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THE PROBLEM OF CULTURAL STEREOTYPING IN THE PASTORAL CARE OF A SUICIDAL PERSON

ABSTRACT

Suicide is a complex phenomenon; attempts to reduce or prevent it remain a challenge. Completed suicide has a deep negative impact on society. Suicidologists estimate that suicide will negatively affect at least ten times as many people as an accidental death or sudden death from illness. This article attempts to contribute to the prevention of suicide. It explores the future of pastoral care for a suicidal person using European and African contexts. It identifies cultural stereotyping as a problem that has influenced pastoral care. It argues that an objective challenge to the stereotypes and a possible dialogue of cultures and approaches is needed. Particular reference to the culture and spirituality of the suicidal person could be proactive to pastoral care of suicidal persons in our multicultural society.

1. INTRODUCTION

The facts on suicide by the World Health Organization reveal that, in every 40 seconds, a person commits suicide somewhere in the world; every 3 seconds, a person attempts to die; suicide is among the top three causes of death among young people between the ages of 15 to 35; each suicide has a serious impact on at least six other people; the psychological, social and financial impacts of suicide on the family and the community are immeasurable (WHO 2000). This statistics impacts on the society a great deal and challenges the meaning attached to life. Suicide is a challenge to all members of the human community, irrespective of their culture, beliefs and world view, to ensure social order, and integrity for the present and future survival of the society.

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Our focus is on the possible prevention of suicide by drawing our insight from European and African cultures and world views which could provide a holistic pastoral care for a suicidal person in, what we call, the global culture. By global culture we mean the fusion of cultures as a result of immigration and technological advancement and accessibility. The possibility of open and dynamic dialogue between cultural stereotypes is a challenge to better pastoral care. This article, therefore, aims to contribute to the future of pastoral care especially for suicidal persons by proposing challenges to cultural stereotypes in the models of intervention. A shift to openness to influence of other cultural tendencies due to diversity of cultures and multiculturalism is suggested.

2. CULTURAL STEREOTYPING FROM EUROPEAN AND AFRICAN PERSPECTIVES

Stereotyping is the process of an oversimplified standardised image of a person or group. In this article, we will discuss how some stereotyping can affect pastoral care in two populations under review, namely European and African. It is difficult and a form of reductionism to have a common representation of all the European or African cultures, because they are not homogeneous or monolithic cultures in themselves. Nevertheless, our use of the definite article "the" implies dominant elements in European culture that differentiate it from the African culture which has a noticeable impact on care. To this effect, we will make some assumptions with regard to the commonality in the two cultures under review. These assumptions are the stereotypes in these cultures which include secularism and religious tradition; relational world view – individualism and community life; freedom of expression and taboos; cultural settings; suicide as mental illness or spiritual problem, and the nature of the human being.

2.1 Secularism and religious tradition

The European thought pattern and behaviour with regard to religion and spirituality are remarkably different from those of the Africans. Gergen *et al*. (2001:697) discuss the effect of silencing religion and the impact of individualism in the European context: "the importance of self-expression and the silencing of religion can be traced to the Western tradition of Individualism". Individualism is the child of secularism. The silencing of religion is made clearer and official in the European Constitution which does not refer to the religious heritage of the European population, but intends to govern the Union as a neutral and secular democracy. The

individual decides and is responsible for his/her personal convictions, values, lifestyle, ethical behaviour as well as social and religious alliance.

Neutral and secular democracy has its advantages for personal development, but it impacts on the individual a great deal due to a lack of social cohesion. Emile Durkheim confirms this in his sociological analysis of suicide. Recently, Dorling and Gunnell conducted research to determine the extent to which the stories of suicide in Britain were more than the sum of thousands of individual acts of misery and the extent to which they reflected the changing social structure of the country. The result of this finding suggests that, as a preventive intervention to suicide at the aggregate level of society, social cohesion needs to be strengthened:

> We need to strengthen social ties to protect people from the ill effects of migration, from unhappy relationships or from lack of relationships and to ensure that those who want to work can work and those who don't want to work don't have to work, particularly in their old age (Dorling & Gunnel 2003:459).

From an African point of view, there is still some sense of community and religious/spiritual affiliation. In the African world view, attention is paid to how Christians grapple with, what Nyende calls, the "enchanted" world that dominates African consciousness. This is the traditional African world view characterised by spiritual entities which they cannot ignore, but which they are particularly prone to deal with in times of crisis (Nyende 2008:44-45). This puts the African stereotype in perspective. A traditional African would rely basically on his religion or spirituality when in crisis. His hope is on his god who determines his future. This kind of religious tradition influences his life and future. An average African finds it difficult to escape from such an enchanted world. Thus, there is the need to challenge both views in the light of dialogue between secularism and over-reliance on religious tradition.

2.2 The interpretation of the world/relational world view: Individualism and community life

The European individualistic and philosophical interpretation of the meaning of life tends to suggest that the world is absurd. Those who tend to tread this path find answer and meaning for suicide. Many philosophers have discussed this problem of the absurdity of the world. Wolfs' interpretation of Camus on completed suicide is very informative in this respect. For Camus, people commit suicide because of the absurdity of the world. Because the world is absurd, life is not worthwhile; therefore, not worth living: "That the world is absurd implies that it has no transcendent

sense of man – no higher or deeper sense" (Wolfs 2010:66). For him, this is found in the paradoxical nature of the absurdity of the world. According to Camus, the paradoxical nature of the absurdity of the world has the potency to make meaning out of it. This is only possible if one can see the power of making this happen. To this end, Wolfs's (2010:72) comment on Camus points out that

> the logical consequences of the absurd – revolt, freedom of action, and the non-indifference to life – not only give life value, but make it also worthwhile, even if man suffers under the absurd.

The power of the mind can trigger revolt and make meaning out of the absurdities in life. However, the reality of suicide shows that not everyone is convinced of this. In Camus' analysis, revolt can transform to "*ressentiment*" (French word) – a lingering hate which, according to him, is the answer to suicide. Wolfs found solace in the understanding of this "*ressentiment*" from Max Scheler's theory, concluding that

> ressentiment can only be avoided when the impotent revolt is able to cancel itself out. Only in this way the rebel can be loyal to the value which precedes it (Wolfs 2010:84).

Life is larger than logic. The question of the meaning of life is a mystery. It goes deeper to the spiritual part of the human being, as argued by Sullender and Malony. For them, "suicide is primarily, although not entirely, a spiritual problem" (Sullender & Malony 1990:204). Answers to the question of meaning in life are not merely logical, but also transcendental. Transcendental, in this perspective, includes God and the spiritual, because the philosophical mind alone is incapable of providing answers to these questions. The answer is imbedded from without the person – the spiritual powers given by God.

The issue is different from an African perspective with regard to relational life pattern due to the traditional community system: "A person's identity is a group identity and so is his or her life" (Kaseneme 2006:303). The deep religious and spiritual environment tends to make an average African view life as lived with others and as being a gift from God. It encourages interdependence and growth. The reason for this is that African systems of thought and practice are based on a spiritual ontology and pragmatic philosophy, which place greatest value on relationality (Lartey 2004:91). In the majority of traditional African settings, corporate existence tends to offer them more opportunity for sharing life stories, but not for suicidal feelings. The reason for this is that, in sub-Saharan Africa, "suicide and suicide-related behaviours are taboo subjects" (Alem *et al.* 1999:65-69). Life and the world are sacred and in God's control. They cannot be so

absurd and meaningless as to warrant completed suicide or expressing suicidal feelings. The branding of suicide as taboo is the ultimate challenge in a traditional African society.

2.3 Subjectivism/Freedom of expression and taboos

From an African perspective, the consequences of suicide as taboo make it difficult to freely express suicidal feelings. This is cause for concern for any meaningful intervention to take place. Gureje *et al.* (2007:821) argue:

> Because of the stigma attached to suicide relatives of persons who commit suicide are typically unlikely to give a true account of the cause of such death. The dearth of data on suicide is compounded by the fact that most countries in the region do not have compulsory registration of deaths.

This hampers any intervention to suicidal persons or suicide survivors. It is difficult to identify such persons. This poses one of the greatest challenges for any kind of intervention for a suicidal person in Africa. In sub-Saharan Africa, there is a paucity of information concerning suicidal behaviour and factors associated with transiting from one suicide outcome to another. There are no indications as to how preventive measures can be taken, because such measures require the identification of persons at most risk for transiting from one level of outcome to another. What is common is denial theory on the existence of suicide in most African societies. This trend is changing.

Gureje *et al.* have published some results from their analysis of the Survey in Nigerian Mental Health and Well-being. They were able to identify some socio-demographic correlates of different suicide-related outcomes. These include that males are more likely to make the transition from ideation to planning of suicide than females; the youngest age group (18-34 years) was significantly more likely to be suicidal than those over the age of 65. Level of education, unemployment, marital status, anxiety, mood disorders and substance-use disorder were identified as risk factors for suicide-related outcomes (Gureje *et al*. 2007:824). All these are basically socio-economic perspectives of suicide.

From a socio-economic perspective, the difference in the suicide rate shows that Africa's suicide rate is substantially lower than that in Western Europe and North America, where estimates range between 1.1% and 4.6% for lifetime prevalence of attempted suicide (Paykel *et al.* 1974; Kessler *et al.* 1999). In a recent survey by Gureje *et al.* (2007), 0.7% of the general population in Nigeria had attempted suicide at some stage in their life; 3.2% had thought of suicide, and 1.0% had made suicide plans. It is

instructive, therefore, that when racial differences have been observed, Blacks/Africans have been found to have significantly lower odds of suicide attempts than Whites/Europeans (Moscicki 1997; Kessler *et al.* 1999).

Relying on the above statistics for Africa, this article highlights the need for a dialogue of cultures to determine the factors that influence this lower rate. The positive appreciation of global culture enables the two systems of thought to intersect and overlap in an individual. This could be a new step towards proactive pastoral care.

2.4 Monoculture and multicultural settings/contexts

Initially, globalisation in pastoral care and counselling entailed the exportation or importation into different cultures, countries and contexts, in whole or in part, of the world view, values, theological anthropology, lifestyle, paradigms, and forms of practice developed in North America and Western Europe (Lartey 2004:91). Close integration of the countries and peoples of the world, which encourages international relations, is the ideal of globalisation. However, in practice, this is its weakness: there is hardly any dialogue or exchange of perspectives, but more unilateral relationships. The reality of our present world challenges the ideals and practice of globalisation as initially understood. There is a need to appreciate the evolvement and dynamism of globalisation.

It is worth noting that the initial idea of globalisation is changing. There is, at present, an exchange of perspectives from the developing world. For example, Philip Jenkins projects African Christianity to be the dominant form of Christianity in the world; these numbers will contribute to a visibly high proportion of world Christians (Jenkins 2007:93-124). Vroom argues that, if this is to be true, the projection implies more openness to other cultures, because cultures are complex, dynamic, and variegated "wholes"; the question concerning our ability to understand people from foreign cultures and religious traditions becomes important in our global society (Vroom 2003:226). The new elements of globalisation challenge pastors to embrace this inevitable change in order to be more proactive and relevant to pastoral practice.

Approximately 50 to 100 years ago, missionaries from Europe and America were sent to all parts of the world, including Africa, to evangelise the people. Currently, many Africans in Europe and in other parts of the world share their religious experience. This means that there is an exchange of cultures and religious/spiritual experience in pastoral care. Jenkins's (2007:113) projection confirms this:

> Third world churches undertake actual mission work in secularized North America and especially Europe. Commonly, though, the evangelism is an incidental by-product of the activities of immigrant churches, an important phenomenon given the large African and Asian Communities domiciled in Europe.

This confirms the reality of multiculturalism. Many pastors in the West and in Europe appreciate this change in understanding. Samuel Lee, an American author and pastor, uses a dance metaphor in describing this reality in pastoral practice. He describes multicultural realities of the United States and argues for the multicultural competences in the practice of the ministry. He argues that

> Multiculturalism and globalization are not matters of faddism. They describe the reality of the society to which we belong. We cannot simply close our eyes to the reality of our society, which has changed and is still changing. We cannot afford to do so. If we carry on with our pastoral practice as business as usual, we will very quickly become obsolete or irrelevant if not unfaithful (Lee 2001:390).

For Lee, pastoral care or ministry would be more relevant in our present world if multicultural strategy is considered a priority. He argues that this can only be possible if Westerners are ready to dance with other cultures. This demands humility and simplicity of mind to learn the dancing steps of other cultures. Lee poses three challenges that could militate to this learning process, namely unintentional racism, making visible the invisibility of monoculturalism and "whiteness", and embracing the complexity of multicultural lived realities.

David Crawford, a European on a mission to the Aborigines in Australia, recommends how this could be implemented. He argues that, in order to ensure the effectiveness of pastoral care, pastors need to cross a cultural bridge. He calls this indigenous pastoral care. He was able to embrace the challenge of the new culture he found himself, dialogued with it and accepted it, even when it is contrary to the European way of life.

> What we Europeans may define as topics for social conversations – connections to family, language and land, for example – have sacred significance to Aboriginal people. For them relationships are sacred, place is sacred, the world and all they do in it has sacred significance. They expect chaplains to understand that. And they value the unique personhood of each chaplain as a part of their important spiritual role (Crawford 2010:11).

Crawford was effective in his pastoral care for the Aborigines, because he embraced their teaching on spiritual practices; this shaped his pastoral

care for his patients. He argues that this is the only effective way to care for people of other cultures. Culture and spirituality interact in the same person. These elements are important in pastoral intervention.

This implies considering the holistic view of human nature. We observe some similarity between the Aborigines and the Africans in this world view, as considered earlier. The model of indigenous pastoral care can also be applied to Africans, especially with regard to their spiritual practices. Taking the spiritual component of the human being seriously could enhance the possibility of coping with suffering and absurdity that could lead to suicidal intention. At the same time, over-reliance on the spiritual as well as on the philosophical world view is simplistic. There needs to be a proper balance of all the components of the human being and to engage in dialogue of models where and when necessary. This is indeed where the challenge lies. In the next section, we shall consider a few suggestions on how these stereotypes could be challenged in order to help save lives.

3. THE CHALLENGE OF THE STEREOTYPES IN THE FORM OF DIALOGUE OF PERSPECTIVES

3.1 Improving the values of traditional forms of community and religious beliefs

There is a correlation between suicide and relational life pattern. From a European perspective, Hogan finds this argument compelling. He divides what he believes is the most significant factor to suicide into individual make-up and family/social make-up. Hogan argues that the structure of society in developed countries has led to a breakdown in traditional forms of community. Modern society tends to be individualistic. He maintains that the traditional forms of community contribute significantly to the rise in the rate of suicide in developed countries. He also identifies decline in religion as one of the major factors that lead to suicide:

> Additionally the decline in religious belief itself has been identified as a factor in rising suicide statistics. It is much easier in the modern world to 'get left behind', to become isolated to find oneself without support. If sickness or traumatic life-events intrude they may lead to suicide (Hogan 2001:268).

Hogan calls for improving these values in families and for fostering the community of faith in Churches to create a new community that has been lacking in the family. These values are the strength of cohesion in traditional African society. Loneliness, isolation and reliance on the power

of the human mind alone cannot provide answers to the meaning of life. Relational life pattern, trust in the higher power and a sense of community strengthen ties and improve meaning in life. In this instance, nobody is left to suffer alone. There is always a shoulder to lean on in times of crisis.

3.2 Encouraging freedom of expression

South Africa has the highest rate of suicide compared to other parts of Africa. Suicide prevention has become a challenge in Africa. The launching and implementation of a secular way of suicide intervention through the use of modern technology is very encouraging. It breaks barriers and the stigma associated with suicide as taboo. It empowers suicidal persons to use their freedom in expressing their feelings. It demonstrates the reality of multiculturalism and globalisation. The National Toll Free Suicide Crisis Line in South Africa is an adapted form of the Samaritans model in Europe and America founded by an Anglican Priest Chad Varah in England in 1953. The aim of the Organisation is to offer help to suicidal persons or persons in crisis using a secular non-judgemental model. This is well documented in their principles and practices code (Varah 1988:69-71). In South Africa, the model is adapted to the needs of the people.

The use of the model is necessitated by the Western influence on life pattern in South Africa. The effect of apartheid makes South Africa a peculiar population for suicide ideation, but other factors such as loss of traditional values and individualism increase the occurrence of suicide. Like South Africa, many other African countries show a noticeable increase in the suicide rate over the years. One of the reasons for this increase is multiculturalism and globalisation. Brown (2001:1175-1177) argues that

> the increase in suicide in developing countries is associated with loss of tradition, social cohesion, and spontaneous social support as the societies in these countries become more individualistic.

The pre-Christian and pre-globalised African society had a sense of community life and social cohesion. Following the trend in the current world, many changes have occurred over time and thus pose a challenge to the so-called cultural stereotypes. The changes resulted in social challenges and problems such as suicide. A reactionary method was to adapt to the modern solution to restore social cohesion.

Since its launching in South Africa in October 2003, the Crisis Line has been found to be a much-needed resource for those who have limited access to more traditional mental health resources. Meehan and Broom collected demographic data from the Crisis Line to evaluate and document

data on suicide. The aim was to create a database that will aid suicide intervention, planning and implementing a suicide prevention programme in South Africa, in particular, and in other African countries. The intervention was motivated by South Africa's suicide rate which had risen higher than the global suicide rate.

> Crisis lines are important support structure (mental health resource) needed to avert a suicidal crisis. Because crisis lines provide counselling, readily accessible via the telephone, they are confidential and an affordable way to seek help (Meehan & Broom 2007:67).

Since the study identified social conditions (extreme poverty and unpredictable social change) as one of the factors leading to a high suicide rate in South Africa, a toll-free crisis line would be very appropriate to provide preventative strategies to suicide, complemented by strengthening traditional social ties open to free expression of feelings.

It is worth noting that, after analysing the data collected from callers, Meehan and Broom (2007:68) found that

> most callers experienced significant satisfaction with the service they provided and hence that psycho-education is an important part of psychiatric care.

It is, therefore, necessary to appreciate this system for self-expression which is such a valuable line for persons in crisis in parts of Africa. This opens up space against the stigma attached to suicide and encourages freedom of expression for those who would still want to remain anonymous. Many suicidal persons are not free to talk about their feelings in public; therefore, the use of such a crisis line that offers toll-free, confidential service, counselling and useful information on suicide is invaluable. Using these different options for suicidal persons encourages a holistic intervention. This holistic intervention is possible if we can appreciate the complexity of the human being.

3.3 Encouraging the holistic view of the human being

The human being is a complex entity of soul, spirit, body and mind. A holistic care for a suicidal person ought to consider this complexity. Disciplines such as medicine, psychology, psychiatry and sociology emphasise one aspect, namely body or mind. The problem of suicide includes the spiritual/soul/mind aspect of the person. These aspects of the human being are interconnected, but often the spiritual aspect is neglected. Spiritual means a type of deeply personal experience that comes out of the core of one's sense of being a person (Brun 2005:429). It refers to the human capacity for

relationship with self, others, the world, God, and that which transcends sensory experience, which is often expressed in the particularities of given historical, spatial and social contexts, and which often leads to specific forms of action in the world (Lartey 1997:113). Spirituality is both implicit and explicit.

Implicit spirituality implies personal spiritual experiences and concerns; explicit spirituality is expressed in organised religion. They are connected, overlapping and intersecting. The elements of spirituality, as represented by Brun and Lartey, include relation to the person (personal), relation to a transcendent being, connection to a sense of purpose or order, understanding and relating to self, to others and to the world, and relationship with place and things (Brun 2005:429; Lartey 1997:113). This view projects the relational nature of a person.

Brun's understanding of the influence of a holistic view of the human being implies that human beings are complex beings involving body, mind, and spirit, that interact with each other. We share Brun's view that the way in which we focus on particular "religious/spiritual" concerns will be influenced by our comprehensive assessment of our client's functioning in other areas, such as physical, psychodynamic, psychosocial, and systemic functioning. Pastoral care needs to be proactive in projecting religious faith, because many people do not know their position on religion until a crisis occurs, and then their religious faith and beliefs are formed (NASP 2003).

It is worth noting that some secular studies now take the spiritual and cultural aspects of the person as fundamental for any kind of meaning in life or for general well-being. Feldstein *et al.* argue for the necessity of integrating spirituality and culture with end-of-life care in medical education, in order to provide, what they call, a high-quality care responsive to spiritual concerns in a multicultural context due to a correlation between spirituality and meaning. Medical students in this study were to explore the place of spirituality in the well-being of their patients and to observe how this can help in realising meaning in life. The students discovered that spirituality is a multidimensional human phenomenon. Their description of spirituality could be compared with that of the American Academy of Family Physicians (AAFP):

> Spirituality is the way you find meaning, hope, comfort and inner peace in one life. Many people find spirituality through religion. Some find it through music, art or a connection with nature. Others find it in their values and principles (AAFP 2001).

Spirituality is recognised as one of the most important elements of human nature and the person. Attention to this dimension of the person

can improve holistic health care. By encouraging and introducing these studies, the students were able to be more effective in their medical care and understanding of the human being. The students were able to

> identify patients' spirituality and sources of meaning, to recognize and respond to ways that spirituality and culture interrelate, particularly at the end of life (…) observe ways that the medical culture may clash with a patient's spirituality and/or culture (Feldstein *et al.* 2008:77-78).

This is a welcome development in the field of medical science, because pastoral care is given in the medical institution or in collaboration with it. In pastoral care, the integration of spirituality and culture cannot be overemphasised.

3.4 Suicide as a mental illness and/or spiritual problem

The most recent qualitative study of clergy in Northern Ireland opens up the debate on suicide as a mental illness or a spiritual problem. This debate emphasised the need for compassion and understanding. The "softer" theological stance was adopted by all the participants (clergies from different denominations) and the need for compassion was stressed, knowing that most of the suicidal persons are mentally ill and need help, not judgement.

> Clergy across the range of denominations, universally and vigorously reiterated their belief that life is sacred. However, without exception, the participants stressed that suicide is predominantly the product of a mental illness – in which case, the previously assumed voluntary nature of suicide, a sin of despair, has been reframed as an involuntary act of a mentally ill individual, perhaps driven by stress beyond his or her 'natural' or usual state by the confluence of various factors (Leavey *et al.* 2011:70).

The outcome of this survey shows that the theological discourse on suicide has diminished and been replaced among the clergy by a psychological understanding of the phenomenon. This is not a contradiction to suicide being primarily, but not entirely, a spiritual problem, as proposed and adopted earlier in this article. A decline in the theological stance is a systematic way of highlighting the need for compassion, since mental illness diminishes culpability to suicide. What remains appropriate is compassion for the suicidal person. Canon Law 1184 no longer specifically condemns suicide. Prior to the revision of the new Code of Canon, a person who committed suicide was specifically denied Church funeral rites. Paragraph

1 of this revised Canon specifies that, "unless these people gave some signs of repentance before death", they are already condemned. Those named are notorious apostates, heretics, schismatics, and so on. It is interesting to note that suicide is not specifically mentioned. It is ambivalent to ascertain whether a suicidal person repents before death. Commenting on this, Father Edward McNamara supports the current stance on suicide: "the general tendency is to see this extreme gesture as almost resulting from the effects of an imbalanced mental state" (McNamara 2005).

At the centre of this perspective are religion, spirituality and culture. Northern Ireland and the majority of European countries are still nominally strongly religious, with a high rate of church attendance, despite growing secularisation. This is considerably significant in the context of suicide either for intervention strategy in terms of prevention or for care of suicide survivors. Leavey *et al.* view this as a credible argument. They argue about the inevitable place of religion in preventing suicide: "Religion offers material resources and a framework of meaning and action for living, suffering, dying and death across cultures" (Leavey *et al.* 2011:65). The explanatory model for suicide maintains that a suicidal person is presumed to be mentally ill before any intervention. Only God knows the state of mind of the suicidal person and thus compassion is needed. This softer theological stance is envisaged to encourage a suicidal person to approach the pastor, because it is believed that religion is a major bulwark against the factors that generate suicide.

Likewise, Clarke emphasises the need for pastoral psychology to construct a diagnostic protocol that is both theological and resonates with the lived experience of the clients by means of the pastoral diagnostic model that uses psychotheological themes. But the challenges of this kind of model, as noted by Clarke, are the growing irreligious nature of our world where religious language and metaphors no longer hold the power they once possessed and building a relational bridge by paying attention to the unconscious. Clarke believes that, by using the pastoral diagnostic model, the pastor is able to deepen his understanding of the human condition, expanding his scope of practice, and engaging other professionals in an effort to alleviate suffering. The aim of the psychotheological approach to pastoral diagnosis is to create mutuality and respect between the pastor and the client; this would enhance the therapeutic alliance which the client experiences as a value. Clarke (2008:225) believes that

> from this very tentative vantage point, the client accesses a degree of freedom that, in turn, allows her to find meaning in her suffering.

Clarke applied this approach to the case of Monica, a crippled girl, by emphasising the psychotheological themes of feeling, freedom, and

meaning. In this instance, the pastor concentrated on the feeling which is the unconscious and goes on to build a relational bridge or mutuality. This empowers the client to deal with her symptoms of depression and fatigue. By claiming the fullness of her humanity, she was able to live with a greater sense of confidence and well-being. This was achieved based on the therapeutic skill of the pastor:

> The pastoral therapist monitors one specific phenomenon; namely, the emotive pathway of the client. By utilizing the individual's self-stated goal of finding a greater sense of freedom, emotively based questions move the relationship beneath pleasantries and into the realm of the unconscious (Clarke 2008:229).

This process helped Monica, together with the pastor, to remove those structures that compromised her ability to act freely, and she ultimately found or made meaning in her life. In the same vein, pastoral care is adapted more to suicidal care than to any other discipline. Historical facts indicate that more persons have been saved from suicide by pastoral counselling than have ever been saved by psychologists and psychiatrists. This is possible because of the personal touch of the pastor who is there for the client, not to condemn him/her, but to compassionately respond to his/her needs. Therefore, we argue that a return to religious belief and a relational life style is apt to prevent more suicides.

4. CONCLUSION

Culture and spirituality play a major role in the mind of a suicidal person. Recent research findings on the role of spirituality in healthcare confirm this. Wills (2007:434) views the role of spirituality as a necessity that

> provides a means for connecting, or reconnecting, with aspects of the self, with others, with the larger community and/or with something greater than the self.

Nonetheless, the lesson from self-expression and a philosophical interpretation of the world is instructive. The elements of spirituality and secular understanding of life ought to complement each other in order to rediscover meaning in life.

Pastoral care aims at enhancing the meaning of life. An intervention strategy based on cultural stereotype limits the complexity of the phenomenon of suicide. Our multicultural and global society demands openness to other cultures. The challenge, proposed in this article, to cultural stereotypes is a proactive pastoral care in our global culture. There

is a need for openness to spiritual and cultural concerns in an intercultural perspective. This entails the primary focus on compassion rather than on moral judgement of the suicidal person. The softer theological stance of regarding suicide more as a mental illness encourages more understanding of the phenomenon.

To be more proactive, therefore, our model aims to encourage more openness to other cultures and spirituality which, we believe, is the core of a human being. It is necessary to engage in discussion on the statistics on suicide which is lower in some developing countries in Africa. It is instructive to stimulate more research in order to determine why this is so, in order to develop a more reliable pastoral intervention strategy to suicide and improve the individual's general wellbeing.

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