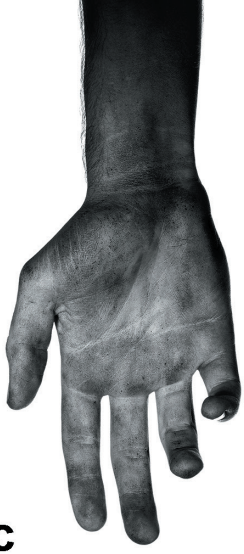
Colin McGregor

Raymond Viger



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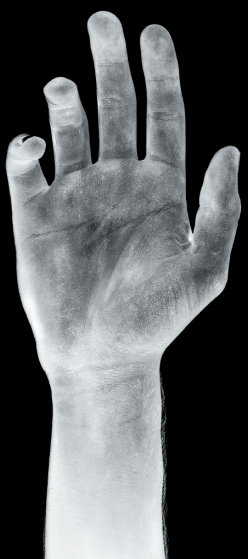

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A Reference for Fieldworkers
and All Citizens

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By Colin McGregor and Raymond Viger

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The words printed herein make up a small slice of the story of our world. They have not been written selfishly, to be kept to ourselves. They are to be shared, offered in all humility, simply presented, and with love for you, the reader.

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Quebec Suicide Prevention Handbook
A Reference for Fieldworkers and All Citizens

By Raymond Viger and Colin McGregor

But suicides have a special language.
Like carpenters, they want to know *which tools*.
They never ask *why build*.

- Anne Sexton, American poet, *Wanting to Die,* 1964 *(Anne Sexton committed suicide in 1974)*

FOREWORD by Colin McGregor

When I was a journalist in Montreal in the 1980s, the media did not report suicides as a matter of policy. It would simply encourage more, went the logic in the city's newsrooms. There was a general sense that Quebec had more suicides than anywhere else you could think of. But given that people never discussed the subject, it was difficult to put your finger on the extent of the problem.

It was known that families, not wanting the shame and humiliation of a suicide in their midst, would often cover up family suicides, listing the death as from some other cause – especially when these deaths involved teens. In elementary school, I recalled, the teacher one morning an-

nounced to us that the older brother of an absent classmate had drowned in the bathtub the night before. That was Quebec, and suicide.

Suicide creates havoc within a family. It makes waves. But like the ripples on a pond, these waves dissipate. All that is left is the human tragedy of a young life cut short before it had time to blossom. All the good a young person could have produced in their lifetime, all the hopes and dreams, all the children and grandchildren they would have produced, die with them. And for what? To forget a lost love he or she would have moved on from in a few weeks? To leave behind problems for others to solve?

Raymond Viger has worked for more than two decades in the taxing, difficult field of youth suicide prevention. I have spent that same length of time behind bars, and have seen a lot of people end their own lives out of despair and anguish. I have thought about doing the same myself, quite seriously, but not for many years. If the product of our experience can prevent one early, senseless passing, this work has served its purpose.

This handbook is dedicated to all those who could not face their demons adequately, and chose the easy, fast, final way out. Their passage is regretted. Their love lives on. May their numbers decrease, even a little, in its good use. It is directed to prevention workers and sufferers alike.

The original French language booklet written by activist Raymond Viger, *L'intervention de crise auprès d'une personne suicidaire,* has helped thousands since it first appeared in 1996. So has Raymond, a decent man, a humanitarian, and a friend. Anything helpful in this work springs from the many thankless hours he has spent talking down young people who considered suicide when their rainbow wasn't enough.

Appreciative thanks to Ron M., Tim S. and H.M. for their help with this work.

Cowansville, Qc, 2014.

How To Keep Decent People from Considering Suicide

The human psyche is not a world of straight lines and precise systems. It is a maze, full of nooks and crannies. Its pathways harbor mysterious dark corners and challenging obstacles; turnoffs leading to sudden glimpses of glory, or of shame. One never knows what lurks in the heart. Not even your own. The principles and suggestions set down here are meant to dissuade suicide, not to cure all phobias.

The idea is to keep the machine running and not to try to fix the machine until it is as good as new. The brain, three pounds of gray jelly perched between our ears, is in many ways a mystery to modern science: 100 billion neurons packed closely together, humming away in ways we can only guess at. But the brain of the person contemplating ending it all works in some specific ways we can observe, over time: knowing tried and true methods to turn this suicide process around is the subject of this guide.

At the beginning of his novel *Anna Karenina*, an epic tale of failed love, Russian author Leo Tolstoy observes this: *All happy families are happy in the same way, but all unhappy families are unhappy in their own way.* This is true for people on the brink: there is no one set formula for why decent people come to consider suicide. Each comes to the edge of their personal cliff in their unique way. There are similarities, but no one narrow path is beaten to that ledge. Nor is there one

set, easy formula for getting people to choose life over death. Nonetheless, the journey a person takes from loss to suicide is for most people – especially for youth – the same downward spiral. No matter what the person's disposition and character, sex or income level, hard experience has taught the prevention community to see the commonality in what these sufferers feel and live. The trajectory is remarkably similar.

Spot the signs, know how to intervene at the appropriate stage in the process, and you can keep people active and alive on this marvelous planet we co-inhabit.

How Did Raymond Viger Become a Suicide Prevention Counselor? He describes his journey…

I began my working life in the field of biochemical engineering. My life was not glamorous. I spent my days sealed away in a laboratory, slicing rats. I felt isolated. I soon switched to the more dashing field of aviation. For five years I trained charter aircraft pilots and bush pilots. That experience led me into the business and corporate world.

Nothing in my background foreshadowed my eventual career switch into the world of counseling. But I had crashed and burned. Stress had caught up with me. Early in my 30s, with two suicide attempts to my credit and a happy marriage disintegrated, I was forced to reconsider my path in life. I studied psychotherapy – first and foremost, so I could work on myself. To keep me out of an early grave. Like the scientist I was trained to be, I took my life apart and examined it piece by piece. Events over the years had accumulated to the point that I'd become a fragile, vulnerable soul. I was defenseless; my life had descended into a perpetual state of crisis.

Once I'd unburdened myself of many of my demons, I felt ready to enroll in a psychotherapist's course. I had no intention of saving the world. But I wanted to stay true to my principles, my values, my new way of life. Working with the distressed was a selfish act – a personal life insurance poli-

cy tucked into my back pocket, there in case the black dog of depression showed up at my door once more. Trained in crisis intervention, I could build my own private lighthouse and watch for the telltale signs of turbulent seas before the tsunami. I built a personal and professional support system. It was, I hoped, sufficiently large for any cries for help to be heard before it was too late.

To realize you need help takes a lot of humility. I apprenticed as an aide to my own personal psychotherapist; then I spread my wings and took flight myself. I felt oddly at ease as those in distress came to see me with their problems. It gave me an air of calm. For better or for worse, I fed off the misery of others. Helping them with their dilemmas gave me strength.

Was I right to draw strength from the weaknesses of my patients? When I wrestled with this question, I tumbled back into that dark place I'd crawled out from. Perhaps it is best to accept the contradictory nature of human existence. The world is not black and white. Joy and sadness, strength and weakness, are not mutually exclusive: accepting that the world is a rainbow makes life a wonderful thing.

- **Suicide as the Solution to All Problems**

My biggest sticking point was with society. I idealized society. I saw my city, my community, my province as

a place where every citizen could fit in and play their role, from the greatest to the least. My Quebec society was an equitable, just place: in short, I saw life as fair. But the more I delved into the problems of the marginal, the more I saw that our socialist wonderland left many people behind. Real and serious needs were not being addressed. The idea that our society takes its responsibilities towards the marginalized seriously is, sadly, something of a façade.

The year I began my crisis intervention work, the Casino de Montreal opened its doors. It was 1990. The Casino is a glittering jewel on an island in the St. Lawrence River, accessible by bridge, subway and on foot from nearby downtown Montreal. The Casino building is an architectural marvel, a white helix reaching into the sky. At night, it is lit up like a thousand stars, reflecting brilliant light into the shimmering river waters nearby.

It is a working Casino, and a profitable one at that. In its basement there is a morgue. It is a suicide hub. As soon as it opened, Montreal's crisis intervention community was swamped. Compulsive gamblers lost their shirts. Many gamblers saw suicide as their only way out. These were not the chronically depressed. Here were pillars of society with lives and families – hard working businesspeople in the prime of their careers; seniors who'd never gambled before in their lives and who'd got hooked by the glittering lights of the slot machines… Middle-class citizens throwing away

their life savings a few dollars at a time, their logic swamped by a new compulsion…

A problem never shows up to the party alone. In the crisis intervention community, we quickly realized one thing: behind the gambler's urge to commit suicide lies loneliness, or emotional dependency, or an introvert's struggle to express despair, or... Those who showed up at our doorstep who had lost their life savings at the Casino had deeper issues underlying their compulsive gambling.

Even if we could save a life today and send that person home, it never prevented their deeper issues from reappearing, at some later date, in some form of compulsive behavior.

The hemorrhage would re-emerge. We had to identify the deeper scar.

For this, the most important tool at our disposal is always the human ear. Listen to people.

- **Suicide and Society**

In the face of this distress, we couldn't continue our intervention efforts without trying to discuss the matter with the proper authorities. Band-aid solutions wouldn't do.

My colleague met with the Casino's management. We offered to work on the premises to help compulsive gamblers directly, one-on-one.

We also offered to train Casino employees on signs of distress to pay attention to. That way, those heading for a darker place could be referred for help before it was too late. A potential suicide could never be allowed to leave the Casino alone after squandering their life's savings.

I was deeply troubled by the management's response. They had no need for our help, or for anyone's help for that matter. They claimed that no gambler *ever* considered suicide!

Did they mean that all of us folks in crisis counseling were delusional? Our intervention services were completely overwhelmed. My colleague and I, for example, remained available 24 hours a day, seven days a week, and we couldn't handle the demand. Were all those late-night phone calls to us by desperate gamblers figments of the imagination?

This train of thinking took us aback. It was the same reply that crisis counselors got from high school principals confronted with evidence of drug use among their students. "We don't have that problem at our school…" Their students were coming to us in droves, relating their severe distress.

Those in authority preferred to camouflage problems rather than deal with them head-on. Pretending a social ill doesn't exist is never a good way of handling it.

As a society, we have to ask ourselves: are we as a collectivity ready to act in the best interests of our fellows?

Are our institutions ready to help those in need? Old or young, weak or strong, male or female, every citizen supposedly has their role to play in our community. But does this, in the real world, extend to the handicapped, the mentally ill, the marginalized?

- **Suicide and Politics**

This line of questioning could well have led me to get involved in politics. But I am a hands-on type. I neither like nor understand the political world. I got involved with a community newspaper aimed at troubled youth in Canada's poorest federal riding, Hochelaga-Maisonneuve in Montreal's East End. The name of the paper was *Journal de la Rue* (*The Social Eyes*, in its English-language version).

A community newspaper, especially in those pre-internet days, was the ideal forum for people's concerns on the ground. It was aimed mostly at youth. It provided valuable information on where people could get help: suicide hotlines, youth clinics, community centres… In its pages, young people were encouraged to share their hopes and fears with their peers. Those suffering through hard times had an outlet, a place to blow off steam through their own creativity.

Personally, it became a way for me to share my uncertainties over the great existential questions rattling around in my mind.

The *Journal de la Rue* became the umbrella organization underneath which we built and organized a host of other youth intervention programs involving art, writing, dance, music, and drop-in facilities. Our community newspaper grew into its current incarnation, *Reflet de Société*, with its almost 500,000 readers, its popular website frequented by teens and people of all ages around the world, and its inventory of help resources: agencies, drop-in centres, websites, information for youth in distress.

- **Suicide and the Young Outcast**

People from different schools of thought within the suicide prevention community have various methods of operating, but we all agree on one thing: young people contemplating suicide don't use suicide hotlines. They usually don't reach out beyond their peer group at all. Amongst the young, suicidal thoughts grow best in the dark.

Prevention must involve establishing a connection with the young person in question. This personal link must be forged *before* the crisis moment arrives. The troubled youth must be ready and able to confide in at least one other soul. They usually don't want to talk to strangers. The only recourse, we decided, was to work at street level to build trust. If we were known to the youth of this depressed, marginalized area, they might come to us when they needed aid.

I became very comfortable in my new role as an on-site resource. I became a familiar figure on the streets and in the alleyways of Hochelaga-Maisonneuve. With my size and girth, I was a bear-like presence, a big brother. Around tough kids, size helps.

I soon lost my focus: I was no longer simply a suicide prevention counselor. Suicide was not an ever-present thing in these kids' lives. There were problems behind suicidal thoughts, issues that vitally needed to be addressed: drugs, alcohol, gambling, purposelessness, mental health… The more youths I dealt with, the easier it became to pick up on subtle signals. I could spot icebergs before the boat rammed into them and sank. I could teach others what those signs are. Experience is the best teacher.

And my team could refer troubled youths to an inventory of possible therapies and solutions. I could help these young people sort out their priorities. I could support each one in their action plan.

The young person remains in command of his or her own destiny. You cannot order a young person around, especially a teen. And hard experience teaches that my priorities, my problems, and my solutions would work only for me. People have to mark out their own path. As Apple Computer's Steve Jobs argued so forcefully before he died, *Life is too short to live out someone else's dream*. Moreover, we all change. A strategy that may have worked for someone

10 years ago wouldn't work for that same person today, and certainly won't work in 10 years' time.

- **A Rescue Line: Self-Expression Through the Arts**

The young person on the precipice of suicide is isolated, alone, focused on the self. Communicating with the outside world is difficult. At our community drop-in centre, we've created a milieu in which we can accommodate young people. They are given the place, and the tools, to express themselves. They can find a seat at the table of life. They can carve out their niche. We draw most of our clientele from Hochelaga-Maisonneuve, where many young people are "taggers," graffiti artists. So our centre was baptized: "Café Graffiti."

By channeling young creative energies in positive directions, we let these young people live their dreams. We give them goals to strive towards, creative ways to harness their abundant energies. A young life takes on meaning. This is at the foundation of our suicide prevention strategy. It's a way that tackles a number of other social ills and youth problems too.

- **Suicide and the Closed Environment**

I have had the great privilege of working as a suicide prevention counselor among the Inuit of Quebec. Their 14 villages are strung along a thousand kilometers of some of

the most desolate-looking land on planet Earth, in Quebec's far north. In conjunction with McGill University, I helped train community workers operating in these villages. At the end of the training process, trainees received a certificate in social work. They were taught how to formulate and execute a prevention plan. Moreover, a group of social service organizations, and a school board, gave us the means and the mandate to train "southerners" to serve in these far-flung communities.

I worked on these northern projects over the course of five years. Again, the best training in this field is to expose yourself to a variety of people and situations. So these efforts helped round out the education I'd received in crowded, urban Montreal.

Suicide is chiefly a by-product of isolation. In the far north, the challenge is this: how do you set up a support network in a place where people live so far apart?

Inuits live collectively. In a land where people go off to the snowy tundra with their dogs for weeks at a time, the answer is the same as in the cities: you set up as wide a social support network as you possibly can. In a way, this is easier in the far north. Inuits share everything within their communities. Personal property, divisions between families, hardly exist at all within Inuit culture.

In Montreal, population 3 million, alienation is rife. It is easy to be alone in a crowd. You have to convince urban

youth that they *deserve* a support network. How do you sell this perspective to a young teen with no job? To a teen who thinks that school is made for others? What do you say to the friendless, lonely teen who thinks nobody cares if they live or die?

- **The Ripple Effect**

Suicide isn't a narrow issue that affects only the vulnerable and the damaged. A self-inflicted death has many victims. It is a tear in the fabric of society. It is a sign that we, collectively, have in some way failed our fellows.

More practically, it has long been established that one youth suicide can lead to "copycat" behavior. Like a yawn in a crowded room, suicide is contagious. In 1897, Austrian professor Hans Gross, in his book *Criminal Psychology*, wrote: *"There is the remarkable fact that suicides often hang themselves on trees which have already been used for that purpose. And in jails it is frequently observed that after a long interval a series of suicides suddenly appear."* This is as true today as it was when it was written over a century ago. There is no more dangerous time period in the life of a family than the days immediately after one of its members takes his or her own life.

- **What is Suicide?**

The reality is that suicide is an assault. In the Italian writer Dante's classic work *The Inferno*, written in 1321, he gives readers a tour of hell. He puts suicides in his seventh circle of hell. He calls them "the violent against themselves." They are on the same level as "the violent against their neighbors" and "tyrants." Dante had a point: *Suicide is violence turned on oneself, causing death.*

But death is usually not the main goal. The sufferer's goal is simply to end his or her own suffering. Through a process of elimination, devoid of all hope, the only choice seemingly left is suicide. Talk of suicide is an alarm signal. ***It is a cry for help***.

Any intervention effort has to be based on listening to that cry.

Above all, an intervener has to be there. Nothing is more important than showing a willingness to listen. That is the best kind of help one can offer. The cry will be different depending on the sufferer. But any suicide is reversible right up until the final moment.

The sufferer in this state is afflicted with tunnel vision. Death seems the only way out. The intervener must present other options.

The intervener is there to listen and to convince the sufferer that their overwhelming feelings of anguish can be extinguished without extinguishing life itself.

- **How Widespread is the Problem?**

The province of Quebec, population 8 million, boasts the highest suicide rate in North America and among the highest in the world. Every day, an average of between 3 and 4 Quebecers take their own lives. Rates among teens are at epidemic proportions. Every year in Quebec sees 10,000 attempted suicides by those under 19 years of age. That represents 1 in 50 youths of this province trying to end their own lives. Moreover, each year 40,000 youths have suicidal thoughts. Which means that in any class of 25 high school students, on average, 2 of those vibrant, dynamic young people have contemplated suicide over the previous 12-month period.

Why suicides are higher in some places than in others is a mystery. There are poorer, more economically unequal places than Quebec with much lower suicide rates.

But statistics never tell the full story. It's always dangerous to base conclusions simply on raw data. Are these numbers accurate? The actual problem could be much worse. Suicide is an iceberg, its bulk invisible below the surface of the reflective, glassy water of our fears and social

taboos. Even coroners are traditionally reluctant to rule a death a suicide without hard proof.

Prior generations were even less prone to talk about a variety of social ills, including suicide, than we are today. So it is impossible to say with any accuracy whether the situation has really got better or worse.

One observation the prevention community has made is that today's youth are less likely to disguise what they are about to do, or what they have done, than were people of their parents' or grandparents' generation.

More people signal their intent beforehand; more suicides leave notes now than ever before. Some recent studies show that 7 out of 10 suicides have openly talked about their plans ahead of time; others signal their intent somehow, so that in the end 8 out of 10 suicides have tried to telegraph their intentions to those around them before attempting the final, drastic act.

An attempted suicide in youth leaves scars on the survivor. It can cause permanent psychological and even physical damage.

The youth will carry these scars for the rest of his or her life. An attempted suicide is never an isolated event. It pulls inside its vortex many emotional victims: parents, brothers and sisters, grandparents, friends, teachers, fellow students, workmates…

Stemming the suicide epidemic doesn't just mean stopping suicides; it means nipping attempted suicides in the bud.

But how can this be done if no one wants to talk about it? How can we break the *Omerta*, the wall of silence, in a society where the whole subject is stigmatized?

- **Demystifying Suicide**

Even in an Internet universe with no secrets, suicide is still a touchy subject. Within the intervention community, we've learned that it's important to talk about it with humility, conscious of our own strengths and weaknesses as prevention counselors.

We all see the world through our own filters. Biases can get in the way of perceiving things as they really are. When dealing with a potentially suicidal person, openness of spirit is important.

There are many myths about what is, essentially, a horrible, brutal act. A myth offers the advantage of being a simple explanation for a complex set of phenomena. When someone close to you tells you they're contemplating taking that final exit, one can always fall back on these myths.

It's important not to jump to conclusions when intervening. Succumbing to easy stereotypes is worse than useless.

It's natural for us to pigeonhole people. If someone is close to you, and is thinking in this way, the myths tend to fall into three categories:

1) *I shouldn't intervene. No one should ever try to intervene. After all, someone threatening suicide is just looking for attention. They want to manipulate us. They just want to be the centre of attention.*
2) *I'm not responsible. After all, if someone wants to take their own life, there's no way to stop them. I can't do anything to change that. Suicidal tendencies are hereditary, after all, and I'm no psychiatrist…*
3) *It's best to close my eyes to the whole sad situation. After all, talking about suicide with someone who has those sorts of dark ideas in the first place will only fan the flames. It'll encourage them. It's not my responsibility. They'll get over their depression and bounce back. Things'll calm down…*

The reality is very different. If someone close to us is feeling low enough to be thinking of ending it all, or if we suspect a depressed friend or family member is heading that way, we are all responsible. We can all help. It is a human duty.

You can feel impotent in the face of someone talking suicide. Fear of saying or doing the wrong thing can be petrifying:

- *What if she actually goes through with it, and I get blamed?*
- *What if he really does commit suicide, and I end up blaming myself?*
- *I'm not good enough at this to be responsible for another life…*
- *What if I end up thinking about suicide myself?*

Suicide is a threatening subject. For reasons of self-preservation, one's first instinct is to withdraw. Confronting your own mortality can be chilling.

A Few Basic Facts

Let's demystify the process. Here are a few basic facts:

- The vast majority of suicidal persons signal their intention ahead of time. The signals might not be completely obvious, but they are there.

- Suicide is not genetic. True, families suffering common problems may find more than one suicide within their midst. One family member's suicide often touches off another – which means that counseling is vital for family members of a suicide. But the same domino effect can manifest itself in a school, a workplace, an institutional setting…

- Suicide is not physically contagious. Both the authors of this book have attempted suicide twice each. Yet, you can touch us and talk to us. The virus of utter despair will not leap onto your body. However, having someone close to you commit suicide can touch off feelings of guilt, remorse, neglect – putting you in danger of tumbling down a staircase of despair.

- Suicide respects no economic class distinctions. Rich or poor, man or woman, educated or illiterate, suicide does not discriminate. However, most completed suicides are male; girls and women carry out the vast majority of uncompleted attempts.

- Being depressed doesn't mean you're crazy. Despair and depression, the chief causes of suicidal feelings, are not indicators of a severe mental illness. As you help someone, think to yourself: *If I were in that person's shoes, going through what they're going through, wouldn't I feel the same way?*

- Talking about suicide with a depressed person won't push them off the cliff. Indeed, a comforting presence and a listening ear are the best therapies. Give the person the opportunity to express their fears, their suffering. Next, open the door to possible

solutions. Encourage anything someone can turn their energies toward to get their mind off of their current troubles.

- The foundation of any successful intervention is honesty. Be frank. Desperate people can smell insincerity.

- Everyone you can get to in the person's circle of friends, family, work and school colleagues should be brought into the process as soon as possible. Too often, after a suicide, friends and family gather to compare notes, to talk about the clues they let slip by, to regret the warning signs they didn't tell anyone else about… They realize, far too late, that all the signals were there and nothing was done about it.

- Suicidal thinking isn't a finite process with a definitive beginning, middle and end. Someone can chronically think morbid thoughts. Several interventions may be necessary before the person recovers their will to live. Building self-esteem is very important.

- Suicide is neither an act of cowardice nor an act of courage. It's simply an expression of unbearable psychological pain at a particular moment in life.

- This is the usual, normal sequence of events:
    I. *The person first suffers a loss, be it real or symbolic.*
    II. *Then, a period of depression follows.*
    III. *The depression builds to a crisis point.*
    IV. *The sufferer actively begins to contemplate suicide.*

- A suicidal person may not necessarily come across as outwardly depressed. A clownish exterior often hides deep pain. So does a "tough-guy" shell. Symptoms will vary according to individual personality and character. People close to the sufferer will be best positioned to pick up on uncharacteristic behavior hiding a deeper problem.

- Any sudden mood swing may be a warning sign. Even an abrupt upturn in someone's mood may be a distress signal. A previously depressed person who has taken the decision to end their life may appear happy, even relieved. Their entourage may think that the crisis moment has passed. It has not… Ask questions.

- Every threat must be taken seriously. Even if we suspect we're being manipulated, we have to carry

on counseling the afflicted person. We can tell the sufferer that suicidal threats should never be used simply as a way to be heard, or to be better understood. Someone that desperate needs our help, whether or not the suicide threat is a serious one.

- A person in deep psychological distress often exhibits signs of extreme behavior. They may suffer insomnia; they may need to sleep all the time; there may be a loss of appetite, or a constant need to eat; there may be extreme fatigue and laziness, or bursts of hyperactivity… We are on the outside of the sufferer's thoughts. We can only judge what we can see.

- We shouldn't brush off a suicidal person. Some think that the best therapy is tough love: *Go ahead, jump, see if I care…* Will that change someone's mind about ending it all? This approach often backfires: it pushes the sufferer to extreme action.

- A sudden upswing in a person's mood doesn't mean that the risk has passed. Often there is a calm before the storm. The mind is made up; a plan is in place; affairs are put in order; the stage is set for the final act…

- Music and movies can't motivate a person to suicide. Suicide results from a troubled soul, not because a rapper advocates the act.

- It's useless to tell the sufferer: *You're all upset over nothing. Everything will work out. You'll see. There are people far worse off than you. Stop feeling sorry for yourself. Leave me alone. No one wants to go to your pity party…* Let the sufferer express his or her worries and fears.

- Focus on the crisis of the moment. Identify what exactly is driving the sufferer to despair at that precise instant. The sufferer should be told that no one can get through such dark times on their own. Everyone needs help. Outside resources, including friends, should be drawn upon to work on problems – and as soon as possible.

- **Mourning and Loss as Triggers**

Any difficult loss we experience in life comes at an emotional cost. Feelings build up. You have to take the time to let those feelings out into the open.

The human mechanism includes safety valves: venting is in our nature. Frustration, anger, feelings of abandonment and rejection, all these are among the emotions we may feel after a significant loss.

Venting after a loss is a growth mechanism. The ways in which we can live out our grief vary. Techniques abound. The way we mourn will depend on the depth and the intensity of our feelings of loss. The death of a child or a parent is likely going to be felt more deeply than a loss by a favorite sports team.

But the same loss can be seen very differently. For some people, the loss of a cat can be nothing special. I know a woman who lost her limping, constantly sick cat, and cried uncontrollably for weeks. The years before, she had lost her kids, her husband and friends. Her cat was her child. The last living thing left for her to love. She had cared for it through several chronic health scares for three years. It had been her constant companion.

The loss triggered a crisis. She felt she had nothing left in her personal life. We can belittle such depths of grief over a cat. But the loss of a beloved family pet can easily be

the trigger for a suicidal downward spiral. It all depends on the context.

It's untrue that if we've survived one major loss, we can easily survive another similarly bad experience, no problem, because we've built up a resistance to shocks. Wrong. Our needs and vulnerabilities change over time. We aren't the same at every point in our lives. Moreover, the time needed to mourn varies from person to person, from loss to loss. Some grieving goes on for years.

You may prefer to turn the page and ignore the grieving process, to not look back at your loss. But you risk having buried scars rise to the surface at a later date. The things you sublimate can hurt both your external relations and your internal psyche.

Bereavement confers emotional stability. Once my grieving has largely run its course, I know I can continue on my life path. Fleeing my sadness, ignoring the mourning process, would be unwise. Buried feelings would come back to haunt me. Burying things makes a person emotionally fragile, and actually less capable of withstanding future emotional shocks. If I don't mourn, I know that the smallest reversal could set me on a dark road.

- **Warning Signs**

Incapable of clearly expressing distress, the suicidal person sends signals to those around them. These signals can be subtle, or jumbo-sized. These signals are appeals for help; a final search for some glimmer of hope before the tsunami hits. Remember, 8 out of 10 suicides indicate their intent before the act itself. But even for the 2 out of 10 who don't send out evident verbal signals, someone close to them may sense their melancholy and malaise.

- ***Direct Verbal Messages***
  - "I'm going to kill myself."
  - "I want to die."
  - "Soon, you won't have me to kick around anymore."
  - "There's no point in even trying."
  - "I'm afraid of suicide."
  - "I'd be better off dead."

- ***Indirect Verbal Messages***
  - "I'll soon be at peace."
  - "I'm useless."
  - "I'm planning a long trip."
  - "I've screwed up everything in my life."
  - "You'll all be better off when I'm not around."

The sufferer may even *joke* about suicide. If you suspect someone near you is heading down that dark road,

don't hesitate. Ask them a direct question: "Are you thinking of committing suicide?"

If the person says no, and you doubt them, make sure they know that your door is always open if they'd like to talk. Show that you care. Say that if they ever think about suicide, they should contact you as soon as possible.

- **Symptoms of Depression**

- ***Physical***
  - Sleep cycle disrupted (insomnia, constant sleeping)
  - Change in appetite (bulimia, overeating, undereating)
  - Change in energy level (extreme fatigue, hyperactivity)

Psychological

- Inability to find pleasure in anything
- Loss of interest in anything and everything
- Sadness
- Irritability, anger, rage
- Loss of sexual desire
- Frequent mood swings: euphoria to depression in very little time
- Low self-esteem
- Guilt, self-accusation

Generally speaking, depression triggered by a personal loss precedes suicidal thinking. It could be a roman-

tic breakup; a job loss; the death of a loved one; failure at school; a health problem; etc. It's important to consider how the sufferer is experiencing the loss in question. Put yourself in their shoes. Don't use your filters to evaluate the importance of their loss.

Suicidal intent can follow a series of losses and shocks, small or large, experienced over a short time period. Or it can come from one major shock.

- **Isolation**

Progressively, suicidal people shut themselves off from the world. They cease to talk to others. They look to be alone. They abandon their usual activities.

Once, during a telephone intervention, *writes Raymond Viger*, I asked a sufferer to describe his environment. The curtains in his apartment were all shut. Complete isolation. And he stayed there. Didn't leave his apartment. Nor was anyone allowed to come over and see him. The door stayed locked.

The suicidal person also works to isolate him or herself psychologically. They say nothing. They become quiet, unresponsive. To those around, the person seems cold, unfeeling, aloof.

Substance abuse often masks a serious depression. The sufferer may begin to overindulge. Drugs, alcohol, prescription medications… Suicide attempts often happen at the end of a binge.

On Isolation, Colin McGregor Writes, from a Prison Viewpoint:

I awake in a sweat, dazed and disoriented. *I turn my pillow over to the dry, cold side underneath, and think: a few seconds ago, I was walking along Sherbrooke Street on a sunny summer's day, rummaging through second-hand bookstores.*

Not now. My eyes adjust to the dim light. I can discern small straight furrows running between the painted cinderblocks of my cell wall. I am still in jail.

A prisoner's dreams can be deceptive. They exist in a realm beyond the drab gray walls that contain us in our tiny individual 7 x 10 foot cinderblock realms. The world of dreams is alluring, seductive.

When I sleep, my spirit travels to other places. Dreams bring me people I love and loved. My dream worlds have no limits. Everywhere I carry my regrets and my melancholy – but in my dreams I have the capacity to make amends, unlike my current state. That's because prison quarantines not just from friends, but also from those who have been hurt by crimes.

In these brief moments of respite, it is natural to ask – would suicide bring me full time into this painless world of reverie? Would opening up the human envelope send me off to a better place? It's a choice that is often made.

An elderly man with not long to go on his sentence complains for months about being in physical pain. He is turned away by the health care facility many times. Eventually, even fellow inmates who at first tried to help him push him away: his complaints become chronic and repetitive. He begins to sleep on the floor of his cell to manage his agony. I become accustomed to passing him as he slowly shuffles along his way. Occasionally he flashes me an intense, knowing stare.

One gray Monday afternoon, an emergency siren wails. I replace my tools at the prison factory where I work and file back to my cell. When we are finally let out, we learn that the old man is out of his pain.

That night, some of us sit in a circle at chapel: 20-odd inmates, a community volunteer and a chaplain who asks us to express our feelings. One man had seen the old man swinging in his cell, too late. Several men express shadows of personal guilt, I among them. Could we have done something more to help?

One participant, clearly informed that the old man had suffered severe psychological problems rather than medical woes, gives an impassioned speech calling for more psychiatric services behind bars. Together, we pray. But prayer will not bring this man back.

Is this life the illusion? Is the dream life real? Philosophers and religions have argued the point for centuries.

The books of Raymond Moody keep me on this planet. An emergency room doctor, Moody was the first to chronicle what the medical profession had always known but never talked about – that patients who die for a time and are then brought back experience roughly the same events in the same sequence, regardless of sex, age or religion.

The near-death experiences of people who attempt suicide, then come back, are uniformly awful. They don't go to a better place. Their woes, their struggles, their psychic pain all follow them into the next realm. They will be stuck in the same ruts for eternity. When they are revived, Moody reports, they choose life.

If you die here, someone tells me, no one will cry. Still, there is reading, writing that can touch people I have never met; there is sports on TV. There are penpals, sunlight, the rare visitor. There is even the possibility, maybe one day, of making amends. I tend to think the world is a dream that represents all we have. ***And we will, we must, always find a reason to live.***

Staying alive in such an isolated place means finding an interest, a goal, a purpose. "It's when you're alone in your cell that the demons come out of the wall," one inmate tells me. "You can't be alone all the time, or else it'll kill you." But how to find positive, life-affirming company in a place where so many are up to no good? During the darkest years of

his 27-year incarceration, Nelson Mandela found respite in poetry and literature. He taught his fellow prisoners to read. Then he had the reading prisoners teach other non-literate prisoners how to read. He found reasons to live in education and literature. He spread these interests to other prisoners, doubtless nipping many suicides in the bud.

There are many ways to give sufferers hope. You the intervention counselor are in the best position to judge the means in the situation you are dealing with.

Other Signs of Suicidal Intent

The sufferer may be seen:

- Giving away precious personal items
- Settling debts, making peace with people
- Making out a will
- Praising the courage of those who have committed suicide
- Mourning a personal loss for an extended period of time
- Engaging in risky behavior (speeding behind the wheel, stunts)
- Acting uncharacteristically intense

Note that these signs taken alone don't necessarily mean that the person is suicidal. But they are alarm bells. They mean you should have your radar up.

And the only way you'll find out is to **directly ask the question**. The sufferer may lie, but you'll get information from the response that may, just may, enable you to save a life.

- **The Crisis**

Every single serious personal crisis doesn't necessarily lead to a suicide. Nonetheless, every crisis has certain characteristics in common:

- A high, accumulated level of stress, making the sufferer very fragile and vulnerable;

- The sufferer's inability to use normal methods to find solutions to personal difficulties;

- The sufferer's inability to find outlets for his/her frustration.

The sufferer experiences confusion. This can be a key growth opportunity in their lives; or, it can cause a tailspin leading to suicidal thoughts.

The word "crisis" comes from the ancient Greek word *krisis*, meaning "decision." In every crisis, there is a choice to be made. Death should not be the only choice the sufferer can see available to them. Tunnel vision can take hold. The sufferer asks: *Is there any other way out of the unbearable emotional pain?* Events have knocked the sufferer off balance to the point that obstacles seem insurmountable.

The crisis counselor's job is to get the sufferer to envisage other options. Encourage the sufferer to explore

new ways of doing things, new activities, new experiences, and new ways of thinking about life. People with goals and a purpose to their lives don't kill themselves. The crisis moment can become a mechanism for letting go of an old way of life that doesn't work, and finding a new way of life that does work. As already stated, both authors of this handbook have found great joy and solace in creative endeavors, and have found that others too can channel their energies into life-affirming arts.

- **The Key Moment**

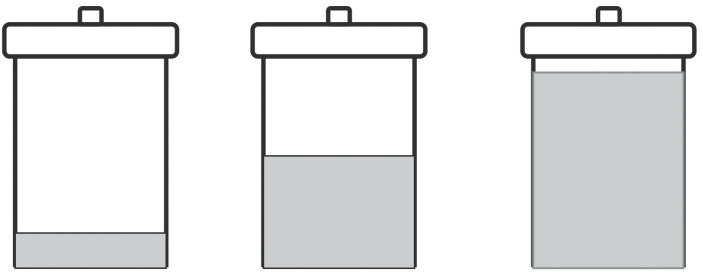
The true crisis moment happens when the sufferer realizes he or she can't digest or handle an event in life that involves personal loss of some sort. The sufferer is drowning in despair. Hopelessness builds. Suicidal thoughts sit at the end of a road, be it short or long. Compulsive behavior takes over.

The sufferer will often choose to try to drown despair in drink, or smoke it out with drugs. Or compulsive behavior may come in the form of compulsive sex, or compulsive gambling, or compulsive criminal behavior… But it soon becomes clear that drugs, alcohol or whatever compulsive behavior is being engaged in won't do the trick. The angst remains, embedded deep within the soul, cutting through the person's psyche like a knife.

The loss still nags; the issues are unresolved. Drugs, alcohol, sex, crime… nothing seems adequate to alleviate the pain. Boredom, a vicious cycle of world-weariness, sets in. Everything seems gray, and not worth it. The sufferer feels compelled to break the vicious circle. Things can deteriorate quickly.

The suicidal crisis can be compared to a chain of events involving a pressure cooker:

The Pressure Cooker



Stage 1: The cooker, at first, easily handles pressure from external events. Blowing off steam isn't a problem. The safety valve, representing the mechanisms we have to blow off steam, is in perfect working order. Our internal resources are enough for now. A rigid worldview, acquired from a narrow education and upbringing, can affect our valve's capa-

city to let off steam. For example: in a difficult marriage, one solution may be to divorce. But if I come from a rigid upbringing that doesn't allow for this way out of a bad marriage, I may become trapped for life…

Stage 2: When life brings us stress, I can let off steam, or I can let it build up inside my pressure cooker. Keeping everything within becomes dangerous over the long term. It reduces the space available for storing life's frustrations and worries. A sort of doldrums, an emotional dead zone, is created within my heart. I lose my capacity to feel.

Stage 3: A series of emotional shocks, or one traumatic event, leaves very little room for other emotional shocks to be digested. The emotional dead zone takes up almost the entire space reserved by my brain for dealing with difficulties. A tiny reversal, one small negative event, can touch off a crisis. My pressure cooker is taxed to the limit: I could blow up at any moment…

- **A Life Contract**

The pressure must be reduced – and fast. Crisis intervention has to focus on the safety valve. First, the steam has to be let out; then, the counselor has to engage the sufferer in a "life contract" – or, in other words, a "non-suicide pact."

Determine the elements in their life that throw the sufferer off balance. These are the events, the influences, the people that cause the deepest emotional distress. This will give us clues as to what to watch for.

For example: does he get anxious every time he runs into his ex-girlfriend? We can suggest that he stay away from places where he might run into her. And if he must meet her for some reason, perhaps he shouldn't be alone. He should take a friend he can trust for support. He can then air out his feelings with his friend after each encounter. The friend should be made aware of what resources are available should warning signs appear: that includes internal resources (our training, attitudes, education, personality strengths and weaknesses) and external resources (help lines, counselors, psychologists, drop-in centres, books and websites, hobby shops, etc.).

- **Everyone is Different**

Emotions can make what seems to others to be an insignificant event feel like it's the end of the world to us. A person's filters can act like a magnifying glass, intensifying a glint of sunlight into a white-hot beam. We're not all made from the same mould.

The American poet Gladys Cromwell [1885-1919] grew up in a privileged, private school environment in New

York City. At the outbreak of World War I, she and her twin sister volunteered for service in the Red Cross. Working in the muddy, bloody trenches of northern France, the Cromwell twins fed and cared for wounded soldiers. Millions of people on both sides of the front experienced this horrific war in different ways. The Cromwell sisters were highly sensitive souls. They came to feel that they had no place in a world with no place for beauty and quiet thought. On their way home from France, in January of 1919, the twins committed suicide. Together, they jumped from the deck of the steamer Loraine.

Through her writings, Gladys Cromwell transmitted her sensitivity. Before her death, she also transmitted her suicidal thoughts in writing. Her poetry is deeply thoughtful and almost sculptural in its chiselled beauty. It shows the reaction of a beautiful spirit to a harsh world. One poem above all is applicable to the subject we are dealing with here:

The Mould *by Gladys Cromwell*

No doubt this active will,
So bravely steeped in sun,
This will has vanquished Death
And foiled oblivion.

But this indifferent clay,
This fine experienced hand,

So quiet, and these thoughts
That all unfinished stand,

Feel death as though it were
A shadowy caress;
And win and wear a frail
Archaic wistfulness.

Has Gladys Cromwell handled the horrors of trench warfare differently, she and her twin would have lived on. We would have been able to enjoy more poetry of exquisite beauty. But hers was a chaotic time, full of death. What we can learn from her life story is this: a person's temperament will determine how each individual reacts to the reversals life deals out.

The steamer Loraine brought hundreds of war veterans back to New York to continue with their lives. Using their war experiences to their advantage, they raised families, worked at productive jobs.

For many, horror deepens the soul and broadens the mind. It can motivate people to try to build a community, a society, in which such destruction is never seen again.

- **The Point of No Return**

There is a point of no return. It is a place in the emotional landscape past which talking is not enough. If as a

counselor you think that the pressure cooker is about to blow, your duty is to call upon emergency measures. These measures will vary according to what is available to you, and what you are permitted to do by law. The organization you are associated with will have its powers as well as its restrictions. It may have specific protocols and procedures. If you work for an organization, you may be able to do some things, and not other things.

It's also vital to evaluate whether or not the suicidal person can function in his or her own environment. Sometimes it's best to remove the person from his or her usual haunts for a period of time, or even permanently. A move can be a renewal of life. But is that within your capacity? What are your limitations?

Knowing how to build a support network outside the sufferer's neighborhood is important. Perhaps more resources can be made available in a different place. Perhaps negative emotional triggers won't be present in a new place.

Referring the sufferer to a crisis centre, even a hospital, may be in order. *Reflet de Société* and the *Café Graffiti* work with a variety of community support groups. An inventory is published in every issue of the magazine. The refletdesociete.com website is linked to many such agencies and organizations in the province of Quebec.

Knowing where you can reach out to makes your job doable. Giving the sufferer places to go is vital: people in this situation must know that they are not alone, that they can change things if they reach out to the right helping hand. Offering that hand is a human privilege. It's all about infusing hope where precious little exists.

The sufferer in crisis must be made to feel, to know, that no situation is insurmountable. Death is not the only option. We are all empowered by our human condition to change things.

- **The Chain of Events**

The length of time between the instant of personal loss and the act of suicide itself will differ. But events normally follow a certain progression, whether it takes hours, days or weeks. Generally stated, the process takes about 6 to 8 weeks. For the chronically suicidal, things can percolate over a course of months or even years.

1) **At the start**, the sufferer experiences a grave, difficult situation. He or she does not find a solution from within the personal or community resources available to them. This provokes a deep desire to flee from the pain.

2) At some point, the idea of suicide crosses their mind. **Suicidal ideation** is at first fleeting. It starts with a vague notion, a momentary flash. There is no real plan formed, no thought of consequences. But the idea will reappear later on.

3) If things don't work themselves out, this ideation will creep into the sufferer's thoughts, gradually, like the tide lapping up on shore. Slowly, as other options don't present themselves, this neat solution will seem almost logical. When thinking about ending it all becomes an everyday part of the sufferer's

mental furniture, the planning process will begin. Suicide becomes an obsession. At the same time, the subject will raise questions. There will be fears: the sufferer will ask, silently, within the private confines of a confused, pained mind: *Am I going crazy? After all, I'm already suffering more than I can bear…* This part of the progression is called the **reflection** phase.

4) Now we reach the danger zone: the **crystallization** phase. The sufferer is fixated on what appears, in their tunnel vision, to be the only possible remedy. Suicidal ideation sets, like concrete. What once seemed absurd now appears feasible, even desirable.

5) This leads quite naturally to the **planning** phase. Generally, with most suicides, the planning phase is no confused, random state of mind. The sufferer is busy choosing a date, time, method and place.

As the sufferer moves towards the ultimate irreversible act, other solutions, other options to alleviate their psychic pains seem outmoded, obsolete, beyond even considering. There is a certain detachment. The sufferer is ambivalent until the final moment. **A suicide can be stopped at any point before the very last second.** The only point of no return is death itself.

- **Possible Outcomes**

  Here are some possible outcomes of the suicidal crisis:

  - If the sufferer receives or gets the help they need to make key changes in their life, there can be some improvement.

  - The sufferer can suddenly, miraculously, seem to snap out of it. Depression changes to euphoria without notice. The sufferer seems to have no problems whatsoever. That's when you *really* have to be on guard. In someone so changeable so quickly, suicidal ideation can reappear at a moment's notice. Suicide can once again seem to be the only option.

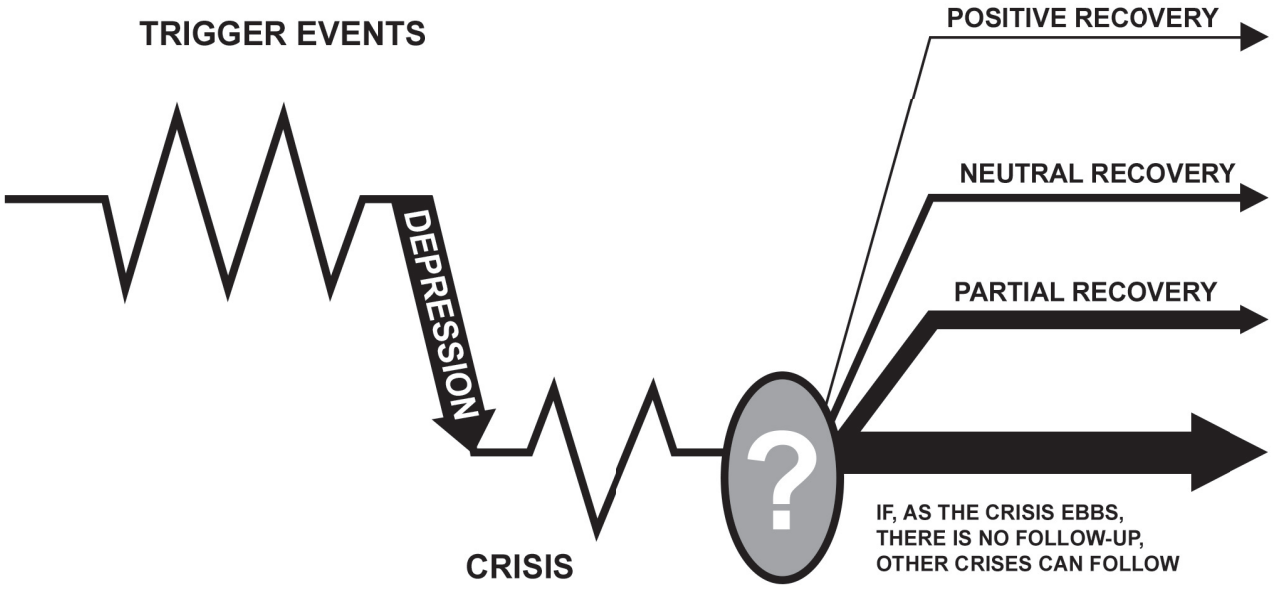
  - The sufferer attempts suicide.

An Attempted Suicide

The sufferer carries out a plan, but, happily, it is not completed. When an attempt is made:

- The suicidal process can be stopped if the right sort of help is offered and accepted *immediately after the attempt*.

Timeline of a Suicide Attempt



- A spontaneous remission to a calm, measured state can be a sign that a second suicide attempt is being planned. Resolving this second crisis depends on several factors, including: the individual's personality, including life experiences, the nature of the events that provoked the crisis, the resources at hand in the individual's milieu.

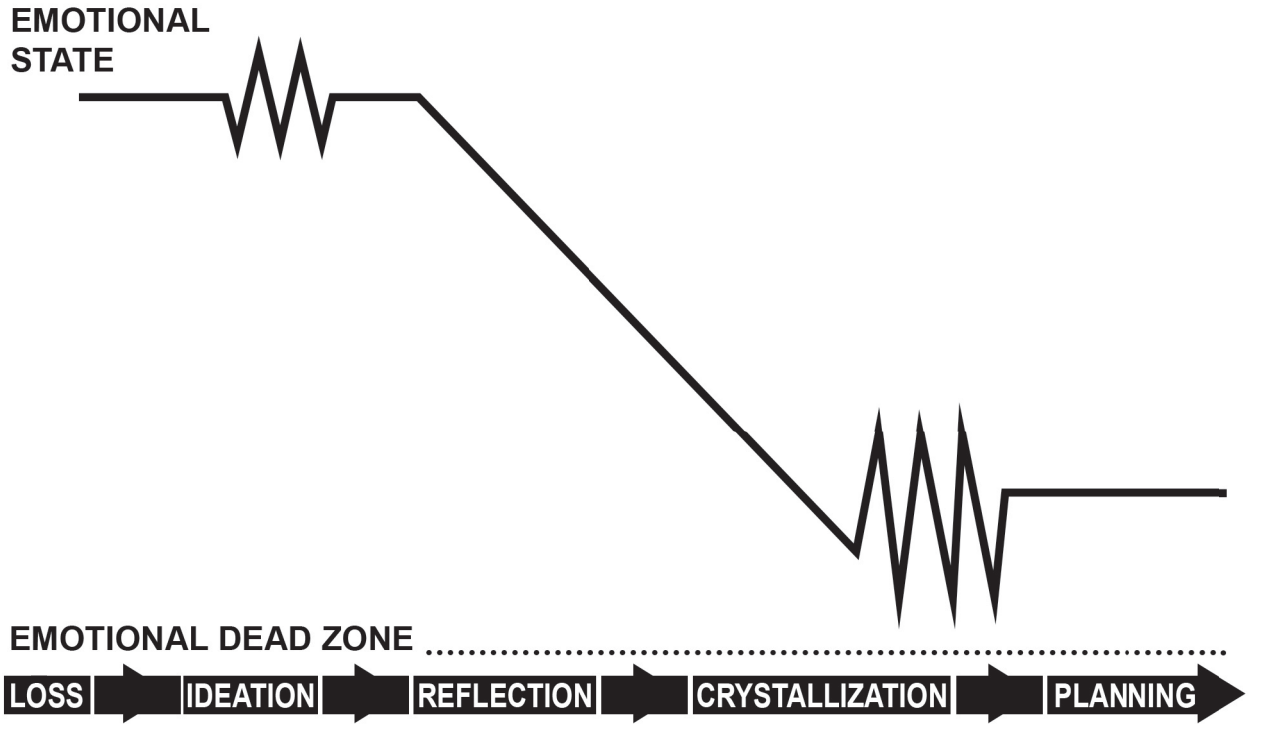
Once the crisis has passed, you as a counselor face a choice: which tools best fit this situation? How can we get the sufferer on the road to recovery? Once suicide has been averted, or an uncompleted attempt has been made, then your work really begins.

- **Formulating a Recovery Plan**

It's often not the place of a crisis counselor to participate in long-term therapy. Other specialist resources might be better suited to the moment. In the short term, the important thing is to get the sufferer to realize that he or she needs a long-term program for recovery. They need a plan.

It's time to establish where the resources will come from – the how and the when. If you can furnish these resources, all the better. Know what's available in your community, on the web, at the library – and within the sufferer's own heart and mind. The human heart is a wellspring of strengths and complexities. Our souls harbor untapped, un-

Evolution of Suicidal Thoughts



told tools and reflexes geared to our survival, built over millions of years of human evolution. The capacity to love, to learn, to struggle, to breathe, is bottomless.

For a thousand years of antiquity, the centre of the universe was determined to be the Temple of Apollo at Delphi, on the slopes of Mount Parnassus, in Greece. There, in Greek, inscribed on the front of the temple was what all humankind believed to be the most profound bit of wisdom in the world. The inscription read: *Know Yourself*. Introduce your sufferer to the best that lies within their own heart.

In the diagram entitled **Evolution of Suicidal Thoughts**, we can see that at the first stage, many solutions cycle through the sufferer's thoughts. But time is needed to deal with the loss. And there is seemingly, in the sufferer's mind, no time to properly deal with the pain being felt. The pain is too great, the loss too important, to adequately grieve.

The means to deal with these feelings aren't at the sufferer's disposal. The mind yo-yos, then goes in a tailspin.

During the depressive phase preceding a crisis, the sufferer starts categorically ruling out possible solutions thought up in the beginning phase. If the slide continues, solutions suggested by others will also be ruled out.

But if the sufferer earnestly looks for ways to deal with their inner anguish, they may find a positive method.

Just being open to talk to friends might be enough for the moment. If the sufferer isolates him or herself, the slope will likely continue downward; if the sufferer reaches out and establishes contact with someone they can call back, then recovery prospects are hopeful. If no one from his or her immediate circle is available, or desirable, then it is up to you the intervener to provide someone to fulfil the vital role of confidant.

You must present the potentially suicidal person with every positive, life-affirming option you can think of. Our role as counselors is to make the sufferer know that life is worth living. That there is light at the end of the tunnel.

As the sufferer eliminates options, suicide looms ever larger on the horizon of their melancholy thoughts. At first, it is one option among many; then, it becomes a likely, practical option; and finally, it seems to become the only way out.

This is when the planning phase begins. The sufferer thinks about “when”, “where” and “how”. Details get nailed down. At this stage, you have to go up to the person face-to-face and ask direct questions about whether or not they are considering suicide. The answers you receive will guide how you continue your intervention.

- **Direct Intervention**

Intervening to save the life of a suicidal youth means conveying a sense of hope: you must be warm and very, very human in your approach. A spirit of simplicity and humility on your part is absolutely necessary. Without humility in your heart, you'll never find the right way to approach a distressed person. You want to convey, from the heart, why life is worthwhile, and what can be done to alleviate the sufferer's emotional burdens.

The following advice is the product of trial and error, of years of efforts by many, many suicide prevention workers, including Raymond Viger. Here, then, is how you should approach a suicidal teen, youth, or anyone in such deep distress, for that matter:

1) Speak Openly

From the moment you suspect that someone might be thinking suicidal thoughts, be direct. Talk like an adult. By raising the topic of suicide, you are in no way increasing the risk that someone might attempt suicide. And you can't make someone suicidal who hasn't considered the option just by raising the subject in conversation. This is the time to be frank.

If you have any doubts or suspicions at all, just ask: "Are you thinking of killing yourself?" If the answer is yes,

determine if any planning has taken place (where, when and how).

Offer help and understanding. By asking these questions and listening carefully and patiently to every answer, the real risk level can be evaluated. How far ahead is the planning process? How much time do you have to intervene? Can you deal with this yourself with the resources at your disposal, or do you have to call in emergency intervention?

Being frank also means openly admitting how this situation makes you yourself feel. You may thank the sufferer for taking you into their confidence. It's appropriate to express your shock and distress over the sufferer's depression. The sufferer at this point feels a sense of powerlessness and paralysis.

When the person shares with you their suicide plans, don't agree in any way to keep what you hear secret. If the person tries to impose that condition, try to discover why they want you to respect their confidentiality. Then, explain clearly and firmly, yet as diplomatically as possible in the circumstances, that you can't do that.

Keeping such a secret would make you an accomplice. You wouldn't be able to continue to offer support and help. It would deprive the sufferer of a whole range of options, of ways to dig themselves out of the abyss they find

themselves in. Stress that you, as a counselor wouldn't be able to continue to share the sufferer's sense of grief and powerlessness if they insist on maintaining confidentiality.

Talking about suicide may be very disturbing. It's common among suicide prevention counselors. That's why you shouldn't remain alone after an intervention. You yourself will need human contact, warmth, support, and many external resources to draw upon. It's never a good idea to work completely alone. Know your own emotional limitations. After all, you are as human as the people you are helping.

2) Be Yourself

When helping a suicidal person, don't take on a persona. Be yourself. Use your strengths, your own character and personality, your sensitivity, to advantage. You wouldn't be in this line of work in the first place if you weren't a sensitive, caring soul. Use that. Your sufferer will smell "fake" if you put on an act.

At the same time, don't fall back on your own myths and prejudices. You may think that someone threatening suicide is simply out to get something out of you. Don't let fears of manipulation creep into your thoughts. Open your heart. Take any suicidal ideation expressed as the real deal. At the same time, this cannot be stressed or repeated enough: be on guard for your own emotional danger signals. These situations can be very upsetting.

Your friend may be manipulating you. The suicide threat may be just a ruse, an act. Still, an intervention is called for. Someone desperate enough to threaten suicide to get attention needs help. There's a big problem there somewhere. Underneath the lie, there is anguish that needs to be dealt with. Listening is worth it. *Don't let fear of manipulation stop you from intervening.*

3) Listen

People on the brink of taking their own lives need to be heard. They need to express their inner pain. Don't try giving a pep talk right off the bat. The time to lift the person's spirits will come later. Be open and warmhearted. This is the time for compassion. Listen. Accept whatever the person has to say as genuine, even if their statements seem exaggerated or off-the-wall. Take the person's perceptions seriously. Don't be pitying or condescending. Indicate that the person has every right to feel low.

You may know the sufferer very well, but you can't be completely familiar with the events that brought them to the brink. Let the person give an account of events in their own fashion, at their own speed. Even if you were there for some or all of these events, you may have seen and experienced them very differently than did the sufferer. Accept that what the sufferer is telling you is real for them.

4) Evaluate the Risk Level: Make a "Life Contract"

It's important to quickly evaluate the urgency of the situation. How close to acting on suicidal thoughts is the sufferer? If the person harbors continual suicidal thoughts; if he or she has the means at their disposal to commit suicide; if the person has already decided on a time and place; you have an urgent case on your hands. The danger level is high. Precautions must be taken.

The person can't be left alone until the risk level has diminished. That would mean that the person has at least calmed down.

At this point in your intervention, make a "life contract," a sort of non-suicide pact. Make this deal: get them to agree that they won't do anything rash if you leave them alone; and that if they think such thoughts, that they'll contact you immediately, before launching on any sort of action.

If the person promises not to do anything rash, and that they will contact you if dark thoughts creep back in, you *may* be able to leave the person on their own for a while. *That is, of course, not ideal*. Be careful. The situation can deteriorate at any moment.

Elsewhere in this handbook, we enumerate specific danger signs. But if you sense that the situation is beyond your control, please contact any of the many suicide hot

lines or help lines, by phone or on the web. They will help you evaluate the situation, and come up with a plan.

5) Look For Solutions

When talking down a desperate person, ask what other possible solutions to their dilemma they may have considered. Encourage them to follow any alternate strategies they have thought over, if they have considered any.

But if they have no way out in mind save suicide, go over their seemingly insurmountable problems with them, one by one. For each problem, come up with possible alternatives. Anything. Think of resources at your disposal. Propose concrete steps to deal with each problem.

Don't be philosophical. This is a time to talk of the tangible, the material. Even if you know in your heart that the solutions you propose are likely to fail in the short term, the important thing is to get the person to explore non-violent exit strategies.

Don't agree to carry out errands. You are there to support anything positive the sufferer wants to try. You are not there to solve all the person's problems in one day. Possible solutions should be tailored to the person and their problems. As individuals, we are all different. Despite the

common trajectory of the downward slide, each situation is different in its nuts and bolts.

Every time you meet with the person you must set a specific date and time for your next meeting – within days, at the latest. Send them away with a concrete plan. It can include things to do, people to contact, hobbies to pursue.

Respect any meeting time you set. Don't be late. Show up, prepared. In the interim, make sure the sufferer knows where you can be contacted. Remain available. Meetings should be short. Your whole attitude should reflect both optimism and realism. Play things a day at a time – an hour at a time, if necessary. Goals should be very short-term.

6) Disarm the Sufferer and the Place of Residence

The questions you've asked have hopefully elicited some valuable information about the distressed person's plans. If they have decided to use a firearm, and they have access to such a weapon, ask whether someone in their entourage can keep the gun for a while until the sufferer's thoughts clear up.

If the method of suicide the distressed person is openly considering involves medication, then ask if you or someone else can destroy the medicine, or at least give it to someone for safekeeping.

If the sufferer is on medication, try to determine the toxicity of their prescription, and if it's dangerous (if for example one bottle taken all at once would kill). Find out if someone can keep the prescription and mete out the required dosage when necessary.

If a specific place has been chosen for the act of suicide, make the sufferer promise not to go there alone. If it's the person's residence, try to get them to stay with parents or friends until the danger passes. If you can, talk to their friends and family to make sure the sufferer is disarmed. There should be no weapons or toxic substances in the sufferer's immediate vicinity at all times.

7) Follow Up; Create a Support Network

Make sure the help you provide is followed up on. Ask the person to contact you regularly, to keep you posted on progress. Keep in touch yourself at regular intervals. Don't try to do it all by yourself. Recruit anyone you can think of who may be able to help – especially, from the sufferer's own circle.

Be the ultimate liaison. Assemble a network of family, friends, helpful resources, community resources, anyone that both you and the sufferer can turn to.

You too will need a support network. Share your fears and joys. Bounce ideas off others. These situations are by their nature very stressful on counselors. Your sup-

port network can, should, overlap on your sufferer's support network.

The arrival of a suicide prevention counselor on the scene can be isolating for the sufferer. Suddenly there's a new person in their inner circle. The sufferer's friends and family may feel relieved of all responsibility for the sufferer's fate and back away. And the sufferer, feeling rejected, may become dependent on you the counselor.

Moreover, if a suicide attempt is completed, some or all of the sufferer's friends and family may blame *you* for the death. Your best strategy, both in terms of your chances of success and for your personal protection, is to act as a liaison between the sufferer and any chosen points of aid and assistance.

The systematic team approach is, realistically, the best way to go about preventing a tragedy. Break the person's sense of isolation by getting a team involved. To build your network, don't hesitate to get in touch with the sufferer's family, friends, work/school colleagues, mentors… Use any institutional resources at your disposal: CLSCs in Quebec, drop-in centres, psychologists, doctors, community centres…

A group populated by family friends and colleagues, will seek and find balance in their relationships. A troubled soul can find stability through communication with those in

their group who form their everyday environment. A desperate, unbalanced mind has many victims. The sufferer's whole circle is thrown into disequilibrium. The darkness spreads; the sufferer withdraws to face the fear alone. As humans, we withstand shocks far better in a group setting.

It is human nature, part of our evolutionary survival reflex, to crave balance. Instinctively, we withdraw from things that cause us unease. Working with a person's circle can help restore balance and peace to the entire group. You are helping not just one person, but many.

If the sufferer is transferred to a hospital setting, you may decide to stop your intervention efforts immediately. Or you might offer to visit the hospital. You can use these visits as opportunities to help the sufferer build a support network. Whatever the case, use any opportunity to work with the sufferer and their support network.

Teach everyone how to use communication to confront and overcome crisis moments. Any group of people working together carry within them a natural ability to manage hard times faced by one member of the group. Working together, we humans are incredibly resilient. Moreover, you get far more out of life within a personal network than you do living life alone. Life's joys, life's learning experiences, life's triumphs are all sweeter when shared. Your network doesn't have to be large. A personal support network can include a spouse, children, and a few friends.

8) Know Your Limits

It goes without saying that any support you can offer the suicidal person on first contact may save a life. But there are things beyond your capacity. You can't be with the sufferer 24/7. You have to live to fight another day, to help another one. Know what you can and cannot offer. Make these limits clear to the sufferer as soon as you think they can handle the information.

When we set limits on our intervention, we have to make sure there are other resources there. Set things up so that there are people to carry the torch when you're not around. Make sure that the suicidal person knows exactly what, who and where these resources are.

Convince the person to draw upon them. Make sure he or she knows that there is no stigma in getting help from places outside of yourself.

9) Refer, Accompany the Sufferer

You can't leave the sufferer alone. You can't agree to keep their secret. Help means talking. Try to find someone else within their immediate circle who they can confide in.

But often, this isn't possible. Regardless, steer the sufferer towards the resources you've identified that can help them through this crisis. Often, those in the inner circle are too close to the situation, too tied up emotionally, or

otherwise unable to provide the help and support the sufferer badly requires. An outsider is better situated to provide that support.

Don't just leave a phone number or a web address, then take off. If the line is busy, or they can't get to a computer, what then? If they don't make the effort to call, what happens next? Accompany the suicidal person to the resources you've chosen for them. Sit in on the first meeting.

If the sufferer doesn't trust a helper you've chosen, you can try someone else. At this point in your intervention, make a "life contract," a sort of non-suicide pact. If you've done so already at step 4, do it again. Commit the sufferer to choosing life. It's a way of assuring the sufferer that there will be follow-up, that your intervention isn't a one-shot deal.

10) Beware

Despite your help, the sufferer may go ahead with their suicide plan anyway. This may happen even if you've done all you can, and you've done everything exactly right. This is a volatile, unpredictable situation. You're not the only factor in the sufferer's thinking. Keep in mind that you're there to help, but that you can't save every life. A failed suicide intervention is not your fault.

You can intervene in several ways. But you can't do it all. Suicide prevention work has its limits: physical, psychological, financial…

11) A Checklist of Suicide Prevention Dont's

Don't:

- ✓ Lecture the suicidal person, or preach morality.
- ✓ Reprimand them for their faults.
- ✓ Judge.
- ✓ Offer your own recipe for personal happiness. No easy formula for personal well-being fits everyone. There is no one-size-fits-all to being content in life. What works for you probably won't work for someone in desperate straits.
- ✓ Pretend to have all the answers. Suicide prevention work demands humility on your part. It's a team effort.
- ✓ Make promises you can't keep. A promise made to someone considering suicide can become a life-or-death proposition.
- ✓ Do everything for your sufferer. This will make them feel useless. Or dependent. Rather, help the sufferer do things for him or herself. Facilitate. Work within a team. Make the sufferer feel part of this team. Help the person get involved in life and in living.
- ✓ Isolate yourself with the sufferer. This requires teamwork.
- ✓ Taunt or challenge the sufferer to commit suicide. This can trigger the act itself.
- ✓ Use language that may justify a suicide attempt.

Talk in terms of the finality of suicide. A decision to kill oneself can never be reversed. The problems left behind for others to clean up will just intensify. Talk of suicide as the absolutely worst option imaginable.

- ✓ Romanticize suicide. Don't talk in terms of courage versus cowardice; don't praise famous suicides of the past, or even people you or the sufferer may have known who made the transition from contemplation to action. It's an act of desperation intended to relieve insupportable suffering, period.

12) The Limits of an Intervention

An intervention involves accompanying another human being through the darkest, most difficult moments they will ever live. Offering an ear entails hearing out a whole series of grim emotions that may provoke demons within your own psyche to rise to the surface.

If you turn a deaf ear to the emotions you yourself feel as you listen, you will end up shutting yourself off to the sufferer. You'll stop listening. You may well miss a distress signal sent your way.

Any intervention is upsetting. You may start to question your own existence. You have to take the time to talk about the emotions raised by the intervention. If you don't,

you'll greatly reduce your effectiveness as a suicide counselor. You'll become cold and indifferent inside as well as outside.

In the midst of an intervention, in a moment of confusion and powerlessness, you may ask yourself:

- Have I done all that's within my power to provide the help the sufferer needs?
- Is there something, a doubt or a worry, that I haven't yet shared with the sufferer?

An intervention can become a moment of personal growth for you as the prevention counselor. But this can't happen if you work solo. The team you assemble around you will provide the context. Be on guard – determine the direction you want to take, and then make sure you're heading the right way. Every intervention will be different. Always make sure you know who you will pass the baton to when you leave the sufferer's presence.

13) The Emergency Phase

If you have determined that there is a high probability that the sufferer will attempt suicide in the next 48 hours, you have an emergency situation on your hands. Act fast.

Your evaluation will take the form of a discussion, including a series of questions. Show an attitude of openness

and of compassion during this interaction. Keep in mind the tools at your immediate disposal, including any outside resources on hand.

These are the three direct questions to ask:

- *Have you thought about taking your own life?*
- *Have you thought about how you'll commit suicide?*
- *Have you thought about when you'll commit suicide?*

The answers you get will determine how you proceed. Keep in mind that a sufferer can rapidly shift from being at low risk to commit suicide to being at very high risk. Surround the sufferer with support as quickly as you can. Familiarize the sufferer with the tools at their disposal.

In a high-risk situation, you have several priorities. Remember to disarm the person and their environment. Get the person away from guns, or whatever tool they may be thinking of using to kill themselves. Secure the vicinity. Accompany the person to the appropriate resources.

Think of hospitalization if necessary. Emergency services have their role to play. There's a point at which phoning "911" is entirely appropriate. If you lose contact with a sufferer, of if a sufferer cuts off contact with you, 911 is the place to go. *Don't hesitate to resort to emergency services even if you don't have the sufferer's consent.*

I've done it several times, *writes Raymond Viger*. It's not an easy decision to make. But it's better for the police to batter down someone's door and find that they're okay than for someone to turn up dead the next morning. Ask yourself this question: *If my sufferer commits suicide, can I honestly say I did everything I could?*

Here is a checklist of points to follow up on in a crisis situation:

- ✓ Help the sufferer to understand that they have been cut off from the help and support that is there for them from those closest to them.

- ✓ With the suicidal person, create a list of significant contacts that can be available in dark times. Usually, the sufferer hasn't realized just how many resources they already have at their disposal.

- ✓ Are there specific problems that some specific person on your list can assist the sufferer with? If not, the counselor can make introductions to people or organizations that can help with a specific problem. You can even accompany the sufferer to any first meeting.

- ✓ With youth, *writes Raymond Viger*, I have found that it's vital to get the sufferer interested in activities. Music,

art, and dance are wonderful creative channels. The sufferer can exorcize inner demons through painting, poetry, rap, dance, sports… Community resources can provide such outlets. And these places can bring the sufferer in close contact with other artists – and with a public that appreciates their art.

- ✓ Create a support network. Draw on every contact you can find from within the sufferer's everyday world. Add contacts from your crisis counseling milieu. Often, you'll find to your astonishment that the sufferer's family and close friends had no idea the sufferer was in any distress at all. In other cases, they may have sensed that something was very wrong, but were afraid to get involved in case any help they may offer might backfire. The more outside contacts the sufferer interacts with, the more opportunities there will be for the pressure building up inside to be relieved. It's all about outlets and safety valves.

- ✓ Convince members of the sufferer's entourage that all human contact will help, especially when interactions are filled with love and hope.

- ✓ Often, by the time you get involved, a professional is already implicated – but the sufferer won't confide in the professional. Your role may be limited to getting

the sufferer to put their trust in the professional. Opening up communication channels is key. That includes both external communication channels and the sufferer's own internal communication channels.

- ✓ When re-establishing contact between the sufferer and his or her circle, you'll have to deal with many of the factors that led to the sufferer's isolation in the first place. Members of the entourage may be afraid to deal with the sufferer in a distressed, depressed state. The sufferer may be afraid to be labeled crazy; to be shut up in a mental asylum; to get fired from a job; to show vulnerability in a tough milieu; etc.

The following table is designed to give you clues on the urgency level of a suicidal situation based on the sufferer's outward behavior:

URGENCY LEVEL FOR POTENTIAL SUICIDE SITUATIONS		
EMERGENCY LEVEL: LOW	**EMERGENCY LEVEL: MODERATE**	**EMERGENCY LEVEL: HIGH**
Doesn't seem too anxious or upset.	Appears emotionally and mentally fragile.	The crisis is obvious: the sufferer appears to be deeply emotional, or else cold and emotionless.
Makes no, or very few, threats to commit suicide.	Harbors suicidal ideas; doesn't question those ideas.	Appears resolute: a plan has been decided upon (where, how, when). The means are at their disposal.

EMERGENCY LEVEL: LOW	EMERGENCY LEVEL: MODERATE	EMERGENCY LEVEL: HIGH
Relatively calm.	Goes from calm to stormy in the blink of an eye.	Agitated, or petrified by depression (difficulties speaking).
Not unusually joyous, elated; not unusually sad or depressed	Elated or depressed, but appears to quickly calm down, but resolved, as if he/she might go through with suicide.	“Sick of living, afraid of dying.” Scared to act; frightened of what he/she is capable of.
Obviously depressed, but is telling you: it’s alright, everything will work out, it’s under control. He/she promises to contact you if things take a turn for the worse.	Troubled, overtly very emotional, but still somewhat under control.	Says he/she can’t take it anymore.
Seems to be accepting your help.	Says he/she doesn’t need your help.	Doesn’t want your help even when you call or visit.
Admits to be afraid of losing control.	Feels as if he/she is starting to lose control.	Has clearly lost control.
Talks of future plans. But beware if those plans involve taking a trip. Verify that the trip is real.	Agrees to not kill self immediately, but only on condition that you see them again very soon.	Rationalizes, justifies suicide
Expresses troubled, disturbed ideas; but is open to exploring solutions.	Troubled; has identified suicide as a primary option, or the main option.	Completely resigned and overwhelmed; or, explains decision to commit suicide.
A suicide attempt is possible	A suicide attempt at some point down the road is probable	A suicide attempt in the immediate future is probable

Evaluating Medium-Term and Long-Term Suicide Risk

Measuring the risk of a suicide entails evaluating the probability that someone will attempt to kill him/herself in the next two years.

If I told you that your father or other close family member might kill themselves at some point in the next two years, you might not run to the nearest emergency ward to get an ambulance. But it would mean that you'd spend more time with your relative, get closer, talk, figure out what was going on inside their thoughts.

You'd help your loved one overcome their internal demons, work to pull them out of their depression, etc. You'd follow your loved one's progress closely. You'd keep track of events in their life.

In short, you'd do everything you could to ensure that their depressed state didn't slip into a suicidal state. You'd provide any help you could think of to get your loved one to fall back in love with life. The risk level rises as the depression deepens. Factors aggravating risk include social loneliness; poverty; absence of external resources; poor health; alcohol and/or drug consumption; a history of previous suicide attempts…

The following table catalogs a few criteria to help you evaluate risk:

EVALUATION GRID: SUICIDE RISK FACTORS		
LOW RISK	**MEDIUM RISK**	**HIGH RISK**
Vague, ill-defined depression; the sufferer feels lonely and/or useless	The person is in crisis. A significant personal loss has been experienced; separation, divorce, death in the family, job loss, health, etc.	Suicidal intentions are expressed frequently and with precision
A depressed state that doesn't last.	The person is drinking and/or taking drugs, feels useless.	The person tries to adapt, change, get better, but experiences frequent failures on all counts.
The sufferer is in therapy with a psychologist or other professional.	The person exhibits frequent bursts of impulsive behavior	The person feels trapped, unbalanced.
The sufferer is hungry for affection and attention and seeks such through occasional expressions of suicidal intent.	The sufferer openly considers suicide as a serious option, but seems to have made no plans yet.	Chronically suicidal, the sufferer feels he/she has exhausted all available internal and external resources.

Given our long-term perspective, any risk evaluation that doesn't foresee an immediate, short-term danger is useful.

No one can see everything going on inside another person's mind – indeed, we never quite know much of what is going on inside our own.

A person can go through a divorce or a job loss and present no suicide risk at all. A whole host of factors must be considered. Keep the person's whole life history and personality in mind.

Mourning a Suicide

"A suicide kills two people, Maggie, that's what it's for."
- Arthur Miller, playwright,
After the Fall, 1964. (*Act 1*)

A suicide has many victims. Those around the deceased in their final days will likely all be deeply affected, as will you, the suicide prevention counselor.

Mourning a suicide is not like mourning any other sort of death. This variety of grieving has many unique features. The emotional damage is more profound and more complex than that resulting from a natural passing. The difference lies in the guilt those left behind may feel, the culpability and shame associated with another's death:

- *"I should have kept in touch…"*
- *"If I'd only taken the time to…"*
- *""What if we'd…?"*
- *"Why the hell did I say that to him?"*

Suicide is still something of a taboo subject. In the past, it was even more taboo. It remains unmentionable and stigmatized in many cultural communities you may end up dealing with. The suicide's entourage may themselves feel a social stigma for being associated with such a tragedy. The remorse, the recriminations, the shame can tear apart

the survivors. Many a family has been destroyed in the witch-hunt for scapegoats…

Many myths and prejudices can quickly reappear in the wake of a suicide:

- *"The whole family's nuts…"*
- *"It gets passed down from generation to generation, everyone knows that…"*
- *"I don't want my children playing with his brother. He might be…"*

Mourning a suicide is incredibly, intensely painful. The bereavement process can be far longer than for a natural death. There are specialized resources available for the families of suicide victims. Groups exist to help survivors deal with guilt: guilt over not having done enough; guilt over being the one left alive…

Don't let pain linger on inside. Reliving the moment will paralyze your life. Writing from a dark, foul prison cell in 1896, the Irish writer Oscar Wilde wrote an open letter of apology to his friends and his public entitled *De Profundis* (Latin for "from the depths"). In it, he explained:

Suffering is one very long moment. We cannot divide it by seasons. We can only record its moods, and chronicle their return. With us time itself does not progress. It revolves. It seems to circle round one centre of pain. The

paralysing immobility of a life every circumstance of which is regulated after an unchangeable pattern…

For us there is only one season, the season of sorrow... It is always twilight in one's heart... And in the sphere of thought, no less than in the sphere of time, motion is no more. The thing that you personally have long ago forgotten, or can easily forget, is happening to me now, and will happen to me again tomorrow.

Group encounters allow a mourner to break what Wilde called the "paralyzing immobility of a life centered on the one moment you live again and again." Wilde was in jail: but there are many prisoners in this world who aren't trapped in any jail of human construction.

You who were close to a suicide victim can easily become a prisoner of the moment in time when someone you cared about took their own life – and a bit of yours as well.

As a counselor, it's vital to not downplay or trivialize events. Suicide prevention continues after someone has taken their own life – now your job is to prevent suicides from within the entourage.

You may forget that you yourself may well be part of that immediate circle. It's a lot easier to prevent further suicides if you've already integrated yourself into the deceased's crowd. And whether or not you've become close to that crowd, don't forget that you have to go through the mourning process, too.

- **Phases of the Mourning Process**

1) Shock

At first the mourner is in shock. He/she will continue to live a normal life. The suicide won't have made make much of a psychological impact, from all outward appearances.

In reality, the mourner hasn't accepted what has happened as a real fact. He/she can't digest the fact that the suicide really happened. We often turn our backs on feelings of abandonment, anger, and personal responsibility in a busy world. It's a survival reflex. But these feelings must be confronted and dealt with.

The shock phase can last anywhere from days to weeks. The longer this phase, the more severe the next phase will be.

2) Protest

This phase can come about very quickly if the first phase (shock) is particularly long. The mourner searches for reasons why the death came about.

When those answers don't readily appear then anger, rage and resentment can ensue, not to mention shame and guilt. The mourner will refuse to accept what has happened: he/she may even outwardly deny that the suicide even took place.

Questions mourners ask of themselves may include:

- *Why him and not me?*
- *How is this possible?*
- *Whose fault is this anyway?*
- *What can I do to prevent other similar suicides in future?*

At this stage, some will react with concrete deeds. They may establish a fund to memorialize the departed; they may go to work to prevent similar tragedies. It can be dangerous to let someone who hasn't completed their grieving launch themselves into such a project. Mourners may quickly feel frustrated and powerless when they realize that they can't change the world in one day. Which can lead to suicidal thoughts.

If a mourner gets involved in suicide prevention solely to avoid mourning, it can lead to no good. This is a disaster waiting to happen. Some in the media will cheer on mourners who get involved in this line of endeavor, especially if the suicide itself was high profile. Death is good for ratings. Death moves people.

We in the prevention community have seen such cases, *observes Raymond Viger*. In one particular instance that still touches the heart, we urged the mourner to finish his grieving before sticking his face in front of the cameras. Journalists convinced him that he was doing important work,

that he could help a lot of people… It's easy to play on the guilty feelings of a grieving man. Within a few months, he had taken his own life. He was completely exhausted. The taxing work of intervening in crisis situations had worn him out.

The media got what it wanted: a good show.

3) Disorganization and Despair

At this phase, the mourner starts to rethink their relationship to the deceased, and comes up with new ways to relate to what has transpired. This will play very heavily on the mourner's own sense of personal identity. This part of the process can take many forms.

The mourner may start to question him/herself as a person. The mourner may take on some of the departed's personality traits. The mourner may feel increasing guilt over the suicide. The mourner may even feel guilty about being relieved over the death – dealing with someone threatening suicide can be challenging to say the least. A loss of self-esteem among the living is often the result of this phase.

Moreover, all those connected with the suicide in the intense final stretch before the death itself may well experience an existential crisis. You as a counselor may ask yourself: *What is life all about? Is it all worth it? What's the point?* Mourners can go through the same thing. This line of thinking breeds suicidal ideation.

4) Reorganization

This phase is characterized by a new interest in the outside world. The mourner is ready to get on with his/her own life. New acquaintances and friends are made. New love may blossom. The quality of this readjustment will depend on the mourner's psychological resilience, as well as his/her capacity to form new bonds with others. Adaptability is key.

Mourners will naturally be fearful of entering into new relationships. They'll act to protect themselves from another separation. They won't at first fully invest in the new person. Eventually, at the end of this phase, the mourner will be able to think about the departed without experiencing crippling grief.

After starting out on their new life, a mourner has to be able to vent, to express emotions of grief and loss. Moral support from others will allow the mourner to return to a normal rhythm of life.

All this is part of human existence. We are all but mortals. Everyone mourns; everyone suffers loss. The mourner must be made to understand that the disturbed, depressed state of mind that follows a loss is perfectly natural. It does *not* indicate feeble-mindedness or insanity.

COMMUNITY RESOURCES

It's important as a prevention worker to find out ahead of time which resources can provide services in English, as well as in cultural community languages. This is true in and out of Quebec. Not all of your clients will be fluent in English or French.

In the province of Quebec, there is a toll-free number for anyone in an emotionally bad state: 1-866-APPELLE (277-3553). The province boasts 33 suicide prevention centres. The operator can refer you in a pinch: just call 411 or consult: centredecrise.ca/centre-de-crise.html.

On the web, the Quebec Suicide Prevention Association (AQPS) is at aqps.info. They coordinate the province's 33 prevention centres. Emergency services in Quebec are provided by Urgences-Santé. Just call 911.

The following listening helplines are available:

Suicide Action Montréal:	(514) 723-4000
Tel-Aide:	(514) 935-1101
Tel-Jeunes:	1-800-263-2266
Jeunesse J'ecoute:	1-800-668-6868
Déprimés Anonymes:	(514) 278-2130

Libraries provide an impressive inventory of books on the issue of suicide. Prevention centres can provide specific materials relevant to your situation.

A Final Note

Suicide prevention is a team sport. This handbook is the product of years of hard experience, but it is by no means the last word on a complex subject. If you see anything in this handbook you'd like to comment on, please do not hesitate to contact the authors.

E-mail raymondviger@editionstnt.com or write to the authors at: 4233 Ste Catherine Street East, Montreal, Quebec, Canada, H1V 1X4.

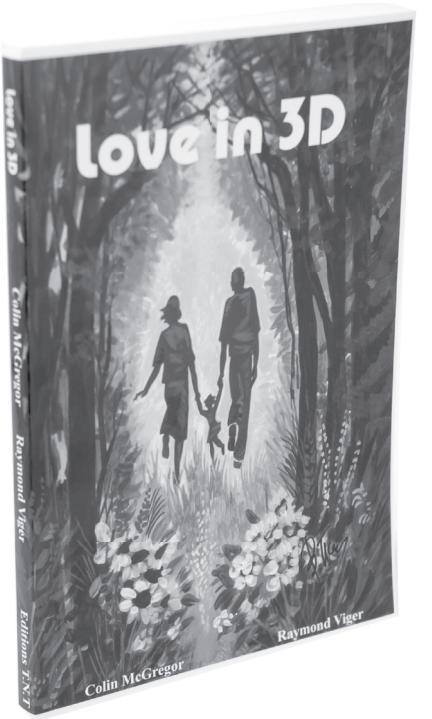
And please check out the refletdesociete.com website, which will give you a window on the Café Graffiti as well as the youth magazine *Reflet de Société*, which boasts half a million readers every two months across the Francophone world.

In December of 2009, 16 year old Vincent Godin killed himself.

His father, Éric Godin, an illustrator and a friend, the artist Zilon wrote and illustrated the book, *Lettre à Vincent*. You can read this book free of charge at: http://www.vincent-godin.com.

In 2011, Canada's National Film Board released a film based on this book. This film can be seen at: http://lettreavincent.onf.ca/#/lettreavincent.

From the Same Authors



Love in 3D

Driven to the brink by divorce and the death of a close friend, the hero of this comic tale finds solace in art, music and dance – with the help of a mischievous, mysterious therapist known only as "Tom." A novel meant to inspire and help guide those who are in the labyrinth of a broken life out into the light. 214 pages; available through editionstnt.com, or at better bookstores in select locations.

There is no one set formula for why decent people come to consider suicide. Each comes to the edge of their personal cliff in their unique way. The journey a person takes from loss to suicide is for most people - especially for youth - the same downward spiral. The trajectory is remarkably similar - and preventable, if help is offered soon enough, in a caring, humane manner.

Raymond Viger, writer, activist, is a veteran of over 20 years working as a suicide prevention counselor in Montreal and in Quebec's far northern communities. His French-language handbooks have helped thousands. To produce this English adaptation he teams with Colin McGregor, journalist and teacher, whose 23 years' experience as detainee in some of Canada's grimmest prisons lend this work depth. The knowledge and techniques in this handbook are meant to be used in any crisis situation: a valuable resource for interveners and sufferers alike.

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