9-Suicide—UUFVB Covenant Groups—September 2016 (suicide prevention month)

Chalice Lighting

May we know once again that we are not isolated beings,
but connected, in mystery and miracle,
to the universe, to this community and to each other.

Check-in: How is your spirit right now?

Opening Reading

Many people have fleeting thoughts of death, but these are much different from actively planning to commit suicide. Most people who seriously consider suicide do not want to die. Rather, they see suicide as a solution to a problem and a way to end their pain. People who seriously consider suicide feel hopeless, helpless, and worthless. A person who feels hopeless believes that no one can help with a particular event or problem. A person who feels helpless is immobilized and unable to take steps to solve problems. A person who feels worthless is overwhelmed with a sense of personal failure. Most people who seriously consider or attempt suicide have one or more of the following risks:

- A family history of suicide attempts or completed suicide
- A personal or family history of severe anxiety, depression, or other mental health problem, such as bipolar disorder (manic-depressive illness) or schizophrenia
- An alcohol or drug problem
- Recent job loss, or divorce, recent death of a partner, or diagnosis of a life-limiting illness.(WebMD)

Topic Exploration

A. Suicide prevention may involve treatment of substance abuse disorders, psychotherapy to help people learn new ways of dealing with stress, and medication to ameliorate mental anguish. If you know someone who is considering suicide, do not leave him or her alone. Try to get the person to seek immediate help from his or her doctor or the nearest hospital emergency room, or call 911. Remove any access he or she may have to firearms or other potential tools for suicide, including medications. Consider your own safety and assess whether you are in danger. Don't argue with the person—arguing may only increase the person's feeling of being out of control. Talk about the situation as openly as possible, tell them you don't want them to die or harm another person. Show understanding and compassion. (National Institute of Mental Health)

B. Suicide & physician-assisted suicide

Most suicides are privately self-directed. However, in five U.S. states (Oregon, Washington, Montana, Vermont, and California) there is some accommodation for physician-assisted suicide, which is always at the request of and with the consent of the patient, since he or she self-administers the means of death, and euthanasia (sometimes called mercy killing), in which the physician administers the means of death, usually a lethal drug. (National Institute of Mental Health)

PRO: "Every competent adult has the incontestable right to humankind's ultimate civil and personal liberty -- the right to die in a manner and at a time of their own choosing. Quality of life judgments are private and personal, thus only the sufferer can make relevant decisions." While those who persuade or provoke persons to kill themselves should be punished according to relevant laws, suicide should not be a crime, and "it is unacceptable to prosecute well-meaning people for 'assisted suicide'. (Derek Humphry, "Liberty and Death," www.assistedsuicide.org)

"There's a whole philosophical history of looking at suicide as a rational choice," says Dr. Joris Vandenberghe, professor of psychiatry and member of the Belgian Advisory Committee on Bioethics. "We, as humans, have the possibility to weigh our own life and decide to end it." (Rachel Aviv, "The Death Treatment," www.NewYorker.com)

CON: "In a society that does such a poor job of protecting its vulnerable, it is naive to think that even the protections embedded in the California law will be sufficient to prevent coercion and misuse of assisted death. The idea that the elderly, the poor, the disabled, and the socially isolated will have their agency protected to freely choose not to suicide is fantasy – California dreaming on a grand scale." It is naïve to believe that "the medical profession can be trusted to be effective watchdogs over all of this….What is needed is assistance to the dying that protects their dignity and mitigates their fears in the form of more and better palliative and hospice care – not assisted dying in the form of active killing." (Dr. Joseph O'Neill, "Welcome to the Hotel Euthanasia," Oct. 6, 2015, www.ricochet.com)

Questions / Sharing

1. Have you known anyone who committed suicide? If so, what was the effect on you and on the family and friends of that individual?

2. What are your feelings about a terminally-ill individual's right to die on their own terms? Is physician-assisted suicide ever acceptable?

3. Should physician-assisted suicide be allowed if the terminal diagnosis is Alzheimer's, or another mental, not physical, ailment? Might the elderly be encouraged to "sign up" to avoid being a burden on their caretakers?

4. Suicide is often undertaken when either a person's physical or mental/emotional pain becomes more than they can bear. What do you think about a person's right to take their own lives under these circumstances?

5. Many religions consider suicide a mortal sin…what is your opinion regarding that definition?

6. Would you be comfortable intervening if you suspected someone you know is considering suicide? What methods might best be employed?

Closing Reading: There are two major ways in which physicians can more easily be made aware of the wishes of their patients relative to end-of-life decisions. The first simply involves participation in the informed consent process, or engaging competent patients in comprehensive discussions of treatment options and likely outcomes. The second of these methods involves advance care planning which ensures that patients tell their doctors, in writing, exactly what they wish to be done in case a medical emergency arises in which they are not able to speak for themselves.

Check- out and reflection on today's session

Extinguish the Chalice

We extinguish this flame but not the light of truth,
the warmth of community, or the fire of commitment.
These we carry in our hearts until we are together again.

Housekeeping

Addendum: Statistics on Suicide

People who attempt suicide often have disorders like depression, substance use, anxiety, and psychosis. Sometimes suicidal behavior is triggered by events such as personal loss or violence. The following statistics are from 2013, the most recent year for which data are available (from the American Foundation for Suicide Prevention, www.afsp.org)--

- The highest suicide rate was among people 45 to 64 years old. The second highest rate occurred in those 85 years and older.
- Women try suicide more often, but men are 4 times more likely to die from a suicide attempt. White males accounted for 70% of all suicides in the U.S. in 2013.
- Nine western states had the highest suicide rates per capita—Montana, Alaska, Utah, Wyoming, New Mexico, Idaho, Nevada, Colorado, and South Dakota. The lowest rates were in District of Columbia, New Jersey, New York, Massachusetts and Connecticut.
- Firearms were the most common method of suicide.
- Each year about 36,000 people in the U.S. die by suicide. However, more than 13 times that number—nearly 495,000—visited a hospital for injuries due to self-harm behavior. Surveys suggest that each year at least one million people in the U.S. engage in intentionally-inflicted self-harm.
- Across the globe, according to Dr. Catherine Le Galesmore of the World Health Organization, 3,000 people die of suicide each day. She says, "Worldwide, more people die from suicide than from all homicides and wars combined." (as quoted by Dr. Deborah Serani, "Two Takes on Depression," www.psychologytoday.com)
- The largest growing number of completed suicides is occurring among women aged 50 and older. The lethal drugs of choice are narcotic pain relievers hydrocodone and oxycodone.