

The No Suicide Contract: A Relational Process

Tony White
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Introduction

The no suicide contract has become what it isn't. Where did the the no suicide contract(NSC) come from?. One of the very first fore runners of the NSC, seems to come from *Goulding (1972)*. Whilst he does not actually mention the NSC he goes into considerable discussion about early childhood decisions and the "Don't Be" injunction. For instance he notes that in response to the "Don't Be" injunction the child can make 4 common decisions:

- "1. If things get too bad I'll kill myself; or
2. I'll get you even if it kills me; or
3. I'll get you to kill me; or
4. I'll show you even if it kills me." (P111).

Goulding discusses making redecisions about these early decisions but does not actually mention the NSC. Then *Holloway (1973)* talks about closing the "Kill myself" escape hatch and quotes *Goulding (1972)* in the article. He also does not actually mention contracting to delay suicidal actions.

However it should be noted that *Steiner (1971)* talks about giving the client with a suicidal script a script antithesis as this can delay the tragic ending of the script. He states: "The script antithesis does not dispose of the script, but it buys time during which treatment can lead to script abandonment"(P59). The therapist gives the client a new injunction to delay the tragic outcome of the script. Clearly this is not a contracting process with the client but its goal is to delay suicidal actions by the client which is similar to the purpose of the NSC.

The first mention of the No suicide contract that the writer can find comes from *Boyd (1972)* who states, "Once the original suicide decision is in the awareness of the patient, he can re-decide by making a 'loophole-free' no-suicide contract with the therapist/group" (P87). So it appears that there were a number of people in the early 1970s writing about suicide and its management within the transactional analysis literature.

Then in 1973 *Drye et al (1973)* wrote an article titled, "No-Suicide decisions: Patient monitoring of suicidal risk." This was later reproduced in *Goulding & Goulding (1978)*. Since that time in 1973 it is this article that is usually given credit for the beginning of the no-suicide contract concept.

It is an interesting article in that it is not particularly well edited and by and large did not talk about the NSC as a way of managing suicidal clients. The article primarily is about assessing and monitoring suicide risk in a client. For instance Goulding & Goulding (1978) state, "The authors describe a simple, rapid method by which patients with any suicidal ideas can determine for themselves and the evaluator what risk actually exists" (P125). Thus the article is about the diagnosis of suicide risk and not about the treatment of the client at risk. Interestingly the term, No-suicide contract is never used. However by the end of the article they state, "This combined diagnostic and management technique..." (P132). So through the course of the article it changes from just diagnosis to both diagnosis and management of suicidal clients.

Since that original article by Drye et al (1973) a huge amount has been written about the NSC with the vast majority of it outside the Transactional Analysis literature. An examination of the Transactional Analysis Journal shows very few articles on the no-suicide contract. There are a few like Mellor(1979) and Boyd, & Cowles-Boyd(1980) in the Transactional Analysis Journal but nothing like the quantity that has been written in other journals. For instance Egan(1997), Hipple & Cimboric(1979), Reid(1998), Assey(1985), Simon(1999) & Goin(2003). Typically Transactional Analysis is neither mentioned nor even alluded to in these articles.

In addition the vast majority represent, in my opinion, a misunderstanding of the NSC concept. Marcia Goin(2003) illustrates a typical misunderstanding. Here the 2003 President of the American Psychiatric Association writes an article titled, "The "Suicide-prevention contract": A dangerous myth.". Firstly the NSC does not prevent anything, it merely delays the suicidal person from acting on their self destructive urges. She goes on to state, "Increasingly, clinicians refer to the need "to contract" with patients who they fear might harm themselves. It would be wonderful if contracts truly prevented such tragedies, but there are no reliable or valid data to confirm their effectiveness."(P3). She demonstrates no understanding of the NSC as being simply a short term stop gap.

One explanation for her misunderstanding is she has taken the concept of the NSC but not the theory with it. She does not understand the theory from which the concept of the NSC evolved, most notably the Gouldings and their theory of early childhood decisions. Thus the NSC gets turned into something else. The NSC is used but not in the context of the theory on which it was built. In the prolific writings of the NSC outside the Transactional Analysis literature this is a typical scenario. Hence the title of this paper that the no-suicide contract has become what it isn't.

The no suicide contract

The NSC has received a great deal of attention and debate, at times heated debate. There are those who will argue that they always get a NSC with each client and there are those who will never get a NSC. Then there are counselling agencies that require their counsellors to get a NSC from all clients as it is their duty of care to have that option covered and also to reduce the possibility of litigation at a later time. There are at times quite strong views about the NSC which the writer has always been a bit bemused by. The no suicide contract is a treatment contract like any other which means it has its time and place. In some clinical circumstances it is relevant and useful and at other times it is contraindicated just like any other treatment contract. So to say that one will always get a NSC or never get an NSC seems a nonsense. It ignores making an assessment of the clinical circumstances in front of the therapist and then one makes the decision to suggest a contract or not.

A common NSC is where the therapist asks the client to make a statement such as:

"No matter what happens, I will not kill myself, accidentally or on purpose, for 'x' amount of time".

It should be noted here that the NSC is not just a collection of words that the client states, no treatment contract is that. It is a statement about the process that the client has just gone through. It is a state of mind or an attitude about something.

The No suicide contracting process

Under certain circumstances I do suggest the idea of an NSC to a client, although it really is more of a no suicide contracting process rather than just getting the person to state a no suicide contract. The complete process is best shown in diagram 1. In discussions with the client the goal is for them to get into the position as is shown in diagram 1. If that happens then I would say that they have made a workable NSC. If they do not get to that position then one could say that they have not made an NSC and one works with the client without such a contract. The various components of the NSC as is shown in diagram 1 will now be elucidated.

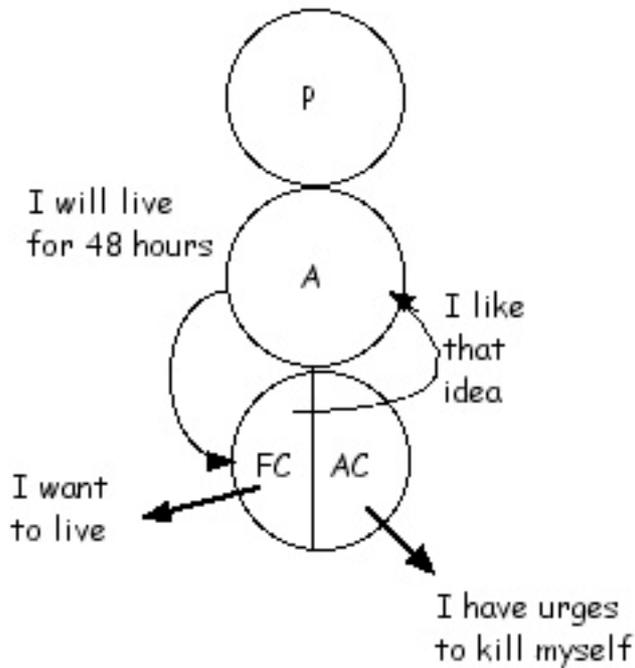


Diagram 1

To reach this position or state of mind the first step in the no suicide contracting process is for the client to gain an understanding of their suicidal ambivalence as is shown in Diagram 2.

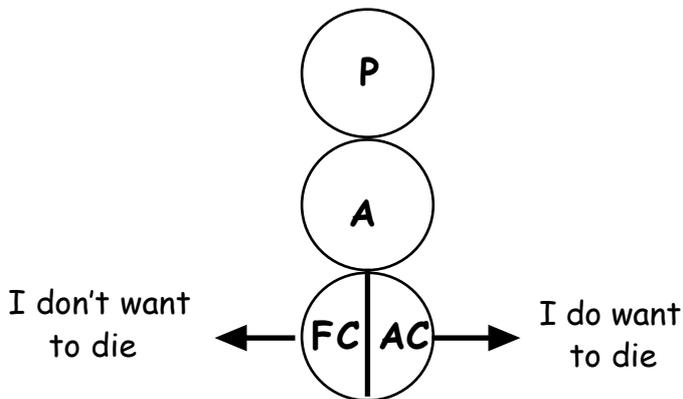


Diagram 2
Suicidal ambivalence

All suicidal people are ambivalent. They have incongruent internal dialogue going on inside their head such as: "I do want to die" and "I don't want to die". Suicidal individuals have this contradictory set of thoughts and urges inside themselves. If a person is 100% "I do want to die" then it won't be too long before they will be dead. If a person is 100% "I do not want to die" then there would be no suicidal thoughts or urges in the first place. The suicidal individual has

percentages of both with the levels waxing and waning over time. Sometimes it will be 50/50 and then on other days it might be 60/40 or 30/70.

One way for the client to gain an understanding of their suicidal ambivalence is for them to take both ego states and dialogue from them. In essence the therapist sets up a 2 chair exercise. In the Free Child chair the client begins to understand that part of self which wants to exist and be alive. In the Adapted Child chair they also gain awareness of their suicidal urges and the part of self that wants to die or kill self. Sometimes they may even dialogue to each other and of course the therapist can also speak to both parts. This allows the client to establish a relationship between the two parts of self and each part is establishing a relationship with the therapist.

Through this process the client can say that they want to live for a period of time and experience what meaning that has for them. How does their Free Child react to that statement? How does the Adapted Child react to it? This is using the original Drye & Goulding idea that was presented in Drye et al (1973). It is purely diagnostic. The client states that they are going to live for "X" amount of time and then they examine their reactions to making such a statement.

In the NSC contracting process and indeed in managing suicidal people in general this is to my mind the most important component. The therapist establishes relational contact with that part of the client which desires to kill self (the Adapted Child). The first thing many therapists do is to try and limit, curb or in some way contain that part of the personality. In my view this is an ineffective way of relating to the client in such circumstances.

Instead one seeks to establish a working relationship with that aspect of the client. To establish relational contact with the suicidal part of the client. This means that you do not try and constrain it or limit it. Instead you develop a working relationship with it. The suicidal aspect of the client and the therapist learn how to coexist with each other. The approach here is quite similar to that as is described by White(1987) and working with the demon sub personality. You learn to coexist and establish a working relationship with it.

So the first step in the no suicide contracting process is to define or clarify the suicidal ambivalence in the client. With the help of the therapist the client clarifies the two opposite urges so they understand them. The second step in the process directly follows on from this. Once the suicidal aspect is clarified that allows the therapist to develop relational contact with it. Once these are done then one can move onto the third aspect of the no-suicide contacting process

Third step

A NSC as described here does not stop the Adapted Child desire to kill self, instead it sits there with it. The two urges sit side by side in the clients mind. Obviously this is different from the usual statement of the NSC: "No matter what happens, I will not kill myself, accidentally or on purpose, at any time". In this statement there is no acknowledgement of the suicidal urges and that is what I like about the NSC process being described here. It openly acknowledges the suicidal urges in the client along with their desire to live. In this way it is being clear, open and factual.

Once this is done the client is then in a position to make some sort of statement about staying alive. It seems that what happen in the past is that the NSC statement - "No matter what happens, I will not kill myself, accidentally or on purpose, at any time" - became an entity in its own right. It lost a lot of its meaning and became a mantra. It became the thing that therapist's got suicidal clients to say whilst the actual meaning of the words were lost, at least to some extent.

This is why I advise against using such a statement. I suggest more of a relational process and this usually takes between 5 to 20 minutes to complete. The therapist and client have a dialogue about diagram one. They discuss the client's urges to stay alive and the client's urge to kill self. Then they discuss acting on the self destructive urges or not. If the client choses to not act on them then there is dialogue about for what length of time.

As you can see in Diagram 1 there is only 3 ego states drawn. In the NSC process described here one uses a relational or interpersonal process which ends up with an intrapsychic process in the client. In this process obviously there are two people in dialogue, the client and the therapist, however the actual NSC involves only the client.

Why? In my 25 years of counselling one thing I have learnt is that people will rarely cheat on themselves. It's like cheating in a game of solitaire, what's the point? If a person makes a deal with them self then very few will go back on that, or cheat on that.

In the dialogue with the client regarding a NSC often the client will try and make the actual contracting part an interpersonal process and the therapist must keep it an intrapsychic one. This is done by crossing transactions, extractive identification, reflecting back to the client and so forth. The actual statement and decision by the client not to act on their suicidal urges must come from an intrapsychic and not interpersonal process. Further explanantion of why this is so is described below

Past problems in making a NSC

As soon as you add a second person into the NSC process (such as a therapist) then it gets more difficult. As soon as the client starts making a NSC statement to the therapist then there is a significant increase in the possibility that the client will switch ego states. They will switch from Free Child and Adult into Adapted Child (either Rebellious Child or Conforming Child). If that happens then the process has broken down and the NSC is doubtful. So it seems wise for the therapist to stay out of it in this sense.

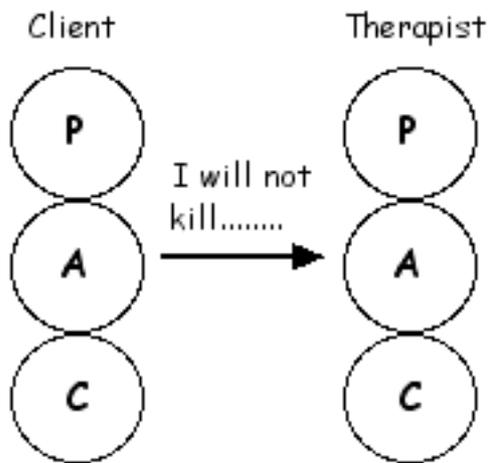
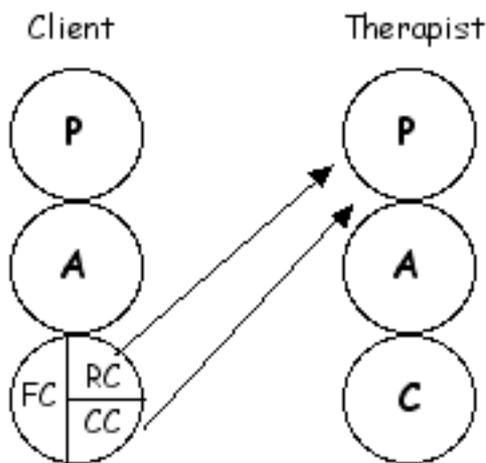


Diagram 3

Historically diagram 3 is a common clinical scenario during the making of a NSC. The client states to the therapist from their Adult ego state the NSC statement. However this is a tenuous situation as it directly involves the therapist and thus it is being made within the framework of the therapeutic relationship. This then of course includes all the transference reactions of the client to the therapist. In addition the therapist may be pressuring a bit unconsciously as they are anxious for the client's welfare and their own feelings. In some instances the therapist may have given the client an ultimatum such as make an NSC or I wont treat you. If the therapist is suggesting an NSC then the client knows this will please the therapist as he is the one who asked for it or mentioned it in the first place.

As a further example of problems consider the article by Reid (1998) which is titled, "Promises, promises: Don't rely on patients' no-suicide/no-violence "contracts"." This again highlights just how distorted the NSC has become outside the Transactional Analysis literature. In this case the therapist asks the client to promise not to kill self. This shows a complete lack of understanding of early decision theory and what the NSC is about.

This is akin to asking a client to state a contract like, "I promise not to push down my feelings" or "I promise to feel important this week". As stated before a NSC is no different then any other treatment contract. Obviously any treatment contract that is a promise of the client to a therapist is a poor contract. It is like a parent getting a child to promise to clean its bedroom or to promise to do its homework. Will the room get cleaned or the homework done? It is unlikely and if it is actually done it will be done poorly.



1. CC: "I promise to you that I will stay alive."
2. RC: "I will say the words but you can't make me keep them."

Diagram 4.

Diagram 4 shows that the client has switched ego states when the NSC is a promise. Instead of making the contract from Adult, a promise is most often a Conforming Child ego state function. As commonly happens when a person is in a conforming position it does not take much for them to switch into a rebellious frame of mind and thus we can have the situation as is shown in diagram 4. Clearly an undesirable situation for any treatment contract but especially a NSC. Whilst people are very reluctant to lie to themselves some are much more willing and able to lie to others. If one makes an NSC from CC then they can readily switch over into RC and break the contract. A NSC contract must never be a promise.

The administrative NSC and writing an NSC

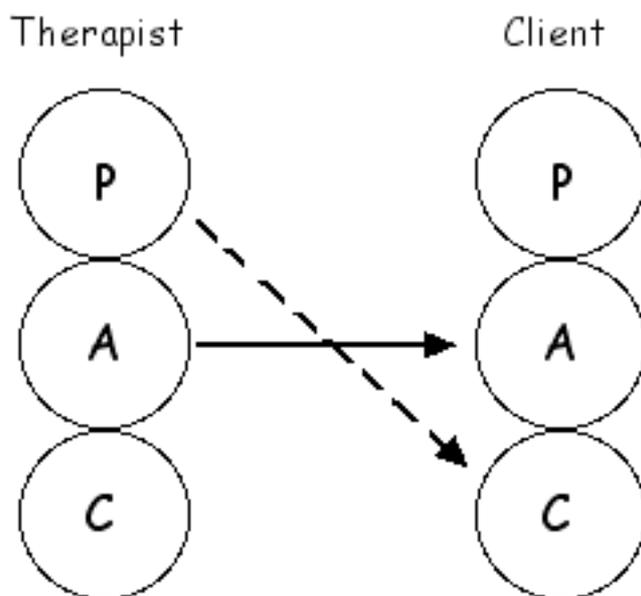
As mentioned before in the state where I live there are some counselling agencies which require their counsellors to get a NSC should the client express

any thoughts of suicide. Part of this requirement is so the agency is less susceptible to subsequent complaints of client mismanagement or subsequent litigation. If one works in such an organisation one obviously obtains such an NSC. At the same time one must distinguish between an administrative NSC and a therapeutic NSC. If one suggests a client make an NSC due to organisational requirements then obviously that is an administrative NSC. Once done then there is the need to assess whether a therapeutic NSC is also indicated. A times is is and at other times it is not.

Another point of interest is when a therapist suggests or requires the client to write the NSC down and sign it. Some counselling agencies have ready made forms where the person fills their name in and the various conditions of the NSC, then signs it and then it is kept on their file by the counsellor.

Baring the administrative NSC why would a counsellor ask a client to write down a therapeutic NSC? As stated before an NSC is a treatment contract like any other and the therapist does not ask the client to write down those treatment contracts.

I am not too sure of the answer to such a question as I have never suggested a client do such a thing. However I suspect there is an ulterior transaction in such a request by the counsellor. See diagram 5.



A>A social level transaction: "I request you write the NSC down and sign it"

P>C psychological level transaction: "Now that you have written it down and signed it you are more obligated to keep to it"

Diagram 5

The Parent to Child transaction could easily elicit a rebellious response at some time. It seems that such a transaction may occur out of the therapist's fear of the client harming self and they are hoping that to have put it in writing then the client is more duly bound to keep it.

Further misunderstandings of the NSC

At times one hears about the client who has made a NSC for the next 20 years. There is probably nothing wrong with doing this, in fact it is probably a good thing to do. However it is not a true NSC in the usual sense of the word. An NSC is used to deal with a crisis in suicidal ambivalence, such a thing does not last 20 years. An NSC is made to buy some time.

A NSC does not cure anything, change anything or prevent anything. It simply buys time and this in particular is misunderstood in the writings on the NSC outside the Transactional Analysis literature. They simply do not understand the theory behind the NSC and thus the NSC is misused and misunderstood in this way particularly. The timeline in diagram 6 highlights this aspect of the NSC.

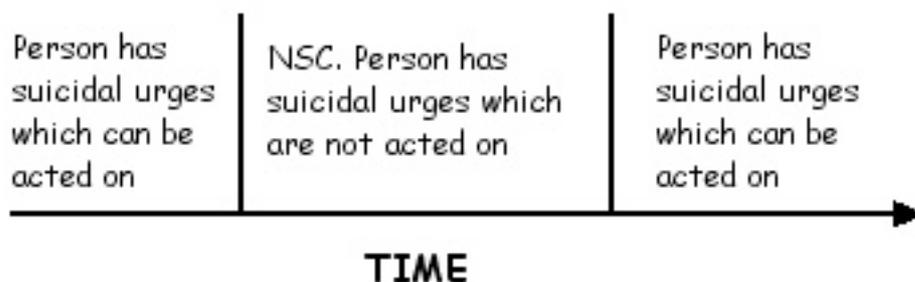


Diagram 6

One can use the NSC to buy time for two reasons. First to do therapeutic work on the "Don't exist" decision made by the client. Secondly it buys time so that the therapist can establish relational contact with the self destructive part of the client. Again I cannot stress how important it is to develop such a relationship with that aspect of the client.

Summary

The NSC as described in this paper is not so much the making of a contract, it is more of a therapeutic process the client and therapist go through where the client may end up with a NSC. Sometimes they do and some times they do not.

Due to not understanding the theory behind a NSC there has been wide spread misuse of this contract particularly outside the Transactional Analysis literature. These have been outlined. What is described is a three step process where the the client and therapist go through a no suicide contracting process.

Step one. Client works with the therapist to understand their suicidal ambivalence. The client, by using techniques like 2 chair, clarifies and identifies the two parts of self. The part which wants to live and stay alive, in this instance it is seen as the Free Child. The client also identifies and clarifies the part of self that feels self destructive and like killing self. This is theorised as the Adapted Child ego state.

Step two. The therapist sets about establishing relational contact with the self destructive part of the client. In doing this the therapist does not attempt to constrain, curb or limit the self destructive urges of the client. Instead the therapist merely wishes to establish a workable coexistence with this part of the personality.

Step three. A dialogue between client and therapist where they discuss and explore the suicidal urges of the client and the client's urges to stay alive. The client and therapist then dialogue about if the client will act on those suicidal urges or not. Then through an intrapsychic proces the client can make a agreement with self about how long they will not act on those suicidal urges. The therapist then returns to step two and keeps evolving the relational contact with the self destructive aspect of the client

If the client does not make such a NSC agreement with self the therapist returns to step two and keeps evolving the relational contact with the self destructive aspect of the client. In the state where I work the therapist must also then decide if the client is at significant risk of a suicide attempt. If they are considered to be, then the therapist must take the appropriate action as is articulated by the state.

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