Assessing Suicide Risk

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INTRODUCTION

The points raised in this article are based on what I have learnt over 22 years of counselling. So they come from a clinical practice point of view rather than a scientific research point of view. Thus it is necessary to take them in that context.

It is a difficult thing to assess - how suicidal a client is at a particular time. Obviously this is a most important thing to assess with all clients. Some are clearly at no current risk of suicide and so the question is not even raised. Others are to varying degrees and that degree is hard to judge. The judgement of how likely is it that an individual will make a serious attempt to end their life. That is, how likely are they to take some action that will kill them or seriously injure them.

This also has importance for the counsellor. Steele & McLennan(1995) note that the possibility of a client suicide is a source of stress for many counsellors, particularly for those with limited experience. They note that often the degree of stress experienced by the counsellor is quite disproportionate to the level of risk of client death by suicide. Consequently, by more accurately assessing suicide risk in a client helps not only the client but also helps the stress levels of the counsellor.

In my view this area is very much neglected in the training of counsellors. That is teaching trainee counsellors about the possibility of having a client that suicides. If one is going to be a counsellor for any length of time then that is a very real possibility. Of course it varies considerably depending on the area you are working in. If you are counselling people who are schizophrenic (psychotic) then there is a very real possibility of that happening, as is the case with counselling depressives or doing crisis counselling. If one does couples counselling or works with counselling people with work place issues then it is much less likely but still obviously possible. People who are training to be counsellors need to be given the opportunity and guidance to discuss the issue of suicidal clients and how they feel about that and how they can cope should such circumstances ever arise. Indeed what are there thoughts and feelings about death and suicide.

CURRENT LEGISLATION

Assessing a client for their potential to commit suicide is significantly hampered by the current legislation in Australia. At present it is legally incumbent on a counsellor or psychotherapist to break confidentiality and inform the relevant authorities (usually the police or the psychiatric emergency team) if they believe

that a client of theirs is a significant danger of harming self. This is deemed their duty of care and they are legally bound to break confidentiality in such instances.

This leads to significant difficulties and hampers the treatment of suicidal clients. Clients are usually aware that counsellors are bound to break confidentiality in such circumstances. So all that happens if they are feeling like harming self is they either do not tell the counsellor, significantly modify what they tell the counsellor and maybe even say untrue things to put the counsellor 'of the scent'. For instance telling a counsellor that they have not stock piled medication when in fact they have. Or telling a counsellor that the urge to kill self is only fleeting when in fact it is very strong and persistent at times.

This of course is very detrimental to the treatment of the suicidal individual as the counsellor is then uninformed or misinformed and thus will make poor decisions about the treatment and management of the client. If there was ever a time that a counsellor needs to be well informed about a clients mental state it is when they are having suicidal thoughts. In my view there needs to be a change in the legislation so that counsellors are specifically prohibited from breaking confidentiality when a client is in danger of harming self. Then clients are much more likely to keep their counsellor fully and accurately informed and much better client management decisions will be made by the counsellor. The current legislation in my view directly increases the mismanagement of suicidal individuals. It forces the client into a position where that have to not tell the truth or at least not tell the whole truth to the counsellor thus increasing chances that an individual will die or be maimed by suicide.

However the law is what it is at the moment as thus the counsellor must never assume that he is being told the truth by the suicidal individual. I am not suggesting that suicidal people are for some reason a group of pathological liars. Instead they are very unhappy and despairing individuals and thus they make poor decisions for themselves at that time.

DECISIONS

I my view suicide is decisional. I have worked with many depressed people over the years and some of them would be classed as having "clinical depression", which means they are very depressed. Some of these people are clearly at considerable risk of suicide, however for others the question of suicide does not even arise.

To add to this Viktor Frankl(1959) in his penetrating book, "Man's search for meaning" discusses the psychological consequences of people who were put into Auschwitz concentration camp. He states, "The thought of suicide was entertained by nearly everyone, if only for a brief time. It was born of the hopelessness of the situation, the constant danger of death looming over us daily and hourly, and the

closeness of deaths suffered by many of the others. From personal convictions which will be mentioned later, I made myself a firm promise, on my first evening in the camp, that I would not "run into the wire". This was a phrase used in the camp to describe the most popular method of suicide - touching the electrically charged barbed wire fence. It was not entirely difficult for me to make this decision"(Pp 36 - 37).

Here we have a situation that could not get any worse. The Auschwitz inmates were put into a situation that could not have been worse in terms of the day to day living circumstances. Some chose to suicide and for others such as Viktor Frankl the question was never entertained in any serious way. My observations have been the same. Some people will endure terrible depression or lose totally everything they had in life and suicide is never even considered as an option. Others need only a slight set of unlucky circumstances to arise and they will seriously contemplate suicide.

THE AMAZING HUMAN BODY

To kill oneself is not an easy thing to do. The human body has evolved over millions of years and the core of that evolution is to design a body so that the owner of it will not cease to exist and thus can continue to reproduce the species.

Again I refer to the comments of Viktor Frankl(1959) who was a medical doctor. "There were many similar surprises in store for new arrivals. The medical men among us learned first of all: 'Textbooks tell lies!' Somewhere it is said that man cannot exist without sleep for more than a stated number of hours. Quite wrong! I had been convinced (By the medical textbooks) that there were certain things I just could not do: I could not sleep without this or I could not live without that or the other" (P35)

"I would like to mention a few similar surprises on how much we could endure: we were unable to clean our teeth, and yet, inspite of that and a severe vitamin deficiency, we had healthier gums than ever before..... For days we were unable to wash, even partially, because of frozen water pipes, and yet the sores and abrasions on the hands which were dirty from work in the soil did not suppurate" (P36). [Suppurate: If a wound suppurates that means pus forms inside it because it is infected].

He is saying here that the facts in medical texts relate to the human body in normal conditions. When the body is put in extreme conditions some of those medical facts are wrong. When someone attempts suicide that often means they put their body in extreme conditions. Pursuant to this, the medical texts can never know how the body functions in extreme conditions because it would be unethical to do research where subjects bodies were put in extreme conditions.

The main point here is that if someone is feeling like killing self that is not

an easy task to carry out. The body has many, many ways of keeping its owner alive when it is assaulted by whatever means. This has good and bad to it. A suicidal crisis can be passed because the body copes with the damage inflicted on it by its owner. The attempt at suicide is not completed. Unfortunately some suicidal people have attempted to take their lives and not killed self but have been left badly disabled such as with some form of paralysis or brain damage. I am reminded here of a wheelchair bound man whom I counselled, he had previously jumped off a building and was left paralysed from the waist down.

This tenacity of the human body to survive significant assault means that to have a high probability of completing a suicide one must do some planning and preparation. To accumulate the medication, to get the tubing and the tape to connect the car exhaust to the inside of the car, to get a gun and ammunition, to get a rope and be able to find a place and tie a knot that would allow for a hanging. This is one of the keys to allow for the assessing suicide risk - the preparations that are being done for a suicide attempt.

SUICIDAL AMBIVALENCE

Another key that allows suicide risk to be assessed is that all suicidal individuals are ambivalent to some degree - "I do want to die vs I do not want to die".

As suicidal people are ambivalent they will have the internal dialogue going on inside their head saying: "I do want to die vs I do not want to die". This is shown below in diagram 1.

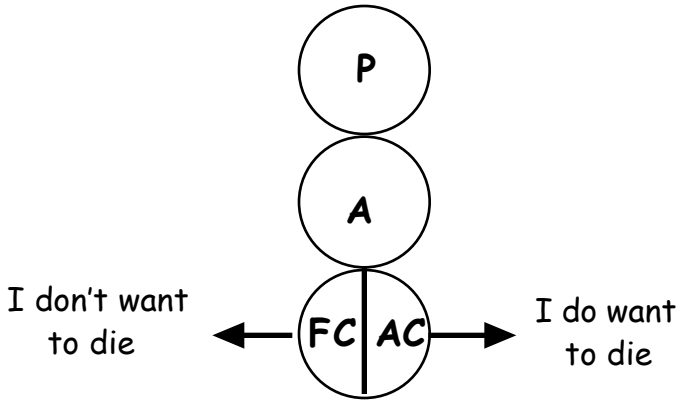

Diagram 1
Suicidal ambivalence

All suicidal people have this contradictory set of thoughts and urges inside themselves. If a person is 100%, "I do want to die" then it wont be too long before

they will be. 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. As they all have some desire to stay alive this will create a time frame or window of opportunity where the individual can get assistance.

SUICIDAL TIME LINE

It is advantageous to view suicidal urges and attempts on a timeline basis. The three timelines shown below in Diagrams 2, 3 & 4 outline the three most common scenarios.

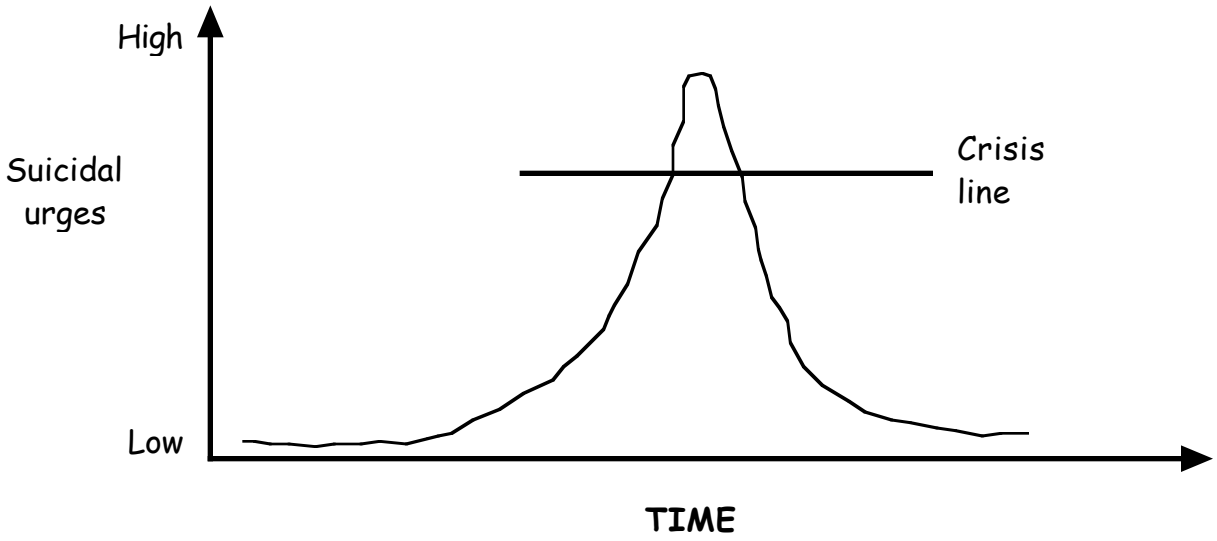

Diagram 2.
Acute suicidal crisis

Diagram 2 shows the case where the individual is going through life and for some reason suicidal urges and ideas rapidly appear and then if there is no completed suicide the suicidal urges disappear quite quickly as well. The crisis line is that point where the individual is a serious suicide risk. This scenario most often occurs in reaction to an event such as a marital separation, financial collapse, imprisonment, psychotic episode and so on.

The good part about this case is that when someone has feelings that rapidly occur then that means they can rapidly "unoccur" somewhere down the track. As they are relatively new to the personality they have not had time to become ingrained in the personality. This of course is good news for the client but at the time rarely will a client appreciate this, because if one is suicidal then one's long term future looks very bleak no matter what the Adult ego state facts are. However

it certainly is important information to pass onto the client and can assist the counselling. Also if suicidal thoughts are a reaction to an event then usually when that event stops then the suicidal thoughts are likely to go away as well. For instance if someone becomes suicidal as a result of being arrested and incarcerated and then they are released on bail the suicidal feelings may subside because they are out or prison.

The down side in this scenario is that you can get the spontaneous type of suicide attempt particularly when alcohol is involved. The person simply walks outside of their house and into oncoming traffic, or the person jumps in their car and drives into a tree or goes to the medicine cabinet in the house and swallows all the medication in it. Such unplanned suicides have an increased possibility of the outcome not being death but some form of permanent disability. Further to this is the difficulty that due to the suddenness of the suicidal urges the individual may have no support network in place. For instance they have no contact with a counsellor or some organisation that can assist in such a crisis and they may at that time have no idea where or how to find such support.

To deal with this situation it is usually a viable option for the person to be hospitalised, put on suicide watch (as in prison) or relocated to some situation where there is a good deal of support, both practical and emotional. If the suicidal crisis is short term then this type of approach often helps in avoiding the crisis resulting in death or disability. With the other two scenarios listed below this approach is of less assistance.

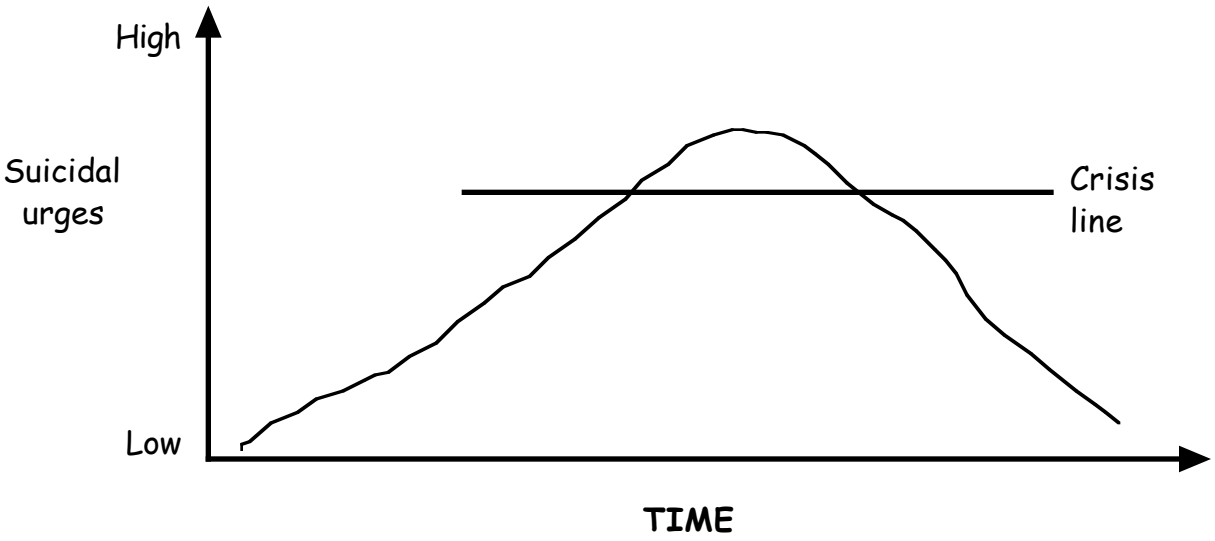

Diagram 3
Slow developing suicidal crisis

Diagrams 2 & 3 are not mutually exclusive and both can occur together. In

diagram 3 the suicidal ideation develops over time and not in a sudden way like in diagram 2. So there is less likely to be an obvious event that precipitates the suicidal feelings. They just slowly evolve over time. The positive to this is that people will tend to seek help of some kind before the crisis line is reached. First this means there is more opportunity for some form of counselling to result in the crisis line being avoided altogether. Second if it is reached then the person is more likely to have some form of support network in place so as to avoid a completed suicide.

On the down side, as the suicidal urges have developed over time that means they do become more ingrained in the personality and thus they will disappear less rapidly and easily than they can do in Diagram 2. Also in this situation there is much less likelihood of the spontaneous type of suicide attempt. The suicides will tend to be better planned and thus more likely to be completed suicides but thus there is less chance of a suicide not going as planned and leaving the individual maimed in some way. For instance the correct amount and type of medication is collected for a completed suicide rather than the incorrect amount which may just leave the individual in a coma.

Hospitalisation or suicide watch is less helpful here. If one is closely watched then the individual just delays any suicidal actions. How long do you keep a person in hospital for suicidal urges - 6 months, 1 year, 2 years?. If the person has felt despairing for the past 6 years they can last out another 6 months with not much trouble. In addition if the urges have developed over a period of time then they will be more ingrained in the personality and just offering a support network will have little meaning for the client. It will have less impact than for the average individual, because the problem is more inside the individuals head than a matter of a difficulty with their social milieu. As a result script work obtains more of a priority.

The third scenario (below) of chronic suicidal ideation usually develops over a long period of time. Over that period the person for whatever reason just begins to feel worse and worse with depression, despair, shame or whatever feeling it may be. All sorts of solutions to reduce the despair may be attempted but with little success.

This results in a very poor quality of life evolving over time and these people just begin to tire of living. It is just all too hard. This case can be particularly with people in the later part of their lives. It is quite likely that at some point in time this individual will make a very concerted effort to end their life. Indeed they may do that on a number of occasions.

This scenario raises the whole contentious area of euthanasia for psychological reasons. Some argue that in this case it is not suicide but self induced euthanasia. The individual may be physically fit but over the last 20 years they have

tried every possible type of counselling, medication and numerous 'alternative' medicine solutions and yet they still just feel chronically despairing. So the quality of life is very poor and the likelihood of finding a solution is very low. What does one do in such circumstances? How long do you keep trying in such circumstances?

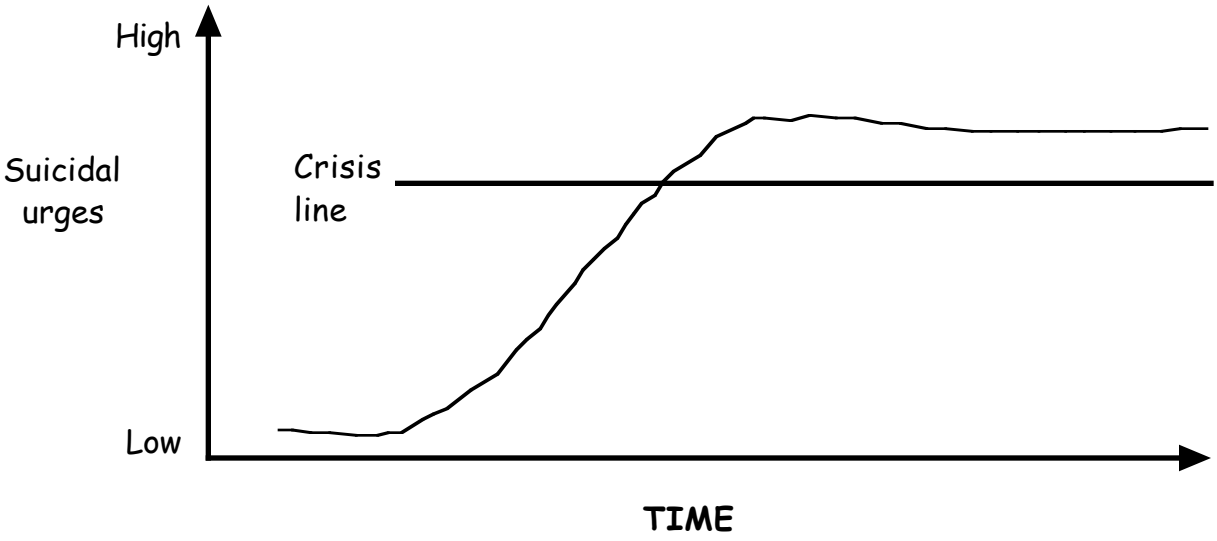

Diagram 4
Chronic suicidal crisis

As with diagram 3 hospitalisation is less useful for the same reasons. Again how long do you place the person in a safer setting instead of being like others who have to deal with day to day circumstances form their home? As a result of suicide frightening some people, they feel like they must do something to make the person safe. So putting them in hospital is often the course of action. (This however is sometimes more for the associates feelings of well being than for the suicidal individual). Hospitalisation does not make a person non-suicidal, all it does is relocate them geographically. It moves a person from being suicidal at home to being suicidal in a hospital. Yes there is more support in a hospital which may or may not be helpful, but it can only ever be a temporary situation. In the long term it is not a guarantee of safety and the suicidal person's friends and relatives need to come to terms with that. The only way to avert suicidal urges in the long term with diagrams 3 & 4 is for changes to occur in their psyche which they carry around with them every day. This is where script work comes to the fore. Sometimes that script work will be fruitful and sometimes it will not.

FACTORS THAT INDICATE THE DEGREE OF SUICIDE RISK

When assessing suicide risk one must first make the distinction between three types of individuals.

1. Those who are suicidal and think about ending their life.
2. Those who make suicide attempts. Those individuals whose goal is not so much to kill self but instead to make an attempt at killing self that will not be completed.
3. Those who self mutilate and are not interested in killing self.

It is not uncommonly believed that if a person mutilates them self by cutting self, burning self or gouging self then that person is suicidal. This is not necessarily so. Some people self mutilate and are not suicidal at all. However there are suicidal people who also do self mutilate. So sometimes self mutilation and suicidal thoughts are linked and sometimes they are not. The first thing the counsellor needs to do with a client who self mutilates is to ask them about their suicidal urges to assess if those urges exist or not.

There are others who are 'suicide attempters'. Those people who will behave in a suicidal way but who have little interest in actually killing self. Such people can slash their writs in such a way that there is only superficial damage or take medication that is very unlikely to kill them. Then there are others who will do some suicidal act and then tell someone. Interestingly, Steele & McLennan(1995) note that the current estimates of suicide attempts to death by suicide range from 50: 1 to 200: 1 in the 15 to 24 years age group.

I am reminded of a situation where I had to write a report for the coroner about the death of a delightful 23 year old woman who had previously been a client of mine. In my view she was a 'suicide attempter'. Her most common pattern was to take medication and then contact her boyfriend who would then come and save her. In this instance she did that by sending him an email that she knew he was very likely to get. There was a one in a hundred chance that he would not get it. As it turned out he never got the email and she died from the overdose. This is the difficulty with such people as sometimes the act which is not designed to kill, goes wrong and actually does kill them. So in assessing suicide risk it is important to diagnose the client as either a 'suicide attempters' or a suicidal individual. Sometimes the line between the two is blurry. The key to making such a diagnosis is to find out by questioning what is the person's true motive and that can be hard to do depending on how frank the person is prepared to be with you. This is a typical scenario when the law as it stands directly puts the person at more risk. It makes it very hard for the counsellor to assess the suicide risk as the person is reluctant to tell the full truth because should they, then they know the counsellor is required by law to notify the police.

Finally we have the person whose goal it is to take their own life. They are not interested in just trying to suicide for some ulterior motive. Sometimes these people will have made a few attempts before completing a suicide due to either suicidal ambivalence or just poor planning. So just because someone has made a few prior attempts does not mean that they are a 'suicide attempter'. Then there is the

person who is suicidal, has not made any attempts, has no ulterior motives such as attention seeking and often just mentions suicidal thoughts in passing. This person is often a very high risk individual. This individual who is often well planned, is thinking of adopting a method that has a higher chance of completion and is fully aware of the counsellors requirements to break confidentiality can be at high risk indeed. After the death of such a person you hear comments like, "I had no idea, he seemed so untroubled and had so much to live for". The law's requirement for breaking confidentiality is very detrimental for the treatment of this type of person. I would go as far as to say that it has contributed significantly to the deaths of many of them because they do not disclose the suicidal urges to anyone including the counsellor.

SUICIDAL THOUGHTS IN ASSESSING RISK

When someone says they have suicidal thoughts what does that mean? It firstly needs to be put in context. Steele & McLennan(1995) researched suicidal thinking. Firstly they found that 66% of the general population (Australia) at some time have thoughts of committing suicide. 32% of general population have had a significant thoughts of committing suicide. An analysis of a number of studies by Steele & McLennan(1995) concludes that 6% of the general population actually attempt suicide

So 66% of people have considered suicide at some point and thus it is not an abnormal event in that sense, and fortunately for the great majority it only ever remains a thought (94% never turn those thoughts into action). However one needs to be cautious what they do with these figures as all suicidal thoughts must be taken seriously and investigated.

Also it means that when a client reports suicidal ideas it is important for the practitioner (& others) not to panic. In my work with parents and children it is not uncommon for parents to seek my counsel because one of their children has reported suicidal thoughts, or they may have found a diary written by the child that included statements about suicidal urges. Understandably many parents are very alarmed by this. To have a child die is a very difficult event for any parent to cope with, but to have a child die by suicide would be even worse for most parents.

I am not for a moment suggesting that parents (& others) do not take statements of suicide by a child seriously. I clearly recommend that they do. I also recommend that they keep it in context, don't panic and seek some form of psychological assistance to have it assessed.

WAY OF TALKING ABOUT SUICIDE

How does the person talk about the suicide. What type of language do they use. Below are some examples of how people can talk about death. Of course these

are just single statements and one would not make a judgement based on just one sentence alone. These are meant to reflect the theme of what the person is saying. It shows the level of suicidal ambivalence or lack of ambivalence. These come from White(1991).

These reflect the psychological basis for the suicidal thoughts. The most forthright statement one can get about suicide is, "I want to kill myself". This is a Child ego state statement that is action oriented and needs to be looked at closely. Compare this to another type of statement like, "I want to die". This is also Child ego state but it is less action oriented. 'Want to die' is more passive than, 'want to kill self'. However they are both very much Child ego state statements and thus represent a significant degree of risk.

Then you can get comments like, "I have to kill myself (die)". The 'have to' comment shows this is Parent ego state and thus less potent. The person feels they have to complete some task that has been placed on them or given to them. So in this sense it is coming less from the heart (Child ego state).

Sometimes there are other statements that show faulty belief systems (delusions). In Transactional analysis terms they are contaminations. For instance we can have statements like, "I have to kill myself (die) to keep someone else alive". This represents magical thinking and thus is a Child ego state contamination of the Adult. By killing self one cannot keep someone else alive. Alternatively there can be fatalistic statements like, "It is inevitable that I will kill myself (die)". The degree of suicide risk in such instances depends on how strong and resilient the delusion or faulty belief system is. If the delusion begins to crumble when clear Adult information is given then the risk is reduced. In other cases the faulty belief will persist no matter how much clear factual information is given and thus the risk is increased.

Then one can get Rebellious Child ego state statements like,
"I want to cheat death" or
"I will show them by killing myself".

This type of suicidal urge varies in risk depending on what is currently happening in the persons life. That is, are they currently in a situation that will promote the Rebellious Child ego state. The most obvious example is that they are currently in contact with a parental or authoritative type person the most usual being the individuals parents. The more a parent is being parental and authoritative to a person the more likely that person will respond in a rebellious way. As a result if they have suicidal urges that have a rebellious origin then this increases the possibility of the person acting on those urges.

Finally one gets the most passive statements about suicide, such as:
What's the point of living
I want to to go to sleep and stay asleep

I want to disappear and never come back

These are statements that indicate the smaller amount of risk but as with any such comments they require investigation.

PLANNING SUICIDE AS A METHOD OF RISK ASSESSMENT

If a client is being forth coming with information then the detail that the person has put into planning their death can give more insight into how committed the person is to carrying out such a plan. As a general rule the more specific the planning the more risk of suicide for the person. This tends to be one of the better indicators of suicide risk.

Has the person thought of planning when, where and how;

For instance

Take an overdose at home or found another place and have they been to check it out.

How they would collect and store the medication. Has this begun.

Where they would get the rope for hanging. Has it been purchased.

How to tie the knot and where to hang the rope.

Where to get the tube to put on the car exhaust. Has it been purchased.

Where and when to throw self under a train.

Co-ordinating times for the suicide with the movement of friends and relatives, so as to be found by the 'right' person

and so forth.

Related to this is circumstances such as has the individual purchased reading material like "Final Exit" (Humphry(1991))?. This book goes into detail about a wide variety of ways by which a person can kill them self. The advantages and disadvantages and the risks involved in each approach. For instance in discussing death by household cleaning products he states, "The prospect of death certainly lies under almost every household kitchen sink. Bleach, lye and drain cleaning fluids may kill. The manner of death is painful in the extreme and in certain cases rescue is possible. I have heard of people throwing themselves through plate glass windows in their death agonies after drinking lye" (P44). I imagine these days it would not be too hard for someone to obtain such information from the internet. If a suicidal individual has acquired such specific information then it would seem that they at some point have seriously contemplated suicide.

The well planned suicidal individual may have researched the area of euthanasia as this covers the scenario where a suicide attempt is not completed but leaves the person severely or mentally disabled. In this state this includes organisations like WAVES, (The West Australian Voluntary Euthanasia Society). Some such organisations have a process called a 'Living will'.

To quote from part of such a will: "LIVING WILL is a formal request prepared by the EEC. It informs the signer's family or others who may be concerned

of the signer's wish to avoid the use of 'heroic measures' to maintain life in the event of irreversible illness.

If there is no reasonable expectation of my recovery from physical or mental disability, I, _____ request that I be allowed to die and not be kept alive by artificial means or heroic measures. Death is as much a reality as birth, growth, maturity and old age - it is the one certainty. I do not fear death as much as I fear the indignity of deterioration, dependence and hopeless pain. I ask that medication be mercifully administered to me for terminal suffering even if it hastens the moment of death." The full document is then signed and dated in front of a witness.

As you can see there is nothing unequivocal about this. If an individual seeks such a living will and signs it in front of a witness who also signs it then this individual has certainly thought about their own death. If the person is healthy and middle aged or younger that certainly begs the question of the degree of suicide risk in this case.

SUICIDE NOTE

It seems reasonable to assume that if a client has written a suicide note then they have certainly contemplated suicide. This would indicate a considerable risk of completed suicide occurring. Such notes can provide invaluable information about the state of the client and assist greatly in their management to avoid suicide occurring. However it seems safe to conclude that few suicidal individuals will allow such a document to be seen by a counsellor as here we have written proof of a persons suicidal urges and thus the counsellor would quite likely break confidentiality as is required by the law. Thus we have another circumstance where the law results in the exact opposite of what it is trying to achieve, keeping a suicidal individual alive.

GETTING ONE'S AFFAIRS IN ORDER

If a client has gone about getting their affairs in order then this is a indicator of considerable suicide risk. Again clients are going to be reluctant to tell a counsellor such a thing because of the confidentiality issue. Have they taken out life insurance, if so they will try and make the suicide look like an accident (such as in a car) as some insurance companies do not pay out for suicides?. Have they recently made a will? Have they arranged their financial affairs so that the death will not result in financial chaos, and so forth.

PREVIOUS SUICIDE ATTEMPTS

This can be a good indicator of the persons attitude and motives for suicide. What is the persons history regarding suicide attempts. This can help identify the

'suicide attempter' from the person who is more determined to complete a suicide. How many previous attempts have there been? Why have the suicides not been completed? Is the suicidal behaviour being used to manipulate someone? How spontaneous have the attempts been or have they involved considerable planning?

SCRIPT ANALYSIS

Finally some of the best information for assessing suicide risk comes from a script analysis with the individual. What are their script messages about the 'Don't exist' injunction? What script messages did they receive from the most important parental figures in their past about their worth and about living or dying. Some times the messages are very clear that the person was not wanted and it would have been better if they were dead. This can be given verbally by the parent figure or may have been given by the actions of the parent figure.

NO-SUICIDE CONTRACT

Finally one feels compelled to make a comment about the No-suicide contract (NSC). For some reason this has become a bit of a political hot potato. Perhaps because suicide is such an emotive issue. On the one side there are those that think a NSC is essential for all suicidal clients (sometimes all clients!) and on the other side there are those who see the NSC as a waste of time, minimising the problem, making the client make a promise they will not keep. To my mind both camps are misguided.

An NSC is no different from any other type of contract, such as a contract to be assertive or a contract to show feelings. A NSC can be a very powerful tool in dealing with the suicidal person when it is used at the right time, the the right way and in the right context. It is one part of the overall strategy in dealing with the suicidal person. To exclude it from ones repertoire for some reason seems such a silly thing to do.

Also I would like to add that there are other points about an NSC that are widely misunderstood. This usually comes from a feeling of scare in the therapist or the organisation the therapist works for. It would not be a pleasant feeling to have one of your clients take their life, for some therapists it would be most distressing indeed. So dealing with suicidal clients can be scary.

Sometimes the NSC can become a promise. In this case the therapist gets the client to make a promise that she will not take her own life. This is definitely not how an NSC needs to be done. Parents get children to promise to clean their rooms or do their homework, and how often does the room get cleaned or the homework get done. Not very often I would suggest. A workable NSC must not be a promise by the client to the therapist that she will not kill herself.

A true NSC is made by the client to herself, and it can be done in the

presence of a therapist. The client makes a contract with herself that she will stay alive for a certain amount of time. This is a very potent type of contract as very few people will cheat on themselves. Its like cheating in a card game of solitaire - what's the point? So if a client makes an NSC with herself then that can be a most powerful contract indeed.

Also it must be remembered that the NSC is a stop gap only. It does not stop suicidal ideation or suicidal behaviour it only delays it. That delay can of course be very useful in that it gives the therapist time to work with the client on there feelings that they want to end their life.

Finally these days it is necessary to distinguish between two types of NSCs. In the community where I work some organisations or agencies require their counsellors to get an NSC from suicidal clients. One of the reasons for this is to reduce the possibility of being sued later on by a relative who claims you did not carry out your proper duty of care by getting an NSC with their son, brother husband and so forth. So this is a CYA NSC (Cover your arse No suicide contract.) So we need to distinguish between a NSC made for legal reasons and an NSC made for psychological reasons. If your agency requires it then you do a CYA NSC but at the same time being aware that it is not a psychologically motivated NSC.

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