Frequently Asked Questions

The QPR training program invariably generates many questions. The following are some of the most frequently asked questions.

Because of the stigma and fear associated with the word suicide, many people find it difficult to actually say the word. The more natural the act of asking the suicide question is, the easier it will be to ask it in future when and if you need to. You will need a partner to practice with and the session should take approximately 15 minutes.

Your partner will need to “act” as if they are in a crisis and thinking about suicide. Ideally, you and someone you know are both completing the QPR training and you can practice QPR together.

**Question: “Is there any type of person that commits suicide?”**

**Answer:** No. There is no “suicide type.” Suicide occurs in every social class, every culture and at all ages. The presence of suicide warning signs in someone should never be dismissed with, “Oh, he’s not the type.”

**Question: “Are young people who repeatedly self harm really at risk of completing suicide?”**

**Answer:**
- Deliberate self-harm is quite common among young people.
- About 50% of all young people who self harm will have more than one episode of self-harm.
- Most of those who repeatedly self harm will not ultimately die by suicide.
- However, amongst those who do repeatedly self-harm, there may be a very small proportion who may be at risk for completed suicide.
• We are not able to predict accurately which individuals, amongst those who self harm repeatedly, will be at risk of completed suicide.

• For this reason, we need to assess, for suicide risk, **ALL** those who repeatedly self harm.

**Question:** “**Do all people who attempt suicide intend to die?**”

**Answer:**

• Not all people who die by suicide intend to die.

• At the time of their attempt, many people are ambivalent.

• Further, many people do not know, with any accuracy, about the lethality (how likely they are to die) of the method of suicide attempt they have chosen.

• For these reasons, **ALL** people who threaten or attempt suicide should be regarded as intending to die, and assessed for suicide risk.

**Question:** “**Is the risk of completed suicide lower if a person’s attempts appear to be attention seeking/acting out?**”

**Answer:** As above, because people do not know how lethal their attempt method may be, even if it appears their attempt may be attention seeking, it is possible that the attempt may result in their death. For this reason, it is prudent to regard **ALL** attempts as potentially life threatening and to assess further to determine suicide risk.

**Question:** “**What is a safety agreement and how does it work?**”

**Answer:** A safety agreement (often referred to as a “no-suicide contract”) is an agreement by the suicidal person not to attempt suicide until help is gotten. There is little published research to support the use of such agreements by professionals. We recommend a safety plan is used, which does not necessarily involve a “no suicide contract”. A safety plan might involve actions such as talking with a friend, contacting a professional or ensuring that alcohol is not used. Active listening, showing you care, and getting the person to plan what steps they will take if they are feeling suicidal may reduce anxiety and instill hope in someone in need of professional help.
Question: “Won’t asking them if they are suicidal put the idea in their head?”

Answer: No. Experts agree on this point. You cannot “put the idea of suicide” into someone’s head by talking about it. In fact, if the idea of suicide has crossed your mind, it is very likely already in the mind of the person at risk, and action should be taken.

Question: “Don’t people have a right to die?”

Answer: This is a very complex question. Certainly each of us can imagine a particular set of circumstances that might justify our choice to end life on our terms and in our own time. However, research has repeatedly shown that the vast majority of people who begin to think of suicide as a solution to one or more problems are suffering from a mental health condition, or psychological and emotional distress associated with physical illness.

Thinking of suicide or wishing you were dead is such a common symptom of untreated depression that, should thoughts of suicide occur to someone, the very next question should be, “I wonder if I’m depressed?”

Becoming depressed is not automatic with growing older, facing a struggle with cancer, becoming HIV positive or even receiving a terminal diagnosis. Depression is a separate problem, with a set of symptoms that respond extremely well to a variety of treatments. Therefore, while thinking of suicide may seem to “make sense” to someone, and perhaps even those around him or her, the more important question is, “Is this person suffering from untreated depression?”

Symptoms of depression may be obvious e.g., crying, impaired sleep, loss of interest in ordinary pleasures, etc., or they can be masked as anger, pessimism, physical complaints, or even unreasonable fears about illness. Recurrent and persistent thoughts of suicide, however, almost always point to an undiagnosed mood disorder. Since disorders of mood often impair the quality of one’s thinking and one’s ability to make good decisions, the trouble with “rational” suicide is that it may not be rational at all.

Question: “What is the difference between suicide attempts that are said to be “behavioural”, versus those said to be related to ‘mental health problems’?”

Answer:

- Clinicians tend not to draw distinctions between so-called “behavioural” suicide attempts, and those said to be related to “mental health problems”.
- The mental health problems associated with suicidal behaviour include:
- Depression
- Bipolar disorder
- Substance use disorders (including alcohol, cannabis and other drugs)
- Offending, antisocial conduct disorders
- Anxiety disorders
- Psychotic disorders (including schizophrenia)
- Personality disorders (including borderline personality disorder, antisocial personality disorder).

The clear majority (90%) of people who make suicide attempts have at least one mental disorder at the time of their attempt. Most commonly these disorders will include depression, a substance use disorder, an antisocial/offending/conduct disorder or an anxiety disorder. Given this, most so-called “behavioural” suicide attempts will occur in people who have at least one mental disorder.

It is, therefore, misleading and potentially dangerous to attempt to draw distinctions between “behavioural” suicide attempts (with the implication that they are “less serious”) and mental health problem-related attempts (“more serious”). It is more prudent to treat ALL attempts as potentially serious, and to assess suicide risk in ALL cases.

**Question: “What do you think causes suicide?”**

**Answer:** Suicide is the most complex of all human behaviours. No one thing can cause suicide. Rather, it is multi-determined behaviour that defies any simple or single-cause explanation. The underlying reasons for suicide are deep and longstanding, and typically involve a wearing away of one’s ability to cope. Feelings of worthlessness and hopelessness, untreated depression, substance abuse, family conflicts and many other “risk factors” can create suicidal crises.

Some of the top risk factors include:
- Mental health disorders, alcohol and other substance abuse disorders and some personality disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- Previous suicide attempt and family history of suicide
- Job, financial or relationship loss
- Stigma about seeking help, barriers accessing treatment, and exposure to negative media
Question: “What if the person I’m trying to help refuses my help and I think they are still a danger to themselves?”

Answer: The compulsory treatment laws allow for suicidal people to be evaluated by mental health professionals and, if found to be a serious danger to themselves they can be hospitalised. Contact your local mental health service for further advice.