because in all the churches we have struggled forever with the question of grace and freedom. That Jesus, the God we believe in never interferes with human freedom. So even when a person is ill or whatever, Jesus does not interfere with our freedom. The strength of the [indiscernible] painting is that Jesus is gently knocking. He is trying to touch. But see, we can only let ourselves be touched if we allow it, otherwise it is a violation. So that one of the things I don't think we have ever taken seriously enough about Jesus, about God, is that's the one person who will never violate our freedom, never. So Jesus will touch us if we allow ourselves to be touched but Jesus will not violate our freedom and touch us in ways or at times that we don't want to be touched. I know that's difficult, it pushes another piece of theology that the God that Jesus revealed is much more of a redeeming God than a rescuing God. So that Jesus -- the same [indiscernible] that the Father did not rescue Jesus from the Cross, he raised him afterward. Jesus does not necessarily rescue us, although we pray for that, but Jesus redeems us. So it is that [indiscernible] the great Christian mystic that said in the end, all will be well and all will be well and all manner of being will be well. Sometimes in between, it won't be well. It's precisely because God and Jesus respect our freedom so much that Jesus will touch us if we invite that touch. Jesus won't touch us in a way

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that violates our freedom even when -- the same if you experience that in love, the same dynamic. Sometimes you would want to do something for someone else that you know is good for them but if they don't allow it, we can't do it. That's the same with Jesus and ourselves.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Thank you. There is actually a related question that is directed to both you and me Fr. Ron. That is someone is expressing their gratefulness that theology has evolved with regard to suicide, but they are wondering -- there are people that previously chose not to die by suicide because they feared that they would face that punishment or that loss of love. And the question is without that threat they might go forward with the death by suicide and can we respond. Maybe I will take -- just start with that and let you join in afterwards.

I think it's a delicate balance in talking about the theology of suicide and the protective factor that religion can be in keeping someone from dying by suicide. I think the key is in what settings the theology is emphasized -- by what theology is emphasized. I have to admit that as a psychiatrist, I sometimes might hold the theology and say something differently. If I am working with a patient and they are contemplating suicide and tell me I think -- I want to die, but I don't know what will happen after I die. Even though my theology is one of love and welcoming that Fr. Ron explained, to that patient and that situation I will say yes, I don't know. I kind of wonder. It might not be good. In a sense I am using in that moment to help dissuade the person from acting. I don't know Father, if you would like to join in on that.

Fr. Ron Rolheiser, President, Oblate School of Theology
A couple of things. One of them is I think that -- and I said this in the beginning of my opening remarks that one of the reason why the Church has always put such a gravity around it is precisely for that reason. It is the ultimate taboo. Don't break that taboo and that gravity has to remain, but I think what you just pointed out Tom is that it depends which pastoral situation. There is a difference between counseling somebody who is contemplating suicide and sitting with someone whose husband has committed suicide. There are two different lines. That is always the risk talking about God's mercy, but at the same time, we can't bracket God's mercy or not talk about it because of some of those dangers. I think it is what pastoral situation we are in, so that when you're counseling someone who is committing -- sorry Claire I just slipped. Who is contemplating suicide. We use all of this, all of the pieces we can use. It's very different than so many pastoral situations that I am in that you are dealing with people whose lives have been shattered, hearts have been broken. We have to use the consolation of our God. The other thing and maybe I am wrong on this, in all the people that I have known that have died by suicide, I don't think in any of those cases was that done lightly or -- I think sometimes that is more of a theoretical question than -- the people certainly that I have known that committed -- killed themselves or have died by suicide, their illness, their sensitivity, their disease had reached a point where that was not going to be an issue. It was not so much that they were scared or un-scared of eternal life, their clothes were on fire and they were jumping out of a window. So that -- I think that -- I appreciate the warning to be really sensitive on that and yet for instance a priest or somebody working with survivors, we have to talk about the consolation of our God.

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Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Right, right. Very much so. Well we have a question directed to Claire. The question is, you mentioned that you asked many questions but eventually stopped asking since you did not need the answers. Why were you able to get the point that you did not need the answers?

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
I think that the answer to that question is that there are stages in a grieving process. One of the last stages is acceptance. And by the time you get to the acceptance you have reached the point of -- with the death and the all-consuming grief is behind you, you still cry, you are still sad sometimes, but it is not all-consuming anymore. You are at peace with what has happened in your life whether the death is a suicide or a battle with cancer. Hopefully you do work through the stages of grief and come to that point of acceptance. When you reach that point, where I wrote in my journal, I don't know why we didn't get to grow old together, but I am at peace with it, that's when the questions stopped because I accepted Ken's death. I don't know why we did not get to grow old together, but I was okay with it. I stopped -- my intense grief had stopped. It just dissipates, that need to know, just kind of diminishes as the grief lessens.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Mhmm, Mhmm. Thank you. Well next we have a couple of related questions that I will try to combine. I think we will maybe address them to Claire and Ron. They have to do with working with youth and teens. One is how do you -- say a teen expresses thoughts of suicide, any ideas of how to respond to them? Let's say for example in a religious education program, a confirmation class. And also working with the youth after one of their peers has died by suicide. What is the appropriate degree of acknowledgment? Some concern expressed that in some situations the death by suicide was not acknowledged or spoken about. Maybe I will start with Claire.

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
I think that last comment that you made that it was not acknowledged and not spoken about, in my opinion, I am not a therapist, I'm not a professional but in my opinion that is just about one of the worst things you can do. You need to acknowledge it because it is foremost in those kids' minds. You need to have -- give them wise counsel. You need to listen to them and you need to give them the opportunity to talk about their feelings and what they are going through with the death of their friend by suicide. Let them get it out of the darkness. Get it -- let them talk about it and give them the signal that it is okay to cry, it's okay to grieve, it's okay to be angry, it's okay to feel guilty and give them opportunities to express all of those emotions. That is the healthy way to grieve. The unhealthy way is to close the doors on the communication and shut them down.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Mhmm. And Father do you have any ideas on that?

Fr. Ron Rolheiser, President, Oblate School of Theology

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It is honestly an area I have not worked in much. I want to be quite humble in my response here. I do want to share a story though. I think what I have to share is not so much wisdom on it but from my own life, when I was 14, our neighbor committed suicide. This has been on my mind since, but it is probably the single most soul scarring experience of my life. I'm priest maybe because of that. He was not even a man that I knew all that well. He was a very sensitive man, but I was 14 and he committed suicide -- sorry Claire. [overlapping speakers] -- in my terminology. But he took his life and I had no tools by which to process that. I remember -- I still call it the summer of my discontent. I did not talk to anybody about it. I really did not talk to anybody about it. It changed my life. I remember just the shock of hearing about it and trying to process why did this healthy man, he was 22 years old, he had the body of an athlete, all of these things going for him, why would he take his own life. I remember going through hell, purgatory or whatever you call it. It took me years to process that, but I remember at the time I did not talk to anybody. I did not even tell anybody this is what I was processing. I just went into this long -- summer long slump effect. I was working on a farm. I would be out on long hours by myself and this was tormenting me. I remember that -- still the soul scarring experience of life has been trying to make sense of a suicide when I was 14 years old. I can only imagine what they are going through, but I think Tom as a psychiatrist you may have better insights then I have as a priest on how to help young people through that. I just know they need to be helped and as Claire said, if it's not talked about, it just stays there and it takes a long, long time to process.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
I agree. I also have limited experience working with younger people. I tend to focus on adults. In my experience, I have found that, as Claire mentioned, being open, naming the suicidal thoughts for what they are and being as neutral as possible, not being -- add valiance (ph) to being in distress and having thoughts of suicide, but just to take it and then respond, acknowledge the degree of distress the person must be in and then go about forming a plan which depending on the degree of the person's suicidal thoughts or attempts may involve even calling 911, calling parents, etc.

Well we have another related question that I would like to address to Claire. It has to do with how do you help people deal with the anger that comes about after someone has died by suicide.

Claire Woodruff, Suicide Bereavement Support - Archdiocesan Religious Education Coordinator
You know, that is something that I encounter all of the time in the Suicide Bereavement Support Groups that I facilitate. Anger is one of the stages of grief and it certainly is a huge, huge emotion after a suicide. What I tell people is to allow it to have its course. I know personally that after Ken died, about 2 1/2 months after he died, I got so angry at him, the bull's-eye was right smack dab in the middle of his back. I raged in the shower and I would scream and rant and rave at him when nobody else was in the house. I -- our car died after a couple of weeks after he did so I was stuck driving his old truck and I hated it. So when I was in that truck by myself it was his face and I would scream and rant and rave. That's what I tell people to do. Just let it go. When you find ways -- punch a pillow, don't take it -- just talk about it with a counselor. If you have insurance and can afford a grief counselor, that is a

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wonderful way to vent it. Write it out in a journal, talk about it with people who will listen to you, go ahead and scream, it's okay. What ever you do, do not assure these people that it is a normal stage of grief and not to feel guilty for being angry with either the person who died or with God. God can handle it. If you are angry at God, God can handle it.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
[laughing] Very good advice.

I would like to turn to Fr. Ron. We have a couple of questions regarding pastoral practices, sacramental issues. I'm wondering if you could address both the issue of a burial of someone who has died by suicide and would you anticipate anything different in that rite and also the application of the Sacrament of the Anointing of the Sick for someone who is experiencing severe depression or may be experiencing suicidal thoughts.

Fr. Ron Rolheiser, President, Oblate School of Theology
Okay, I will do the first one first. The sacramental part, the sacramental part -- you would not change that. I have done you know, funerals for suicide and usually I will talk to the family and ask them at what comfort level they have in terms of addressing it. You know because the thing in our culture and I want the family to make the call, how explicit, how much do you address it or don't address it in the homily. Usually they say address it. I have found it has been very, very helpful. It is not so much the ritual part of the funeral that you would change. I think it can be very important that in your opening comments, in the prayers, in the homily that it be addressed. But I always give the family a choice. If they say well, no, we are not comfortable with it, I respect that. The sacramental ritual stays the same but there is a lot of leverage within the sacramental ritual in terms of how you pray for this person, what kind of homily to give, what kind of text you choose, even what kind of eulogy or no eulogy and so on. I try to work that out with the family. In terms of the anointing, I have anointed people after the fact and that is a consolation to the family. For them -- it's the church's rite and gives its rite and so on. God is infinitely merciful and I think God gives us lots of leverage with these things. Before the fact -- I mean ideally I would like to see the anointing, but again Tom it gets back to the fact that how the person himself or herself understands the anointing is a little bit like what we talk about the consolation. It's just extra [indiscernible] so now I can go through with the act now. That plays in there. It gets a little delicate -- what the anointing means, how it is understood. That is an umpire's call there. Again, I usually try to work that out with the family. How does the family feel? What do they want? And also they know the person best. They usually have the best indicator of how it will go.

Dr. Thomas Welch, Member, NCPD Council on Mental Illness
Great, thank you. The next question I will address. It has to do with suicide in teens and why that rate might be so much higher than a lot of other age groups and what might be leading to that.

I think a couple of things. Particularly with regard to death by suicide is that when people -- or when -- teens by nature tend to be kind of impulsive and have not learned some of the tools that adults hopefully have learned about tolerating distress, waiting

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for things to change and they may be experiencing some depression, may be having some other mental health issues and then have a stress that then makes them impulsively do something or want to do something that would end their life. They may not even have the full cognitive appreciation that their life will be over by what they do but unfortunately they have access to such lethal and irreversible means like guns. They can go from a very impulsive feeling to a permanent consequence from that. Again that is why -- and part of this is my own opinion, editorializing, the reason why I tell my patients if you have a teenager at home, don't have a gun in your house. Don't try to kid yourself that having a lock box or a hiding place will keep the kid away from the gun because we were all teenagers and we know there was no part of our homes that we were not able to get into. Just [indiscernible] yourself of that fantasy. And also just again being able to talk with teens, trying to get a sense that they are developing symptoms of depression and being sources of support.

The next question has to do with the phrase assisted suicide or in the state of Oregon, we have had legalized, so called physician-assisted suicide. That is probably a topic that would fill up several hours. From my perspective again as a physician and a Catholic in the state of Oregon, I don't -- again I don't think there really is such a thing as a rational suicide. I think people develop despair, depression and then contemplate suicide and unfortunately we in Oregon and Washington and some other states have the capacity to enlist physicians in providing the lethal means to bring about one's death. That is a separate category, but I would still say is a death by suicide because the person is wanting to die and is bringing about their own death. I think that is entirely preventable not just by having it outlawed but by providing adequate end-of-life care, pain control, hospice care, [indiscernible] supports.

Well, we have had an overwhelming number of questions submitted and I apologize that we have not been able to get to all of them.

I would like to just direct you to a couple of things that there are a variety of resources that you can access to have some of your questions answered that we were not able to address today. So if you go to the www.NCPD.org website, there is a webinars button and if you scroll down, today's date and topic will be listed. You can then click on that and then in that webinar page you will be able to download a transcript which will be uploaded shortly after the completion of this call. You can download a resource list, resources for people who are survivors of suicide as well as other web links to organizations like the suicide hotline and SAMHSA.

So as we come to a -- and the webinar will be archived on the www.NCPD.org website.

So as we come to a conclusion, just wanted to remind you that NCPD serves some 14 million Catholics with a disability by supporting the work of the diocesan and parish work. All disabilities, not just mental illness. NCPD does this solely from donations, grants, individual sponsors and we would certainly encourage you, if you are able to support the work of NCPD, that when you are on the NCPD website, you can click on the button that looks like what you are seeing on your screen and contribute.

So we have gone over some very powerful and very important topics today. We just want to thank you all for being with us. We wish you God's blessing in your support of people touched by suicide. And we hope that you will continue to ask questions and to seek ways to eliminate mental illness and prevent suicide.

Before you log off today, we would appreciate it if you would fill out an evaluation of the webinar. You can answer the few questions that are asked. I will show you the evaluation now. You have a few minutes to do that but within 20 minutes, the website will be logged off and you will no longer be able to submit your evaluation. So please do your evaluation now.

On behalf of NCPD, our cosponsors, our presenters today, Fr. Ron Rolheiser and Claire Woodruff, I would like to say thank you and goodbye.

Operator
This concludes today's teleconference. You may disconnect your lines at this time. Thank you for your participation.

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