Thank you for taking QPR training.
Congratulations!

This brief course review includes enhanced and additional information to help you help others. If you so choose, you may retake the quiz for an updated Certificate of Course Completion at any time over the next three years.

As a trained QPR Gatekeeper you know that:

- Suicidal thoughts are common. Suicidal acts, threats and attempts are less common, but much more frequent than most people realize. Suicide is the most common psychiatric emergency and a leading cause of premature death.
- If you are a professional caregiver, police officer, fireman, member of the clergy, school nurse, coach, youth leader, paramedic, high

school counselor, case manager, volunteer or paid staff in any of a hundred different kinds of human service organizations, you will very likely have firsthand contact with suicidal people or may know someone who has made a suicide attempt or died by suicide.

- Suicide is difficult to talk about, but you also know that research has shown the majority of those who attempt suicide give some warning signs, verbal or behavioral, of their intent to kill themselves in the final days and weeks of their journey from the idea of self-destruction to the act of suicide.
- You have been taught some of these warning signs and that by recognizing the suicidal person's cries for help and offering hope through persuasion toward positive action, suicide can be prevented. To do this, you must overcome your reluctance to become involved.

Too often, those who are in a position to recognize the warning signs of a suicidal crisis either fail to see them, deny their meaning, or minimize these communications as "not serious."

As a trained QPR Gatekeeper you also know that:

- People talking about suicide create fear and anxiety in us. The very idea that someone wants to die is frightening. When someone threatens suicide the most natural reaction is fear. Fear leads to denial. Denial is how we humans cope when we are confronted with something too terrible to contemplate.
- Sometimes, to convince ourselves we didn't hear what we heard, we deny the warning signs of suicide by believing the old myth that "people who talk about suicide don't do it" or

that the person is only seeking attention. While fear and denial are normal reactions to someone talking about ending his or her life by suicide, remember this fact:

> *People who talk about or threaten suicide often do go on to attempt or complete suicide. To prevent suicide we must overcome this dangerous form of denial, apply QPR and, perhaps, save a life.*

- Sometimes we are both shocked and angry that someone we know is expressing a wish to die. What more disturbing communication from one human being to another is there? "How can this be?" we ask ourselves. Shock, and sometimes anger are also normal reactions to statements of desire for death and intent to attempt suicide. You may be angry because the

person didn't come to you sooner or upset that any problem could be so serious.

- Fear, denial, shock, anger: These are some of the expected and ordinary reactions to someone whose behavior or words suggest to us they want to kill themselves. Effective QPR means controlling, recognizing and accepting these emotions while we try to help.

Understanding suicide

Suicide is the premeditated taking of one's own life.

Suicide is the most complex and difficult to understand of all human behavior. Yet, suicidal people are just like you and me. They have problems; we have problems. The difference between us is that, for the moment, we feel we can handle our problems and do not feel overwhelmed by them.

In its simplest terms, suicide seems to be a solution to a problem. More often, it seems to be a solution to many, seemingly insoluble problems. Thoughts of suicide occur during times of personal crisis, unrelenting stress or depression, when we are confronted with a fear of failure or the specter of an unacceptable loss.

Although sometimes an impulsive act, most people will think about suicide for days, weeks, months or even years before they make an attempt. Oddly, thinking of suicide produces a curious blend of terror and relief; relief in that all one's problems can finally be solved and terror at the idea of having to die to find that relief.

Since the beginning of time, suicide has been one way to seemingly solve life's problems. Tragically, suicide is the wrong solution. Most people who end their own lives do so for ordinary

reasons, not extraordinary ones. Far too frequently what seemed worth dying for could have been treated, mended or endured until time worked its own magical cure.

Suicide takes many forms and some suicide threats are efforts to control the behavior of other people. Most often, though, wanting to die and feeling suicidal is a primary symptom of an untreated mood disorder, a substance abuse disorder or both. These are medical conditions for which excellent treatment is available. It is important to understand that suicidal thoughts are strongly associated with disturbances in brain chemistry and that these changes can be reversed with appropriate biological and psychological treatments.

Review of suicide warning signs

As covered in your QPR training, suicide warning signs take many forms. Some of them will be verbal, others may be behavioral. Some warning signs will be direct and obvious statements of desire and intent to die by suicide. But because suicide is so stigmatized, such a taboo subject and may even be impolite to talk about, other warning signs may be indirect and a bit of challenge to recognize.

Cutting and self-injury: Suicide warning sign?

Cutting and other self-injurious behaviors constitute a significant risk factor for suicide. While most incidents of self-injury are not meant as a suicide attempt, many self-injurers have attempted suicide and even more think about

suicide frequently. Therefore, it is important to follow our protocols for assessing suicidal thinking and intent for each incident. Whatever the reason for self- injury, the best course of action is to take the person to a professional for assessment and possible treatment. (This commentary provided by Wendy Lader, Ph.D., M.Ed., President, S.A.F.E. Alternatives. Please visit www.selfinjury.com for more information.

Direct statements about suicide are not difficult to interpret or understand, e.g., "I'm going to kill myself." But indirect statements such as "I think I'll go away forever" or some behaviors, such as giving away a prized possession, are more like clues. Clues require not only recognition but clarification of their meaning by asking the S (suicide) question.

One clue or warning sign may not mean a great

deal but any sign or behavior suggesting acute distress, despair or hopelessness about the future or desire to "end it all" is worth asking about.

From published research, expert suicide prevention specialists from the American Association of Suicidology have recommended positive action be taken any time:

- Someone is threatening to hurt or kill themselves
- Someone is looking for ways to kill themselves: seeking access to pills, weapons, or other means
- Someone is talking or writing about death, dying or suicide

Or when there are signs of:

- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless or engaging in high risk activities, seemingly without thinking

- Feeling trapped – like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family or society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic changes in mood
- No reason for living, no sense of purpose in life

While this list of warning signs is helpful, what language people actually use may prove more helpful to the Gatekeeper. Many of the following statements were made by people who subsequently went on to kill themselves.

Examples of direct verbal warning signs

I've decided to kill myself. I wish I were dead. I'm going to commit suicide. I'm going to end it all. If (such and such) doesn't happen, I'll kill

myself.

Examples of indirect or coded verbal clues

I'm tired of life. What's the point of going on? My family would be better off without me. Who cares if I'm dead anyway? I can't go on anymore. I just want out. I'm so tired of it all. You would be better off without me. I'm not the man (or woman) I used to be. I'm calling it quits. Living is useless. Soon I won't be around. You shouldn't have to take care of me any longer. Soon you won't have to worry about me any longer. Goodbye, I won't be here when you return. It was good at times, but we must all say goodbye. You're going to regret how you've treated me. You know, son, I'm going home soon. Here, take this (cherished possession); I won't be needing it. Nobody needs me anymore. How do they

preserve your kidneys for transplantation if you die suddenly?

Examples of behavioral warning signs or clues

Donating body to a medical school. Purchasing a gun. Stockpiling pills. Putting personal and business affairs in order. Making or changing a will. Taking out insurance or changing beneficiaries. Making funeral plans. Giving away money or prized possessions. Changes in behavior, especially episodes of screaming or hitting, throwing things, or failure to get along with family, friends or peers. Suspicious behavior; for example, going out at odd times of the day or night, waving or kissing goodbye (if not characteristic). Sudden interest or disinterest in church or religion. Scheduling of appointments with a doctor for no apparent physical causes, or

very shortly after the last routine visit. Loss of physical skills, general confusion, or loss of understanding, judgment or memory. Relapse into drug or alcohol use after a period of recovery.

Situational Clues

Sudden rejection by a loved one, (e.g., girlfriend or boyfriend), or an unwanted separation or divorce. Recent move, especially if unwanted. Death of a spouse, child, friend (especially if by suicide or accident). Diagnosis of a terminal illness. Flare up with friends or relatives for no apparent reason. Sudden unexpected loss of freedom (e.g., about to be arrested). Anticipated loss of financial security. Loss of a cherished counselor or therapist.

(Sources for suicide warning signs: Marv Miller, *Suicide after Sixty*, New York: Springer, 1979; Rudd, M. D, Berman, L., Joiner, T.E., Nock, M., Silverman, M.M., Mandrusiak, M., et. al. (2006) Warning signs for

suicide: Theory, research, and clinical application. *Suicide and Life-Threatening Behavior; 36,* 255-262. Schneidman, E. & Farberow, N., *Clues to Suicide*, New York, McGraw- Hill, 1957; Span, D., *Post-Mortem*, New York, Doubleday, 1974; and Wekstien, Louis, *Handbook of Suicidology*, New York, Brunner/Mazel, 1979.)

A reminder about depression

Most suicidal people are depressed. Depression is the common cold of modern life. Depression is both biological and psychological in nature. If detected through QPR, depression is highly treatable and lives can be saved.

Wishing to be dead is a frequent symptom of untreated depression. Other symptoms include nervousness, crying, inability to concentrate, poor sleep, fatigue and a general or specific loss of interest in friends, food and fun. The bad news is depression is common; the good news is that it responds well to treatment.

As someone who cares, you need to know a

couple of things about depression and suicide. First, since depression saps energy and purpose, sometimes the depressed person is "too tired" to carry out a suicide attempt. However, as the depression finally begins to lift, the person may suddenly feel "well enough" to act.

As strange as it sounds, once someone decides to end his or her suffering by suicide, the hours before death are often filled with a kind of chipperness, even a blissful calm. This change in appearance is a good time to apply QPR.

Any sudden "happiness" in someone who has been depressed for a long time should alert you to the need to apply QPR. If in doubt, ask the question!

A reminder about alcohol or other drugs of abuse

People who finally take their lives by their own hand must pass through a sort of psychological barrier before they act. This final wall of resistance to death is what keeps many seriously suicidal people alive. Quick-acting and readily available, alcohol at intoxicating levels dissolves this wall and is found in the blood of most completed suicides whether or not they ever had a drinking problem. Other drugs of abuse also increase risk of death by suicide.

Alcohol worsens depression, impairs thinking and judgment, increases impulsively and, like driving without a seat belt, alcohol often contributes to tragic accidents, including "accidental" suicides.

Many suicidal people who are not sure they want

to die drink to intoxication to dull their pain and then, because of the added depression and despair they feel under the influence play "dangerous games." These dangerous games include taking handfuls of pills, driving fast, playing with loaded firearms and other high-risk behaviors.

Sometimes they practice or rehearse how they will attempt suicide and may use drugs or alcohol during these practice sessions, some of which end in a death they did not fully intend or desire.

Life's decisions are difficult enough when we are angry and depressed.

Adding drunkenness to our problems only makes things worse and usually, much worse. The best thing you can do for someone contemplating suicide is to keep them sober until help is found.

For the suicidal person, there is no safety without sobriety.

A quick review of the Q in QPR

Because suicide is such a taboo subject, asking the "S" question may at first seem awkward or difficult, like asking the other "S" (sex) question.

Remember that you may be the best person in the best possible position to recognize the warning signs of a suicide crisis and to prevent a suicide attempt or completion.

Just as you have the courage to apply the Heimlich maneuver or CPR to help a stranger choking on a piece of meat, you apply QPR to someone considering suicide.

Tips for applying QPR

- Plan a time and place to ask the "S" question.
- Try to get the person alone or in some private setting.

- A QPR intervention may take up to an hour, so make sure you have plenty of time.

Many people who've just been asked if they are thinking of suicide have a great need to talk. Listening skills will be discussed in a moment.

The Q in QPR

There are several ways to ask the S question. You can begin by acknowledging the person's distress.

Less direct approach

"Have you been unhappy lately?"

"Have you been very unhappy lately?"

"Have you been so very unhappy you wish you were dead?"

"Do you ever wish you could go to sleep and never wake up?"

"You know, when people are as upset as you

seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way, too."

More direct approach

"Have you ever wanted to stop living?"

"You look pretty miserable. Are you thinking of killing yourself?" "Are you thinking about suicide?"

If none of these questions sound "like you," then please use whatever phraseology works best for you. A bit of practice asking the S question helps.

The most important step in QPR is asking the question. It is the hardest step, but also the most helpful to someone considering suicide. Perhaps you feel only a professional person should ask such a delicate question. Not so. Suicide prevention is everybody's business.

Feeling some reluctance to ask the S question is natural and for good reasons. First, a "yes" to the S question puts the subject of suicide on the table for discussion.

Once we ask someone if they are thinking of suicide and they say "yes," we must now do something. We now have an obligation we didn't have only moments before.

This is good, not bad. Research has repeatedly shown that once a person has been asked if they are thinking of suicide, they feel relief, not distress. Anxiety decreases, while hope increases. A chance to go on living has been offered.

By asking the S question it is as if we send a ray of light and hope where there has only been darkness and despair. So, if you cannot ask the S question, find someone who can.

Research published in the Journal of the American Medical Association in 2005 by Dr. Madelyn Gould and her associates confirms that asking about suicide does not increase risk. In a word, you cannot put the idea of suicide in someone's mind.

Once the question has been asked, most people thinking of suicide want to talk. Now is the time to apply step two, Persuade.

A quick review of the P in QPR

Persuading someone not to end his or her life and to get help begins with the simple act of listening.

Listening can be life saving.
Listen first, then persuade.

Listening is the greatest gift one human can give to another. Advice tends to be easy, quick, cheap

and wrong. Listening takes time, patience and courage, but it is always right.

Ask yourself, "Whom do I go to for advice?" Your answer is seldom someone who lectures or makes quick judgments about what you should do. Rather, it is the good listener to whom we turn in times of trouble.

When someone is feeling suicidal and needs to be persuaded to get help, the gift of active listening becomes priceless.

To become a better and active listener:

- Give your full attention
- Do not interrupt and only speak when the other person has finished
- Do not rush to judgment
- Do not condemn the idea of suicide
- Tame your own fear so that you can focus on

the other person

After asking the S question and getting suicide on the table for discussion, listen for the problems death by suicide would solve. Confirm your guesses and suspicions with questions and, if you get nods or "yes's," you have, in no small part, helped that person to find a way to live.

The goal of persuasion is simple. All we want to accomplish is for the person to say "yes," that they will get some help. A "yes" to any of the following questions confirms that you have been successful.

"Will you go with me to see a counselor?" (Or a priest, minister, school nurse, psychologist, or whatever kind of professional person they are willing to see.)

"Will you let me help you make an appointment

with ...?"

"Will you promise me...?"

Sometimes suicidal people will agree to get help but not get it. Or they will resist the idea of getting help even though they seem to recognize that they need it. The more hopeless and helpless they feel the more difficult it may be for them to make a commitment to get help.

Therefore, it is often a good idea to get the person to agree to go on living and make a recommitment to life. Simply say to them, "I want you to live. Won't you please stay alive until we can get you some help?" A promise not to hurt or kill oneself and to go on living until help is gotten is most frequently met with relief and an agreement to stay alive.

Because making a public promise to stay alive

appeals to our honor, and agreeing to stay safe provides relief to the suffering person, the answer to this request is almost always "yes."

When the answer is "no" don't worry, there is still something you can do.

Ask yourself a simple question. If you were angry, depressed or terribly upset and not thinking clearly, would you want those who love you to stand by while you killed yourself?

The answer is no.

Just as you would not allow a friend or loved one to die if they were drowning, having a heart attack or in a car crash while driving intoxicated, neither would you allow someone you cared about to end his or her life by suicide.

But what if they refuse to get

help?

Refusal to accept help does not mean QPR failed. In fact, just the opposite is true.

At present, the laws in most countries do not permit someone to kill him or herself without first receiving the benefits of treatment. The law correctly presumes that suicidal people are suffering from disorders of the brain and are not thinking correctly.

The law allows that temporary suspension of civil rights may be necessary to assure that a mentally ill person receives proper assessment and care. Every enlightened society has now decided that no one has a civil right to complete suicide without first being given an opportunity to get help.

In the view of the majority suicide is not an

acceptable solution to the problems of living.

If someone you are trying to help is refusing your assistance you should call the emergency numbers in your community and seek assistance. Authorized by law, these emergency responders are trained in what steps to take to reduce the risk of a suicide attempt. At some time in this process a mental health professional will objectively determine if your friend or loved one represents "a danger to self."

If these evaluating professionals believe significant danger to self exists, and your loved one is not willing to accept an alternative outpatient plan for treatment with a good faith commitment to remain alive, a court of law may order him or her into involuntary, inpatient treatment.

The treatment is time-limited (usually less than two weeks), and typically consists of crisis resolution, counseling, and – only if your loved one agrees – medications aimed at reducing the mental and emotional pain and problems that often cause suicidal thinking.

Society stands with you against death by suicide.

When confronting a friend or loved one with QPR, remember it is better to have an angry friend or loved one than a dead one.

Involuntary treatment laws are wise laws, especially when you consider that studies show that the vast majority of people who have taken their own lives suffered from a treatable brain disorder. The message is clear. Treatment works even if, for a time, it has to be forced.

Persuasion works best when you do the

following

- Persist in statements that suicide is not a good solution and suggest that a better alternative can be found.
- Focus on solutions to problems, not the suicide solution.
- Accept the reality of the person's pain, but then offer alternatives.
- Offer hope in any form and in any way.

A quick review of the R in QPR

The last step in QPR is making the referral. Here are some general guidelines.

- The best referrals are when you personally take the person you are worried about to a mental health provider or other appropriate professional.
- The next best referral is when the person agrees to see a professional and you know they

actually kept the appointment.

- The third best referral is when the person agrees to accept help, even in the future.

Most suicidal people who agree to get help will act in good faith and get the help they need. However, because of the stigma associated with accepting counseling or professional help for disorders of the brain or emotional problems, some people may not follow through and see a professional. This is why we recommend that you actually take the person to someone who can help. Once you apply QPR you will rest much easier if you are assured the person you helped actually made it from your intervention and into the hands of a professional.

Don't know a mental health professional?

If you do not know anyone in the counseling or helping professions call your own family doctor, your community crisis line, a professional mental health organization or professional association. You can always call your local emergency numbers for a free consultation and help.

Often the suicidal person will want to talk to a clergyman, counselor, school nurse or other competent adult and may be more willing to talk to someone they know rather than to a stranger. Ask them to go with you to the person they know and trust.

Finding the courage to act

To help you act with courage, here are some things to remember.

- Don't worry about being disloyal.
- Don't worry about breaking a trust.
- Don't worry about not having sufficient

information to call for help.

- Again, if you don't feel comfortable asking the S question, find someone who can and share your concerns and fears with them.

Remember, we are only responsible for what we know at the time we know it; not for things we will learn later on. So, if in doubt, act!

- Reach out.
- Don't wait.
- Do something!

4 Tips for effective QPR and conclusion

1. Get others involved. To broaden the safety net for someone at risk of suicide immediately after applying QPR ask the suicidal person, "Who else would you like to know that you're feeling this bad?"

Sometimes the suicidal person will name a parent, a family member or best friend who doesn't know how desperate they have been feeling. With the suicidal person's permission you may wish to call this person, or persons, and let them know what is going on.

2. Remove the means of suicide. Remember when Abraham Lincoln, one of America's most beloved presidents, was depressed and suicidal as a young man, his friends kept a close watch on him for the better part of year until his depression lifted. They asked him for his pistols and knives and tried to make sure he was never alone. Make every effort to remove the means of suicide. This may mean asking for the car keys, pills, or other methods by which someone might attempt suicide.

3. Join a team. As with most serious, life

threatening human crises, a team approach is best. Professionals can provide treatment for the mental and emotional conditions that often result in thoughts of suicide, but those who live and work with the suicidal person are often in the best position to help with day-to-day problems while they observe and monitor how the person at risk is doing.

4. Set up a crisis plan. In case professional help cannot be gotten immediately, it often helps to be accessible to the suicidal person. Give them your phone number and emergency numbers they can call and be sure they know how to get to a hospital emergency room in case of crisis. All of these efforts communicate to them that you care, that you will be there for them and that you have hope for their future.

Planting the seeds of hope

When you apply QPR you plant the seeds of hope. Applying QPR brings a personal crisis out of the dark and into the light. QPR is a positive, hopeful intervention and it is hope, more than anything else, that helps reduce the risk of premature death by suicide.

Hope begins with you!

Thank you for caring.

If you are interested in more advanced suicide prevention training, including how to assess and manage persons known to be at elevated risk for suicide, please visit www.qprinstitute.com for a description of courses.