INTERVENTIONS FOR PREVENTING VIOLENCE TOWARDS OTHERS AND TOWARD ONESELF IN THE AFTERMATH OF THE PANDEMIC

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BIOGRAPHICAL SKETCH

Donald Meichenbaum, Ph. D, is Distinguished Professor Emeritus, from the University of Waterloo, Ontario from which he took early retirement 25 years ago. Since then he has been the Research Director of the Melissa Institute for Violence Prevention and the Treatment of Victims of Violence in Miami. (Please visit www.melssainstitute.org). Dr. Meichenbaum is one of the founders of Cognitive behavior therapy and in a survey of clinicians, he was voted "one of the ten most influential psychotherapists of the 20th century." He has received a Lifetime Achievement Award from the Clinical Division of the American Psychological Association. He was the Honorary President of the Canadian Psychological Association. He has presented in all of the Canadian Provinces, in all 50 U.S. states, and internationally. He has published extensively and has authored several books including Roadmap to resilience that he has made available as a website for FREE (Please visit roadmaptoresilience.wordpress.com). His most recent article " How to spot HYPE in the field of psychotherapy " was chosen the best article in the filed of psychotherapy. His latest book "Treating individuals with addiction disorders: A strengths-based workbook for patients and clinicians" is being published by Routledge Press. He celebrated his 80th birthday publishing "The evolution of cognitive behavior therapy: A personal and professional journey with Don Meichenbaum" (Routledge Press).

WHY YOU SHOULD ATTEND DON MEICHENBAUM'S WORKSHOP

"I'm writing to express my deep appreciation for your work, style, and influence, I have all of your books and frequently cite your articles. I am a sponge when it comes to your interventions and overall approach to therapy.

Please let me tell you how I have made a gift of your work to others. I own a large private practice. I have 90 therapists and interns working with me and we see thousands of clients every year. After I attended your workshop, I was so motivated that I decided to implement your model into the daily work we do with clients. I have been teaching your philosophy, using your handouts and books. I changed the way we keep our progress notes to reflect your Case Conceptualization Model and now require every therapist to complete a Case Conceptualization form for each case.

As a therapist, I want to comment on how much I appreciate the ease of using the online version of your Roadmap to resilience book (roadmaptoresilience.wordpress.com). It's so user friendly. I am able to go to the fitness areas and ask what area my patient might like to discuss. Equally, it is possible to go to the Appendices and take a look at the checklists or the topics and move forward from there. It is really brilliantly done. My client has said that he really likes working with Roadmap to Resilience and after having the opportunity to explore the online book in greater depth I'm certain I will use it with other clients.

It is a very generous gift for you to have shared your book in this way at this time. I thank you very much.
(NOTE: The FREE Roadmap to resilience website in the first six months has had 20,000 visitors from 114 countries worldwide).

TREATING INDIVIDUALS WITH ADDICTIVE DISORDERS:
A STRENGTHS -BASED WORKBOOK FOR PATIENTS
AND CLINICIANS (Routledge, Taylor and Francis Press, 2020)

Don Meichenbaum is not only one of the foremost psychotherapy scholars of our lifetimes; in keeping with his book's theme, he is an excellent "story-teller." This Patient Workbook provides a wealth of practical, user-friendly, and evidence-informed coping tools that addicted individuals can use in their journey of recovery. Meichenbaum's workbook is a refreshing new approach to treating addiction, and an antidote to the ever-present hype in the addiction field. Highly recommended!

Scott O. Lilienfeld, Ph.D., Samuel Chandler Dobbs Professor, Emory University, Atlanta, Georgia Editor, Clinical Psychological Science

This is a valuable workbook that provides concrete explanations and recommendations for people who struggle with addictive behaviors. Dr. Meichenbaum has vast experience in field of mental health and is considered a world-renowned expert. He certainly understands that the skills needed for overcoming addictions go well beyond "Just say no." He focuses on cognitive, behavioral, interpersonal, general coping, and life skills in accessible, conversational ways – and his vivid case examples ("Recovery Voices") are particularly helpful. I highly recommend this workbook to anyone seeking relief from addictive behaviors, as well as those professionals who help people with addictions.

Bruce Liese, Ph.D., A.B.P.P., Clinical Director, Corrin Logan Center for Addiction Research And Treatment; Professor of Family Medicine and Psychiatry, University of Kansas, Kansas City

This book offers an excellent combination of hope and inspiration, useful factual information, and actual skill instruction and the language needed to achieve and maintain recovery. There is also valuable attention to managing interpersonal problems and to the use of cultural strengths and spiritual-religious resources. I expect that both therapists and their clients/patients will want to have a copy for their frequent reference. Strongly recommended!

Michael F. Hoyt, Ph.D., author of *Brief Therapy and Beyond*; editor of *Therapist Stories of Inspiration, Passion, and Renewal*; and co-editor of *Single-Session Therapy by Walk-In or Appointment.*

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ADDITIONAL RESOURCE PAPERS ON THE MELISSA INSTITUTE WEBSITE

Visit **www.melissainstitute.org**. ***Click Resilient Resources***

35 years of working with suicidal patients: Lessons learned

Child and adolescent depression and suicide

Treatment of individuals with prolong and complicated grief and traumatic bereavement

Self-care for psychotherapists and caregivers: Individual, social and organizational interventions

Trauma, spirituality and recovery

How to spot HYPE in the field of psychotherapy

See presentation by Joan Asarnow

Assessment of depression and suicide risk: Strategies for relating youth to optimal interventions

Under the COVID -19 Resources

See paper by David Jobes and colleagues

The COVID -19 pandemic and suicidal risk: The tele-psychotherapy use of CAMS

See paper by Golnaz Tabibnia & Dan Rodecki

Resilience training that can change the brain

See the two papers from the National Child and Traumatic Stress Network

Telehealth consultation for youth suicidal and self-harm ideation and behaviors

Suicide, self harm and LGBTQ youth: Tips for therapists

Also see a Video interview conducted by Don Meichenbaum with a patient who has attempted suicide seven times ---Missy.
order@apa.org.

MELISSA INSTITUTE'S INITIATIVES IN RESPONSE TO TRAGIC EVENTS

TRAGIC EVENT	INITATIVES
Newtown school shooting	Conduct an attitude survey of local NRA members toward guns Resulted in a Report on how to use Motivational Interviewing with NRA members
Parkland FL School shooting and the March for Our Lives	Create a Toolkit for School Safety and Attitudes towards guns. Distributed to thousands of Educators
Mass shooting in Thousand Oaks, CA	Article published in the Police Chiefs' Journal on “How to identify a potential mass shooter "
Onset of the COVID 19 Pandemic	Create a COVID 19 Internet resource for parents, educators and clinicians Write an Instructional Guide on ways to engage "anti-maskers" to wear a mask that has been distributed to Universities for their students
Help frontline hospital staff bolster their resilience	Visit roadmaptoresilience.wordpress.com (This Website has had 20,000 visitors from 1I4 countries worldwide) Post articles on ways that resilience can change the structure and function of the brain)
Address the increase in violence interviews during the pandemic	Conduct and distribute Video on domestic violence and street violence
Address Police Misconduct	Create an Anger Management and Bystander Intervention Program Provide a FREE webinar with Dr. Meichenbaum and Video interview with Dr. Ervin Staub

Address increase in Suicidality and Prolong Grief Reactions	Webinar and Treatment Manuals Telehealth assessment of suicide by Jobes
Address school bullying	See www.teachsafeschools.org Material by Ron Slaby, Debra Pepler, Leena Augiemeri and others
Prevention of the development of antisocial behavior	See Literacy Diet

Dear colleague,

We are pleased to share with you a new Melissa Institute ***Anger Management and Bystander Intervention Program***. The program incorporates time-tested cognitive-behavioral anger management techniques, bystander intervention and mindfulness knowledge with insights and strategies from the evidenced-based SNAP (STOP NOW AND PLAN) Bystander Intervention Program.

In collaboration with Dr. Leena Augimeri and Katherine Shaw, we have put together a SLIDE presentation that consists of four sections, namely:

1. Educating individuals about how anger can escalate to the point of violence;
2. How to prevent and defuse violence by using a *SNAP Active Bystander Intervention* skills;
3. Ways to employ a variety of cognitive behavior skills in the midst of highly provocative situations; and
4. Ways to deliberately practice and teach these skills.

The training program can be used in several ways:

1. The program can be used as a self-administered instructional program either alone or with others. The program includes opportunities to "*Pause*" and "*Think/Reflect*" and ways to "*Challenge*" oneself to develop and practice these skills.
2. The program can be incorporated into a group bystander intervention training program. Each section can be the basis of discussion, role playing and deliberate practice.
3. The program can be used by individuals facing potentially violent situations such as police and military personnel.
4. The program can be used as a supplemental tool for a variety of anger management programs, intervention programs for men who batter, domestic courts, and programs designed to prevent violence in schools, workplaces and places of worship.

In the resource section of the Melissa Institute's website (www.melissainstitute.org), you can find relevant articles on the SNAP Bystander Intervention program by Dr. Leena Augimeri, links to a YouTube video of the use of the SNAP program, and related articles by Dr. Ervin Staub on ways to "Prevent police misconduct using Bystander intervention," Dr. Ron Slaby on "Ways to

foster active bystandership at home and in the community" and by Dr. Debra Pepler on the use of bystander interventions to prevent bullying in schools. We welcome your reactions to this ***Anger Management and Bystander Intervention Course.***

PLEASE SHARE THIS WITH OTHERS.

With much appreciation,

Donald Meichenbaum, Ph. D.
Research Director of the Melissa Institute for Violence Prevention

Etiony Aldarondo, Ph.D.
Executive Director of the Melissa Institute for Violence Prevention

ANGER CONTROL
Don Meichenbaum considers the nature, impact and ways of controlling anger

Professor Don Meichenbaum is currently Research Director of the Melissa Institute for Violence Prevention **(www.melissainstitute.org)**. He was a Professor of Clinical Psychology at the University of Waterloo, Ontario, Canada. He was voted one of the ten most influential psychotherapists of the twentieth century.

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Have you ever known someone who is “hot tempered”, easily riled, who has a short fuse, overresponds to frustrating events, carries grudges, desires revenge, and all to easily becomes aggressive?

Have you ever known someone who carries a “chip on his or her shoulder,” has his/her antennae up all-the-time on the lookout for provocations, takes slights very personally, so disagreements all to quickly escalate into confrontations?

What do these individuals do with their anger? Does their anger take the form of verbal and physical assaults (sarcasm, swearing, hitting), or does it take the form of passive indirect forms of aggression (becoming silent, do something to hurt others).

What is anger?

Anger is a feeling or emotion that ranges from mild to intense fury, irritation to feelings or rage. Anger is a natural response to those situations where you feel threatened, or believe harm might come to you, or where you believe that another person has wronged you on purpose. Often, but not always, anger is accompanied by the tendency to retaliate or undo the perceived wrongdoing. Anger is an accusatory response to some perceived misdeed.

Anger is associated with absolutistic judgments of “musts”, "ought", "should have" or "could have". Anger attacks may take various forms including irritability, emotional overreactions to minor annoyances, frustration, fury and rage with accompanying physical reactions, including chest tightness, sweating, dizziness, shortness of breath, racing heart, and feelings of being out of control.

Consequences of anger.

Anger becomes a problem when it is felt too frequently, is felt too intensely, lasts too long (not letting the anger go), or is expressed inappropriately. Anger can take both a physical and behavioral toll. Anger places extreme physical strain on the body. Anger, chronic cynicism, hostility have been implicated as contributing to high blood pressure, hypertension, heart disease, diminished immune system efficiency and increased mortality. In short, anger can be a killer.

Hostile individuals who evidence high levels of social conflict and who have low levels of social support are particularly vulnerable to Coronary Heart Disease (CHD). In fact, anger and hostility have been implicated as key elements of what is called a Type A personality. Such negative health consequences of anger are compounded when there is the accompanying use of substances like alcohol, drugs and the accompanying presence of depression.

At the behavioral level, inappropriate expression of anger (verbal abuse, intimidating and threatening behaviors) often results in negative social consequences from family members, friends, classmates and co-workers. If anger escalates into physical aggression it can result in trouble with the police. But note, not all forms of aggression involve anger.

How widespread are anger episodes?

Studies by the psychologist, Jim Averill has found that in normal (nonclinical) populations, individuals on average experience one incident of anger per day (7.3 per week or 23.5 episodes of anger per month). In 88% of these anger episodes, the anger was directed at another person and in 75% of these instances the targeted individual was familiar and liked by the angry individual. Only 13% of anger episodes involved strangers. Most interpersonal angry exchanges result from disputes between individuals who have an ongoing relationship. Over 85% of such angry exchanges were considered to be justified, but yet perceived to have been

avoidable (e.g., being treated with insufficient respect, people failing to fulfill commitments). Although overt physical aggression is rare (occurring in less than 10% of such episodes), angry individuals report frequent impulses toward verbal (80%) and physical aggression (40%) when they are angry. That is, many angry individuals are "on the brink" of saying or doing something to hurt others, and that later on they may be sorry for. But most angry people do not act out.

In fact, when one compares individuals who are low versus high in anger, it turns out that they encountered a similar number of provocative situations, but it is the high anger individuals who respond to such perceived provocations with a greater emotional response.

Anger is not only related to aggressive behavior as in the case of family violence (where arguments and disagreements get out-of-hand), but anger is also related to road rage, substance abuse, suicide, antisocial behaviors, and as noted, to physical health problems. At the clinical level, anger is one of the most common symptoms that occur in some 19 different psychiatric disorders.

Analyzing Anger.

Anger consists of various components that include:

a) the appraisal of external and internal triggers;

b) primary and secondary emotions;

c) thinking patterns, forms of self-talk and images and accompanying beliefs and mental scripts;

d) behavioral acts and resultant consequences.

Let's consider each of these components in turn and then consider the implications for ways to manage and control anger. A useful model is to think of these four elements as positions on a Clock.

At **12 0'clock** you can put the concept of Triggers--both external triggers (what someone does or does not do that you perceive as a provocation), or internal triggers such as a remembrance of a past harm, or "old anger" reappearing, a flashback, or a feeling of apprehension about a possible future hurt, or feelings of humiliation and disrespect. Research indicates that angry and aggressive individuals tend to carry with them a "hostility bias", where they are more likely to view the world through a prism of perceived provocations. Angry-prone individuals tend to not only be hypervigilant and selectively focus on certain cues, but they also tend to disregard and/or discount neutral and prosocial cues.

At **3 o'clock** on the Anger Model are primary and secondary emotions. Angry individuals have a lower threshold that trigger emotional reactions and they evidence more extreme emotions which last longer. They "can't" seem to, or they "won't", let those disturbing emotions "go". In some instances anger is a secondary emotion that is a response to the primary emotions of humiliation, embarrassment, rejection, insecurity, abandonment, disrespect, jealousy, fear, shame and guilt. Moreover, high angry-prone individuals may hold a theory about their emotions ("meta-emotions") that ***"These angry feelings just come.",*** or ***"Once the anger blows, I can't do anything to stop it.,"*** or that ***"I am a walking time bomb ready to explode.,"*** or that, ***"Anger is like a tea kettle that just builds and builds and blows"***.

Next at **6 o'clock**, we can examine the role of the thinking processes of high angry and aggressive individuals. What do angry individuals have to tell themselves (and others) to not only get angry, but to stay angry over a prolonged period of time? What is the self -talk, inner dialogue, or conversation with oneself that perpetuates the anger cycle that can contribute to aggressive behaviors? Here are some examples.

Low frustration tolerance	***"I can't stand it"*** ***"They should have done it my way"***
Assign blame, attribute intentionality, be accusatory	***"He did it on purpose"*** ***"She was out to get me"***
Lack of emotional responsibility	***"Anger just happens to me"*** ***"Anger controls me"*** ***"I can't stop it once it starts"***
Instrumental act	***"This is the only way to get them to listen"*** ***"It is a way to show them I am no wimp"*** ***"He dissed (disrespected) me and I am going to get even"*** ***"Hold images of revenge"*** ***"Anger works!"***
Ruminative behavior (Focus on trying to answer "why" questions, as compared to "what" and "how" questions)	***"I can't let it go"*** ***"I brood, why did she do this to me?"***
Over generalized and Black/White thinking	***"He is a _ _an inflammatory, emotionally-charged racial epithet*** ***"They are <u>always</u> doing it their way"*** ***"It <u>never</u> goes my way"***
Catastrophizing thinking and "musturbation" thinking	***"It is (horrible, awful, unbelievable, intolerable) hateful way to behave"*** ***"They <u>must</u> do it my way"***

This pattern of thinking and the learned accompanying scripts predispose angry individuals to "lose their cool" and become aggressive. The anger-prone individuals are more likely to view themselves quite favorably, and when their views are challenged or disputed by

someone else's actions, they are prone to become angry and to act out, especially if they think the other person did it “on purpose”.

The psychologist, Roy Baumeister, has characterized this highly favorable view that leads to anger and to a sense of entitlement as "threatened egotism", which acts like a mental script or blueprint (with implicit "if..then" rules) for anger and violence.

Finally, the **9 o'clock** features of this cycle are the specific behaviors and resultant consequences. In short, what does the individual do with all of his/her anger? Does he/she act out, become sarcastic and verbally assaultive, stuff his/her anger, drink such feelings away? What is the impact of such behavioral acts on others? When individuals act in an aggressive fashion, it often elicits counter-anger and counter-aggressive acts. Such responses from others confirm the angry-prone individuals' beliefs and expectations. In this way, angry and aggressive individuals may inadvertently, unwittingly, and perhaps even unknowingly, produce the very reactions in others that confirms their views of the world. Life becomes a self-fulfilling prophecy. ***"You see, I am not making it up. They are picking on me".***

In summary, we can analyze anger as consisting of a "vicious cycle", that feeds on itself.

12 o'clock
Internal/External Triggers

9 o'clock
Behavior and Resultant Consequences (Reactions of others, physical and social consequences)

3 o'clock
Primary and Secondary Emotions

6 o'clock
Thinking patterns, beliefs, self-talk images and mental scripts

Ways to reduce anger.

How can individuals who are prone to angry feelings and aggressive behavior learn to regulate their emotions? Perhaps, you can use the clock metaphor to anticipate the therapeutic interventions that have been found to be helpful. Cognitive behavioral therapies have been found to help angry individuals control their emotions and behaviors. [Meichenbaum has developed a Stress Inoculation Intervention (SIT) that has been employed successfully with angry and aggressive individuals. This multifaceted SIT interventions include psychoeducation where angry individuals learn about the negative and positive aspects of anger, the warning signs or "red flags" that anger is building, the impact of anger, the risk factors that exacerbate anger (alcohol, stress, anger-prone friends, availability of weapons), and ways to regulate emotions, cope, and ways to break the "cycle" of triggers, feelings, thoughts and behaviors. Angry individuals learn ways to appraise events in a more benign, less provocative fashion. If angry-prone individuals can learn to view potential provocations as "problems-to-be-solved", rather than as personal threats, then a more adaptive "script" can be called into play. (12 o'clock Interventions)

Angry individuals can also learn a variety of ways to regulate primary and secondary emotions and arousal by such means as relaxation, (breathing retraining), acceptance, mindfulness, time out procedures. Such 3 o'clock-based interventions can, in turn, influence the angry individual's self-talk, so he/she does not feel a "victim" of feelings, thoughts and events.

Angry feelings usually don't just arrive unannounced. How angry-prone individuals appraise both events and their ability to handle such emotions, what they say to themselves determines the ways in which they cope.

A key element of the SIT intervention is to help angry individuals alter their thinking patterns and beliefs. There is a need to help individuals generate non-angry, non-aggressive behavioral alternatives and to practice these coping skills, both in treatment and in their everyday settings. (9 'clock Interventions).

Angry and aggressive individuals need to learn how to become assertive without becoming aggressive. They need to fine tune their communication and conflict resolution skills. There are adaptive ways to transform angry feelings into effective interpersonal acts.

Thus, there are several ways to break the cycle between angry feelings, anger-engendering thoughts and images, and aggressive behaviors. These are summarized in Table 1.

Finally, it is important to recognize that there is nothing wrong in becoming angry. Anger is a useful and healthy emotion. Anger is experienced when there is a discrepancy between the way you think things should be and the way they are. Anger rises when you perceive an injustice and lack of sensitivity. Without anger there would be no social changes, no Amnesty International, no Gay rights movement, no Feminist movement, no efforts toward achieving civil rights and peace. It is not that individuals become angry. Rather it is a question of what one does with that anger. Like other emotions such as anxiety which acts as a warning sign, or depression which is an occasion for others to provide support, anger can also be a bell-weather emotion to take action. Remember, high and low angry individuals had the same number of provocations. It is how they responded to such triggers that has major physical and social consequences.

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See **www.melissainstitute.org** for information on how angry and aggressive behavior develops and means of prevention.

TABLE 1

Examples of Anger Management Skills

Learn about what triggers your anger. What do these various situations have in common?

Learn the cues, warning signs, “red flags” that your anger is building or that you might be losing control.

Develop an anger-control plan. “If ...then” rules. Both immediate coping strategies and preventive strategies.

Monitor your anger using a 1 to 10 scale, where 10 is when you lose control and experience negative consequences.

Keep a journal of your anger episodes. Analyze anger episodes using the Clock model. (Triggers, emotions, thoughts, and behaviors). Ask yourself what you have done to make the “anger cycle” worse? Figure out what you can do to break the “anger cycle”.

Change hostile attitudes.

Question and challenge your self-talk that makes anger worse.

Lower your arousal level and regulate emotions by using breathing and relaxation exercises.

Blow off steam through physical exercise.

Distract yourself with positive activities.

Take a “time out” or “cool down” . Remove yourself from a provocative situation.

View the provocation as a problem-to-be-solved, rather than as a personal threat.

Talk to a friend about what is angering you.

Imagine how a friend or relative who does <u>not</u> get angry would handle this situation.

Act assertively (not aggressively) by standing up for your rights, but in a respectful way. Use “I” statements-- “I feel X, in situation Y, when you do Z.”, instead of “You” accusatory statements.

Use your Toolbox of coping strategies.

Remind yourself that being angry will most often not help you achieve your goals and it may harm important relationships.

Remind yourself that anger also hurts your physical health.

Remind yourself that there is a price you pay for ruminating and carrying a grudge.

Remind yourself that there is nothing wrong with being angry. It is what you do with that anger that is critical.

USE "CLOCK" ANALYSIS

12 o'clock
Triggers
(External/Internal)

9 o'clock
a. Behaviors
"What did you do"
"What you did not do"

b. Reactions from others

3 o'clock
Primary/Secondary Feelings
(What did you do with all these feelings?"
"What thoughts or beliefs do you hold about your feelings?")

6 o'clock
a. Automatic thoughts, images, memories
b. Thinking patterns
c. Core Beliefs/Values

USE CLOCK METAPHOR

In order to help patients appreciate the interconnections between their thoughts, feelings, and suicidal behaviors, the therapist can use the following CLOCK metaphor.

12 o'clock - - external and internal triggers
3 o'clock - - primary and secondary emotions
6 o'clock - - automatic thoughts, thinking processes such as ruminating, schemas and beliefs
9 o'clock - - behaviors and resultant consequences

1. Place hand at 9 o'clock and move around imaginary clock and say "It sounds like a vicious…". Allow client to finish this sentence with "cycle" or "circle". Explore how his/her account fits a "vicious cycle".

2. Treat 3 o'clock primary and secondary emotions as a "commodity". What does the client do with all these feelings. For example, "stuff them", "drink them away", "act out".

3. If that is what he/she does with such emotions, ask, "what is the impact, toll, price he/she and others pay, as a result? If the client answers, "I do not know", then the therapist should say "I do not know either, how can we go about finding out? Moreover, how will finding out help you achieve your treatment goals of X (be specific)?"

4. Encourage the client to collect data (self-monitor) when the vicious cycle, as the client describes, actually occurs. Explore with the client when he/she engages in such behavior and the impact, toll, price. "If it has this impact, then what can the client do?" It is not a big step for the client to say, "I should break the cycle or circle". The therapist can then explore how the client now goes about breaking the cycle - - thus view present symptoms and behaviors as their attempt to "break the vicious cycle". (Use dissociation, substances, avoid, act out).

5. Explore alternative more adaptive ways "to break the cycle".

PARENTING STRESS: PROVOCATIONS

I I C E H O P E

Interruptions of plans and behaviors

Implications of child's behaviors

Concerns of child well-being

Expectations violated

History repeats itself

Overload on the part of the parent

Personal Peeves

Embarrassing child behavior in public

CONTROVERSIES IN THE FIELD OF PSYCHOTHERAPY

1. There has been no improvement in the treatment outcomes in the field of psychotherapy in the last 30 years.

2. The quality of the therapeutic alliance is 5 to 6 times more important in predicting treatment outcomes than is the specific treatment that is implemented.

3. Some therapists are 50% more effective and have 50% fewer patient dropouts than their colleagues.

4. The person of the psychotherapist WHO is implementing the treatment is more critical in influencing outcome, than WHAT treatment is being implemented.

5. Therapists routinely fail to successfully identify patients who are not progressing and who will drop out of therapy.

6. The extent of the therapists' experience, professional discipline and affiliation, theoretical orientation, and Certificate status do NOT predict treatment outcomes.

7. What increases with years of clinical experience is the therapists' level so self-confidence that they are effective, not their treatment outcomes.

8. There is a need to employ Feedback Informed Treatment Session by Session patient feedback in order to individualize the treatment approach.

9. The field of psychotherapy is filled with HYPE in the form of exaggerated claims of efficacy, psychobabble and neurobabble. (See the Award-winning article by Meichenbaum and Lilienfeld on “How to spot HYPE in the field of psychotherapy” that is on the Melissa Institute Website).

10. There is little or no differences between various Acronym-based interventions (“Distinctions with little differences”).

TREATMENT OF SUICIDAL INDIVIDUALS

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SOME FACTS ABOUT SUICIDE

Each year some 40,000 adults die by suicide in the U.S. For each individual who dies by suicide at least 20 more have attempted suicide.

10% of those who attempt suicide will eventually take their lives. 90% of people who survive a suicide attempt do NOT go onto to die by suicide, even many years after their attempt.

In the U.S., it is estimated that 10 million adults and 2 million adolescents seriously consider suicide each year. That is, 1 in 5 high school students report they seriously consider suicide in the previous 12 months. It is estimated that a quarter million people attempt suicide in the U.S. each year.

Between 1949 and 2017, the suicide rate has increased by 33%. Since the recent pandemic calls to Suicide Hotlines have increased 800%.

Suicide is the 10th leading cause of death in the U.S. overall. For people ages 35 to 54 it ranks fourth, and for 10 to 34-year-olds it ranks second.

Suicidal thoughts by themselves are not necessarily a sign of a suicidal act. Only one percent of adults with suicidal ideation will die of suicide.

Some 40% of mental health providers report having considered suicide and 5% have made a suicide attempt.

80% of suicides are committed by males, Females attempt suicide more often than males, but men are three times more likely to die from such attempts. Men are more likely to use firearms.

85% of people who intentionally shoot themselves die, in comparison to the fatality rate of 2% of those who intentionally overdose by medication.

Two thirds of folks who have attempted suicide have a recurrence of such suicidal thoughts, even years later.

Up to two thirds of those who die by suicide have had contact with health care providers in the month before their death. As many as half of individuals who die by suicide are in active treatment at the time of their death.

The average reattempt rates during treatment is as high as 47%.

The first month following discharge from a psychiatric hospital, suicidal patients are most high risk for a reattempt. The entire first year constitutes a risk period.

90% of suicidal individuals are suffering from a mental disorder at time of their deaths. Mood disorders account for 50% of all completed suicides. For example, patients with Bipolar disorders, 25% to 50% will make a suicide attempt during the course of their illness, with 10% to 20% dying. For those diagnosed schizophrenic, between 20% to 40% will make a suicide attempt and 5% will die. For patients suffering Major Depressive Disorder, 2% receiving outpatient treatment and 9% of depressed inpatients treatment will die of suicide.

On average, of people who die by suicide, roughly 40% had consumed alcohol before the suicidal act. Various forms of anxiety disorders, eating disorders and traumatic brain injuries are high risk for suicide.

As compared to single attempters, multiple suicide attempters evidence more significant suicidal Thinking, depression, helplessness, higher rates of alcohol and substance abuse, greater history of victimization, poorest histories of interpersonal coping, less availability of social supports and a higher incidence of co-occurring disorders. They are also at greater risk of reattempts and deaths by suicide.

THE GOOD NEWS is that there are effective and helpful interventions for suicidal patients.

> ***"A sensitive and deeply caring therapeutic relationship is still the best form of suicide prevention." Bongar & Sulllivan, 2013, p.199.***

CHALLENGE FOR HEALTH CARE PROVIDERS: THE INCIDENCE OF SUICIDAL PATIENTS

The first patient I ever treated as a graduate student at the Veteran's Administration hospital in Danville, Illinois died by suicide. While my supervisor and fellow clinical students tried to reassure me that his death was not my fault, nor due to my clinical incompetence, I felt "deep down" that his suicidal death was a reflection of my inexperience. This incident caused me to wonder if becoming a clinical psychologist was the correct occupational choice.

In the 40 years since this initial clinical episode, I have had three other clients die by suicide being either one of my clients, or the client of a trainee I was supervising.

In fact, clinicians often have to treat suicidal clients. Consider the following findings:

- 30% of psychologists and social workers and 50% of psychiatrists have had a client die by suicide
- Full time psychotherapists will average up to 5 suicidal clients per month, especially among those clients who have a history of victimization and substance abuse;
- 1 in 3 clinical graduate students will have a client who attempts suicide at some point during their clinical training and 1 in 6 will experience a client's suicide;
- 1 in 6 psychiatric clients who die by suicide while in active treatment with a health care provider;
- Work with suicidal clients is considered the most stressful of <u>all</u> clinical endeavors. Therapists who lose a patient to suicide, experience such a loss as much as they would the death of a family member. It can become a career-ending event.
- Such distress in psychotherapists can be further exacerbated by the possible legal actions. 25% of family members of suicidal patients take legal action against the suicidal patient's mental health treatment team (Bongar, 2002; Kleespies, 2017).

What can psychotherapists do in the aftermath of the suicidal death of his/her patient?

In a paper entitles "35 years of working with suicidal patients: Lessons learned", I summarize the "Dos and "don'ts" of working with suicidal patients and the need to Document, Document, Document risk and protective factors and accompanying interventions in progress notes (Meichenbaum, 2005). The American Association of Suicidology has offered the following advice on "What to do if you lose a patient to suicide. These include both Procedural and Psychosocial steps to follow. I have inserted some additional suggestions.

1. Procedural (Immediate) Steps

A. Notify your supervisor and supportive colleagues. B. Notify the Director of your Service. C. Contact the Hospital Attorney. D. Consider contacting the client's family members and ask whether you should attend the client's funeral, only with the family member's permission.

2. Meeting your emotional needs.

A. Seek support from your supervisory, colleagues and significant others. B. Attend to your needs to "mourn", in any form, this may take. C. Monitor any stress-engendering self-blame, hindsight bias thinking processes. D. Use cognitive strategies to cope with the emotional aftermath of the client's suicide. Engage in the mindful path of self-compassion (Gerber, 2009).

3. Education (later with supervisor, colleagues or review groups).

A. Review progress notes. B. Write a case summary of the ongoing risk assessment and the course of treatment interventions. C. Enumerate the lessons learned and share this with interested and supportive others. Make a "gift" of your clinical experience with others, transforming the loss into a "teachable experience".

A number of clinicians have offered ways to bolster the psychotherapist's resilience, and nurture post-traumatic growth in the aftermath of a client's death by suicide. See Hernandez et al., (2010), Norcross and Guy (2007), Pope and Vasquez (2005), and Wicks, and Maynard (2014). Elsewhere (Meichenbaum, 2006, 2014, 2017), I have discussed ways to bolster resilience in psychotherapists and ways to "help the helpers".

Finally, find ways to work with others to reduce suicide.

IMPLICATIONS OF A CONSTRUCTIVE NARRATIVE PERSPECTIVE (CNP) OF SUICIDE

"The accurate understanding of suicide risk starts with a thorough and detailed* understanding *of the patient's suicidal thinking". David Rudd 2014 p.332

The following descriptions of the characteristic thinking patterns of clinically suicidal individuals highlight the cognitive vulnerability factors and sequelae of suicidal behaviors. Ellis and Rutherford (2008) have provided a similar account of the relationship between cognition and suicide. Consider what suicidal individuals have to tell themselves and others in order to convince themselves that self-annihilation should outweigh self-preservation. Below I will consider the assessment and treatment implications.

The nature of the "stories" that individuals who engage in other forms of suicide (e.g., "altruistic suicide", suicide bombers, or end of life suicides) may be quite different and involve concepts of "perceived burdensomeness on others" and "self-sacrifice" for a higher good. (Joiner & Van Orden, 2008). Whatever the exact nature of such "story telling", it is proposed that a CNP will help explain such suicidal behaviors.

These tormenting thought patterns illustrate the suicidal patients' "drama of their minds", cognitive constriction, tunnel vision, overgeneralized autobiographical memory, poor problem-solving ability, all of which limit their ability to consider the range of alternatives. These thoughts are engulfed by feelings of estrangement, worthlessness, emptiness, self-hatred, inadequacy, purposelessness, helplessness and hopelessness, often accompanied by additional feelings of shame, guilt and anger. These feelings and thoughts are viewed as being intolerable, inescapable and interminable.

CHARACTERISTIC THINKING PATTERNS OF SUICIDAL INDIVIDUALS: IMPLICATIONS

a) dichotomous (black-white) thinking
b) cognitive rigidity and constriction
c) perfectionistic standards toward self and others with high levels of self-criticism
d) lack of specificity in autobiographical memory. Such over general and vague autobiographical memory has been associated with depression, PTSD, and suicidal behavior. Ellis and Rutherford (2008) highlight that such over general memories interfere with interpersonal problem-solving because past experiences cannot be used as references for effective coping strategies in the present.
e) impaired problem-solving and poor problem-solving confidence
f) "looming vulnerability" or the perceived experience of negative occurrences as rapidly escalating, mounting, quickly approaching adversities that generate distress (Riskind et al., 2000).
g) such looming vulnerability can stoke hopelessness and helplessness with negative expectations about the future. (Anticipate few positive events or outcomes and accompanying vagueness in future thinking).

h) ruminative process- - feeling "locked-in" to their current perceptions, unable to imagine alternatives, nor consider new courses of action.
i) more present-oriented and view death in a more favorable light
j) have difficulty generating Reasons for Living
k) absence of protective factors such as attraction to life, repulsion by death, surviving and coping beliefs, sense of personal self-efficacy, moral and religious objections to suicide, fear of self-injury, and sense of responsibility to one's family

Examples of the Narratives of Suicidal Individuals

"I can't stand being so depressed anymore." "I can stop this pain by killing myself." "I am damaged goods." (Schneidman, 2001 has characterized this intractable emotional pain as psychache)

"Suicide is the only choice I have." (The word "only" is considered one of the most dangerous words in suicidology)

"My family would be better off without me." "I was just a lifeless thing-breathing, but worthless. I knew everyone would be better off if I were dead. It would end my misery and relieve their burden". "***My death will be worth more than my life to my family"***. (Joiner, 2005 and Joiner and Van Orden, 2008 have highlighted the perception of being a burden on others as related to suicidal tendencies).

"I am useless and unwanted." "I am unlovable, abandoned and estranged." (Joiner, 2005, highlights a sense of "thwarted belongingness", as contributing to suicidal ideation and actions.) Perceive others as uncaring and unsupportive; feel socially disconnected and lack emotional intimacy.

"No one cares whether I live or die." "I thought no one could help me." (Feel rejected, marginalized, worthless, unlovable, isolated, alone, and a failure)

"I am worthless and don't deserve to live." (The presence of guilt, shame exacerbates suicidal ideation)

"I have an enemy within that I have to escape." (Baumeister, 2004, has viewed suicide as a form of escape from self. It also reflects the "drama of the mind" that suicidal individuals are prone to engage in).

"I am in a tailspin, like a freight train or tsunami hit me. There is no hope. I can't get caught up. What is the point?" (Riskind et al. 2000 and Rector et al. 2008 have noted that anxious and suicidal individuals are prone to produce elaborate mental scenarios anticipating rapidly rising risk with multiply increasing threats. They tend to exaggerate the time course of perceived catastrophic outcomes and have an increased sense of urgency for escape and avoidance).

"I hate myself." (Suicidal individuals have an over-generalized memory and tend to selectively recall negative events that contribute to invalidating themselves)

"I can't fix this problem and I should just die." "Things will never get better." "Nobody can understand my intense feelings that I am experiencing." (Tunnel vision, inflexibility in generating alternatives. Feel trapped and perceived inescapability)

"I would rather die than feel this way." "It would be easier if I killed myself." (Evidence poor distress tolerance)

"I have lost everything that is important to me." My future looks empty." "Life is no longer worth living". "Nothing will change." "There is no hope for me." (Ghahramanlou- Holloway et al., 2008, highlight the impact of such loss-related cognitions and the role of feelings of helplessness and hopelessness that exacerbate suicidal tendencies)

"I have screwed up, so I might as well screw up all the way." (Perception that he or she does not deserve to live which contributes to suicidal ideation)

"Those who hurt me will be sorry." (Perceived benefits of suicide, revenge).

"Suicide is a way of life for me and I can't stop it" (Kernberg, 2001).

These thoughts fall on a continuum from mild self-criticism to extreme self-hatred and thoughts of suicide.

TREATMENT IMPLICATIONS

- There is a need for the psychotherapist to become an "exquisite listener" of how suicidal patients tell their "story", paying particular attention to the patients' thinking patterns and accompanying feelings and behaviors. There is a need to explicitly assess for suicidality and for the accompanying narrative.

- There is a need to determine the individual's capacity for self-injury and determine suicidal history, differentiating between single versus multiple attempters by conducting a detailed assessment.

- There is a need to be attuned to the presence of earlier victimization and the resultant conclusions that patients draw about themselves, others, the world, and the future.

- There is a need to consider the role of developmental schemas, metaphors and images, mental and behavioral scripts and conditional assumptions ("If...then" rules) that predispose individuals towards suicidal behavior.

- There is value in specifically treating the cognitive vulnerabilities that predispose individuals to engage in suicidal behaviors. Recent studies that focused on reducing suicidal thinking (Berk et al., 2004; Brown et al., 2005) and on nurturing coping skills (Linehan et al., 2006) have reported a 50% reduction in suicidal behaviors. ***(A description of such cognitive behavioral interventions is offered below.)***

- Interventions need to help suicidal patients transform hopelessness into hopefulness. Treatment needs to help suicidal individuals to develop healthy coping strategies, employ problem-solving skills to challenge and combat, what the English poet and critic A. Alvarez called **"The Savage God"**. As he described:

  "Suicide is a closed world with its own irresistible logic...Once a man decides to take his own life he enters a shut off, impregnable, but wholly convincing world, where every detail fits and each incident reinforces his decision".

  Suicide may be seen as the only option, and even a "rational course of action", as Aaron Beck 1976) observed some time ago.

While CBT is considered an effective intervention for a range of disorders (see Beck, 2005; Butler et al. 2006), debate continues about the mechanisms involved in instigating and maintaining such behavior change. In two Clinical Handbooks (Meichenbaum, 1994, 2002), I have offered an evidential model of change where patients collect data that is incompatible with their prior expectations and beliefs. Out of the strength of the therapeutic alliance, the therapist helps the patient accept such "data" as "evidence" to unfreeze the beliefs they hold about themselves, others, and the future. The psychotherapist also ensures that the patient has the courage and the intra- and interpersonal coping skills to undertake "personal experiments" that will yield disconfirming data. A variety of psychotherapeutic procedures including Socratic

questioning, cognitive restructuring, problem-solving and coping skills training, and relapse prevention procedures may be used.

This evidential model of change is consistent with proposals offered by Brewin (2006), who noted that cognitive therapy does not directly modify negative information in memory, but rather influences the relative retrievability of different meanings of emotional content that is stored in memory. For example, some of the psychoeducational procedures described below (e.g., use of Clock metaphor, collaborative goal-setting and use of Time-lines that pull for the rest of the patient's story of strengths and signs of resilience), each illustrate ways to strengthen positive autobiographical representations. These interventions yield “data/evidence” that are in “retrievable competition” with the negative suicide-engendering representations and “stories”. These “mental heuristics” impact on the “internal debate” suicidal individuals engage in.
When such changes come about, the psychotherapist needs to ensure that patients take personal credit and ownership for the alterations in ideation and behavior that they have brought about.
These various psychotherapeutic interventions are demonstrated in the recent APA film I made with a young lady, Missy, who attempted suicide seven times.
Before we consider specific interventions, we need to first recognize the challenges of working with suicidal patients.

Meeting The Challenges of Working With Suicidal Patients

An important lesson to keep in mind is just how much energy and resources are required in conducting psychotherapy with suicidal patients. Suicidal patients have a high drop out rate from psychotherapy, they may be no-shows and often nonadherent to treatment plans, as well as evidence a number of antitherapeutic behaviors (being late, nonparticipation, denial, low distress tolerance and emotional explosiveness). As noted, only 20% to 40% of suicidal inpatients attend referred out-patient treatment services when they leave the hospital. The therapist has to be proactive in ensuring continuity of care, demonstrate flexible scheduling, use reminder phone calls, conduct phone sessions when needed, and engage a treatment team including the suicidal patient's family members (where indicated). The therapist needs to collaborate with the suicidal patient to anticipate and address potential individual, social and systemic barriers to treatment. A number of practical qualities of life issues (like housing, transportation, self-care) may also need to be addressed.

Such psychotherapeutic contact with suicidal patients should begin soon after a suicide attempt (within 72 hours), as suggested by Ghahramanlou-Holloway et al. (2008). Such early intervention with suicidal patients can even begin in emergency room settings. There is need to engage suicidal patients in formulating and implementing a Safety Plan early in treatment.

ASSESSMENT OF RISK AND PROTECTIVE FACTORS IN SUICIDAL PATIENTS

RISK FACTORS

Previous suicide attempts -- multiple suicide attempts -- with each additional attempt the lethality increases / Psychiatric diagnosis- Borderline personality, Substance abuse disorders, anxiety and depressive disorders, Traumatic brain injuries/Prior hospitalization / History of victimization, losses and grief / Health problems, especially chronic pain and the intake of opioids / Family history of suicide / Caucasian elder male / Homeless / Social isolation / Unemployment and poverty t / Member of certain American Native tribe, especially Alaskan Native / LGBTQ - especially transgender youth who have been bullied.

WARNING SIGNS

Talking and writing about suicide / Making preparations for suicide, rehearsal / With previous suicide attempts made explicit efforts against discovery / Express regrets that previous suicidal attempts were not successful / Make arrangements to wrap up one's affairs / Write a suicide note -- 60% to 80% of people who die by suicide do NOT leave a suicide note / Frequent intense suicidal thoughts -- search Internet for suicidal information and Websites / Dramatic mood changes, irritability, agitation, / Feelings of anxiety, depression, hopelessness worthlessness, feel trapped, rage -- have a suicidal MINDSET -- a critical inner voice / No sense of purpose or reasons for living/ Impulsivity and engage in high-risk reckless behaviors / Exposure to violence / Abuse substances / Experience stressful life events such as divorce, break up of a relationship, loss of a job, financial setback, Medical problems / Belief of being a burden on others / Perception of rejection or social isolation / Disconnection from others -- "thwarted belongingness" -- withdrawal from others / Changes in sleep behavior - significant increase or decrease in sleep patterns / Access to a firearm -- half of all suicides in the US are by firearms / Access to other means of suicide such as possible overdose of medication.

PROTECTIVE FACTORS

Being an African American female -- lower suicide rate than Caucasian women in the US / Having a religious affiliation or being a member of a cultural group where suicide is not sanctioned -- note, that in some instances membership in a religious group can act as a trigger for suicidal behaviors -- a cult membership / Willing to engage in treatment such as take medication, willingness to abide by a Safety Plan / Involved in a therapeutic alliance and insight into one's difficulties / Have an optimistic , future-oriented outlook -- Reasons to live / Has a variety of coping skills such as problem-solving ability, positive self-esteem, a sense of competence / Have "social capital" in the form of supportive others / Engage in meaning-making activities, making a "gift" of one's life experiences to others -- pass forward activities / Has a fear of suicide and death.

The search for risk factors and warning signs of potential suicidal behaviors has been pursued for over 50 years. In a meta-analytic article, Franklin and his colleagues concluded that the ability to make such effective predictions of suicide is "no better than chance." They note that more recent predictive efforts, using Machine-based algorithms, have proven more successful, when these predictive efforts have been tailored to different types of suicidal patients (adolescents, elderly, returning soldiers, victims of Adverse Childhood Experiences and other forms of victimization). (SEE Franklin et al. 2017 Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychology Bulletin, 143*, 187-232).

With this CAVEAT in mind, let us consider so-called time-honored risk factors, warning signs and protective factors in assessing suicidal potential.

ASSESSMENT STRATEGIES AND THE ART OF QUESTIONING
(Compiled from Brent et al., 2011; Freedenthal, 2018; Jobes, 2006; Miller, 2011; Rudd, 2006; Shea, 2002).

(Asking directly about suicide does NOT make people want to die by suicide. Such risk assessments should be conducted repeatedly over the course of treatment.)

Stacey Freedenthal (2018, p. 37) highlights that "It really matters how you ask questions". She advises therapists to employ a narrative assessment approach, or what she calls "Suicidal Storytelling," so patients can tell their stories and therapist can become an exquisite listener of the suicidal patients' thinking and feeling processes. The therapist can ask the following type of questions in order to conduct a cognitive behavior chain analysis.

"Could you tell me how you got to the point that you could put an end to your life?"
"I would like you to tell me the story of what led you to this suicidal crisis?"
"I would like you to tell me, in your own words, how it came about that you harmed yourself?"
"Feel free to start where ever you wish. There is no right or wrong way to tell your story."
"Okay, you have now given me a short account of what happened. In my experience there is always a personal story behind suicidal thoughts and suicidal attempts."
"Can you tell me more?" "Can you help me understand …? "What happened next?"

The following set of QUESTIONS are designed to access the presence of RISK and PROTECTIVE factors.

Assessing Suicide Ideation and Behavior

Have you ever thought you would be better off dead?
Have you had thoughts of taking your own life?
Have you ever made a plan to commit suicide?
Have you ever had the intent to carry out your suicide urges/plans?
Have you ever attempted suicide?
If answer positive to any of these questions assess for specific details and examine the most serious episode.

Assess for the frequency and severity of suicidal ideation

For what proportion of the day do you find yourself having suicidal thoughts?
In a given hour, how much time are you thinking about suicide?
To what extent can you push away the suicide thoughts and think about something else?
On a scale of 1-10, if 1 is easy to push away, and 10 is completely preoccupied, where would you rate yourself?

To what extent do you feel you can <u>resist suicidal urges</u> (on a Scale of 1-10, where 1 is completely able to resist suicidal urges and 10 is not at all able to resist suicidal urges), would you rate yourself?

As a result of such probes, the therapist should be able to answer the following questions:

What drives the patient's desire to die?
What method of suicide was contemplated and what was implemented?
How close did the patient come to completing suicide: For example:
How many pills did you take?
Did you put the razor blade to your wrist?
Tell me what happened next?
How serious were the actions taken?
How serious were the patient's intentions?
Did the patient tell anyone of the attempt?
Did the patient tell anyone beforehand?
Did the patient make the attempt in an isolated area or in a place where he or she was likely to be found?
Did the patient engage in preparatory steps (e.g., write a suicide note, say goodbye to significant others, give away prized possessions, take other steps?)
Was the patient's attempt well planned or an impulsive one?
How long did the patient think about this suicidal plan?
What other ways has the patient thought of killing oneself?
Did alcohol or drugs play a role in the attempt?
Were interpersonal factors a major role in the attempt?
Did a specific stressor or set of stressors prompt (trigger) the suicide attempt?
At the time of the attempt, how hopeless did the patient feel?
Why did the attempt fail? How was the patient found, and how did the patient finally get help?

"When are your suicidal thoughts strongest and when are your suicidal thoughts weakest? What is the difference between these two times? What is the difference in terms of your feelings and thoughts? REMEMBER - - no feelings will last forever."

How does the patient feel about the fact that the attempt was not completed?

What are some of your thoughts and feelings about the fact you are still alive?
Are you sorry your suicide attempt failed?
Can anyone be of help?

The clinician should assess for <u>previous</u> <u>suicidal</u> <u>attempts</u>.

What is the most serious past suicide attempt?
Does the patient view the current stressors and options in the same light as during the past attempts?

Are the current triggers and this patient's current emotional state similar to when the most serious attempts have been made?
How many previous suicide attempts has the patient engaged in? Has the patient exhausted all hope?

Assess for Current Safety Plan

The clinician can ask:

What would you do later tonight or tomorrow if you begin to have suicidal thoughts again?
Right now, are you having any thoughts about wanting to kill yourself?
Do you still have the gun (pills) in the house?
Have you ever gotten the gun out with the intention of killing yourself?
In the past, what stopped you from pulling the trigger?

Assess for Protective Factors or "Buffers" to Suicide

The clinician can select from the following questions.

You have mentioned that your suicidal thoughts are pretty intense. What is keeping you from acting on these suicidal urges?
You have mentioned some reasons why you are thinking of attempting suicide. What are some reasons to keep on living? Is there any way we can make that stronger?
To what extent are you hopeful that treatment can help you? What would make you more/less hopeful?
To what extent do you regret having survived? To what degree do you regret having attempted?
Help me understand the reasons for hurting yourself or killing yourself?
What problem(s) are you trying to solve?
What would you tell a close friend who was in the same circumstances (situation)?
How else could you reasonably view your situation?
What steps can you take to begin to change your life, rather than kill yourself?
How might you make your life better in the future?
How can you reinvest in life?
What do you like best about yourself?
What happened recently that made you feel good?
The one thing that would help me no longer be suicidal would be ____ ?
Is suicide the best way for you to cope or change the situation?
Who are 3 people you will call if you are feeling like hurting yourself? (Get specific names and contact numbers). Which one would you be most comfortable in calling?
Promise me, that if you feel suicidal you will call ___ (not just leave a message) about how you are feeling before you try to hurt or kill yourself?

REASONS FOR LIVING INVENTORY

http://depts.washington.edu.uwbrtc/resources/assessment-instruments

The following set of QUESTIONS can be used to supplement the patient filling out the Reasons for Living Inventory. There are adult and adolescent versions of this Inventory.

"What are your Reasons for living and staying alive?"

"What made your life worth living BEFORE you became suicidal?"

"What would be your REASONS for living if you felt better?"

"With all of the Reasons you have for dying, what has kept you from killing yourself?"

"What keeps you going?"

"What is missing from your life that, if you could have it tomorrow, would make you want to live?"

"The one thing that would make you no longer feel that you should be suicidal is…?"

"If there were another way you could feel better, would you still want to kill yourself?"

ASSESSMENT OF ONGOING SUICIDAL RISK-JOBES (2006) CAMS COLLABORATIVE APPROACH
(www.cams-care.com)

David Jobes (2006) has provided a practical and promising approach to the assessment of suicidal risk in his book Managing suicidal risk: A collaborative approach (New York: Guilford Press). Also see Jobes and Drozd (2004). This assessment approach is called **CAMS**, which stands for **Collaborative Assessment and Management of Suicidality**, and combines both quantitative and qualitative tracking measures and case resolution forms.

At the quantitative level, Jobes has the patient rate him/herself on six areas that include:

1. **Psychological pain and suffering** (anguish, misery)
2. **Stress** (feel pressured, overwhelmed)
3. **Agitation** (emotional urgency, feeling have to take action)
4. **Hopelessness** (expectation that things will not get better, no matter what you do)
5. **Self-hatred** (general feeling of disliking yourself)
6. **Overall risk of suicide**

These patient ratings are followed by the patient filling out a **Reasons for Wanting to Live and Reasons for Wanting to Die** forms and accompanying ratings. (Jobes provides a comprehensive rating system for the two Reasons Scales). There is also a set of Sentence Completion items that patients are asked to complete that are designed to capture the "nature of a patient's suicidal mind". Jobes has provided a comprehensive coding system for the clinician to code the patient's responses, so this information can inform the treatment plan that the patient collaborates ("co-authors") in establishing and implementing.

The Sentence Completion Items include:

- ***"What I find most painful is..."***
- ***"What I find most stressful is..."***
- ***"I need to take action when..."***
- ***"I am most hopeless about..."***
- ***"What I hate most about myself is..."***
- ***"The one thing that will help me no longer feel suicidal is..."***

The Collaborative Treatment Plan which is updated regularly covers the

- Problem Description
- Goals and Objectives and Evidence for Attainment of Specific Interventions (type and frequency)
- Estimated Number of Sessions

The Treatment Plan is designed to reduce Self-harm Potential and foster Outpatient Safety. **A Crisis Response Plan** is also formulated which emphasizes what a patient will do if he/she becomes acutely depressed, impulsive and suicidal. The patient is also asked:

> **"Were there any aspects of your treatment that were particularly helpful to you?"**
>
> **"What have you learned from your clinical care that could help you if you became suicidal in the future?**"

In the **CAMS**, there is also a **Checklist** for the clinician to fill out in order to assess the presence of **Suicidal Risk Factors** that include the presence of:

> **A Suicidal plan Preparation and rehearsal History of suicidality (Ideation, frequency, duration) Prior attempts (single, multiple) Current intent Impulsivity Presence of substance abuse Significant loss Interpersonal isolation Relationship problems Health problems Physical pain Legal problems Shame Mental status and DSM-IV-R multiaxial diagnosis.**

Jobes also advocates that this Risk Assessment be accompanied by having patients fill out a symptom-based assessment tool such as the Brief Symptom Checklist SCL-90/Brief Symptom Inventory-BSI, the Behavioral Health Monitor- BHM and the Outcome-Questionnaire (OQ 45.2) that assesses symptom distress, subjective discomfort, interpersonal relationships and social functioning. (See Jobes, 2006, pp. 43-46). For example, the endorsement of the item on the OQ **"I have thoughts of ending my life"** can trigger the need for administering the CAMS. The CAMS is administered using a side-by-side seating arrangement to reinforce the collaborative nature of the assessment process. This adjacent seating arrangement conveys to the suicidal patient that the clinician is trying to see the world through the patient's eyes. Based on the documentation of these risk factors, the clinician is called upon to evaluate the patient's **Overall Suicide Risk Level.**

- **No Significant Risk**
- **Mild**
- **Moderate**
- **Severe**
- **Extreme**

The **CAMS** provides a practical, comprehensive and empirically-based way to collaboratively assess and manage suicidal risk and develop a suicide-specific treatment plan. A central message of the collaborative **CAMS** approach is"

> ***"The answers to your struggle lie within you- together we will find those answers and we will work as treatment partners to figure out how to make your life viable and thereby find better alternatives to coping than suicide."***
>
> ***"Let us see if together we can find viable alternatives to suicide to better deal with your pain and suffering" (Jobes, 2006, p. 41).***

SELF-REPORT MEASURES

Brown (2002), Ghahramanlou-Holloway et al. (2008) and Range and Knott (1997) provide comprehensive reviews of suicide measures for adults. (Also see Goldston's review to be found on ***http:/www2.endingsuicide.com/TopicReq?id=1919***). A variety of measures have been employed including the Beck Scale for Suicide Ideation (SSI) and SSI-Worst, the Beck Depression Inventory-II (BDI-II), the Beck Hopelessness Scale (BHS), the Beck Anxiety Inventory (BAI), Suicide Probability Scale (SPS), Adult Suicide Questionnaire (ASIQ), Suicide Behavior Questionnaire (SBQ), Suicide Ideation Scale (SDS), Linehan Reasons for Living Scales (RFL-Adult and Adolescent Versions), and the MultiAttitude Suicidal Tendency Scale (MAST). For example, Bisconer and Gross (2007) found that in an inpatient setting the BDI-II was the best predictor of suicide, but **it also had considerable error**. These self-report scales need to be supplemented by other risk assessment tools (clinical interview, observational data, history of risk and protective factors and current ecological assessment procedures). The following list provides information on the self-report measures.

SELF-REPORT ASSESSMENT TOOLS

Suicide Intent Scale-SIS

(Reactions to suicide attempt-glad to be alive, ambivalent, wish they were dead predicts subsequent suicide attempts)

Lethality Scale

(Planfulness, efforts not to be rescued, seriousness of attempts)

Scale of Suicidal Ideation (SSI) and SSI-Worse (SSI-W)

Assesses suicide ideation, intent and plan (current) and at its most severe point in the patient's life. (Suicide ideation at its most severe point has been found to be a stronger predictor of suicidal risk than assessment of current ideation).

Hopelessness Scale

(Psychiatric patients who score 9 + are 11 times more likely to commit suicide than patients who score 8 or below). Hopelessness should be assessed over time. Stable levels of hopelessness, even in remitted depressed patients, are more predictive of future suicide attempts. The value of Hopelessness in predicting suicide attempts has been found to vary across ethnic and racial groups.

Depression Inventory- BDI-II, $\leq$ 20 (Mild) BDI $\geq$ 20 (Moderate-severe)
Also see Jobes (2000) **Collaborative Assessment and Management of Suicidality (CAMS)**

Assess for Possible Barriers (Scheduling conflicts, Health insurance, Child-care, Transportation, Language and Cultural barriers, Compensation issues, Significant others interfere with treatment, Individual's "paralysis of will", Therapeutic-interfering behaviors)

Joiner (2005) in his book Why people die by suicide proposes that precursors of suicide include:

a) An acquired capacity to enact lethal self-injury (e.g., engaging in high-risk behaviors);

b) A sense that one has become ineffective and a burden to loved ones;

c) A sense that one is not interpersonally connected with a relationship or group (sense of thwarted belongingness)

Joiner (2005, p. 227) assesses these attributes by asking such questions as:

a) Acquired Ability to Enact Lethal Self-injury

Thing that scare most people do not scare me.
I can tolerate a lot more pain than most people.
I avoid certain situations (e.g., certain sports) because of the possibility of injury (Reverse scored)

b) Burdensomeness

The people I care about would be better off if I were gone.
I have failed the people in my life.

c) Belongingness

These days I am connected to other people.
These days I feel like an outsider in social situations (Reverse scored)
These days I often interact with people who care about me (Reverse scored)

As noted earlier, no one indicator is sufficient to predict suicide. Rather, the lesson to be remembered is that it is the combination of risk factors and the absence of protective factors improves the accuracy of suicidal risk assessment. For example, the combination of nonresponsiveness to treatment, treatment noncompliance, high scores on suicide ideation at worst period, and consistently elevated scores on Hopelessness Scale increases the level of suicide risk. (Ghahramanlou-Holloway et al. 2008).

Another factor to consider in the risk assessment is the presence of neurological involvement as in the case of Traumatic Brain Injuries and also in the changes in the adolescent's brain development, as the following summary highlights.

DOCUMENT THE RECORD

"If it was not recorded and documented, it is assumed it did not occur. Rather, think out loud for the record".

Bongar and Stolberg (2009) propose that good record keeping is paramount and should include the following:

1. A systematic and thorough assessment of suicidal risk (present and past), and a how this was determined by the therapist (Enumerate any measures that were used, Interview questions that were covered and the answers given).

2. Indicate the information that alerted the clinician to the suicidal risk.

3. List the risk and protective factors and actions taken (e.g., Include a copy of the Safety Plan, the Treatment plan and adherence data, for example with regard to psychotropic medication and the removal of any firearms and other risks due to drug overdoses).

4. Document ongoing risk assessment and consultation efforts with colleagues or with your clinical supervisor.

ECOLOGICAL ASSESSMENT

I have been involved as a consultant in the assessment and treatment of both suicidal inpatient and outpatients. I have summarized the Lessons Learned in an article entitled "35 Years of working with suicidal patients: Lessons learned" which was published in the Canadian Psychologist, 2005, 46, 64-72). The Lessons Learned can be summarized in the form of nine questions that can be asked of the clinical staff. These include:

1. What did they do to establish and maintain a therapeutic alliance with their suicidal patient?

2. What specific assessment strategies and assessment measures (interviews, observational data, self-report measures, measures of current and past risk and protective indicators) did the health care staff employ on an ongoing basis to monitor the patient's suicide risk?

3. How was this information conveyed to the suicidal patient (feedback) and to significant others in the patient's life (family members and to members of the treatment team)?

4. What specific diagnoses (primary and comorbid) were formulated and how did this information impact the treatment plan?

5. What specific steps were taken to reduce the presence of risk factors (psychoeducation of patient and significant others, removal of risk factors, provision of aftercare interventions, provision of a specific safety plan and back-up supports)?

6. What was done explicitly to address treatment adherence to psychotropic medications, address both barriers to treatment and antitherapeutic patient behaviors?

7. What specific psychotherapeutic interventions were provided and evaluated for their efficacy?

8. When the suicidal patient was an inpatient, what explicitly was done to ensure that the patient's safety (supervision, safety checks, maintain and communicate risk status to other treatment team members)?

9. Where and when was all of these steps documented?

When members of JACHO visit a psychiatric setting or when a patient suicide occurs, the staff should consider each of these nine questions, as well as the additional items I raised in my article in the Canadian Psychologist. The lesson to be learned is that suicide should not be viewed as a result of the characteristics of a depressed patient, but as a by-product of a complex transaction between an individual and significant other in his/her ecological and cultural niche.

For example, imagine that a recently discharged psychiatric patient commits suicide and you and the mental health workers are going to be sued for malpractice. In 25% of the cases of when a patient suicide has occurred, the family members sue the psychologist and his/her treatment center. If you were hauled into court because of a survivor's family lawsuit, do you believe that based on your progress notes you would be able to answer each of these nine questions? Where in your progress notes did you document on an ongoing basis the answers to each of these probes

A CASE CONCEPTUALIZATION MODEL (CCM)

A well-formulated CCM should:

1. identify developmental, precipitating and maintaining factors that contribute to maladaptive, mental health and substance-abusing behaviors and adjustment difficulties and that reduce the quality of life;

2. provide direction to both assessment and treatment decision-making;

3. provide information about developmental, familial, contextual risk and protective factors;

4 highlight cultural, racial, religious and gender-specific risk and protective factors;

5. identify individual, social and cultural strengths that can be incorporated into treatment decision-making;

6. provide a means to collaboratively establish the short-term, intermediate and long-term goals and the means by which to achieve them;

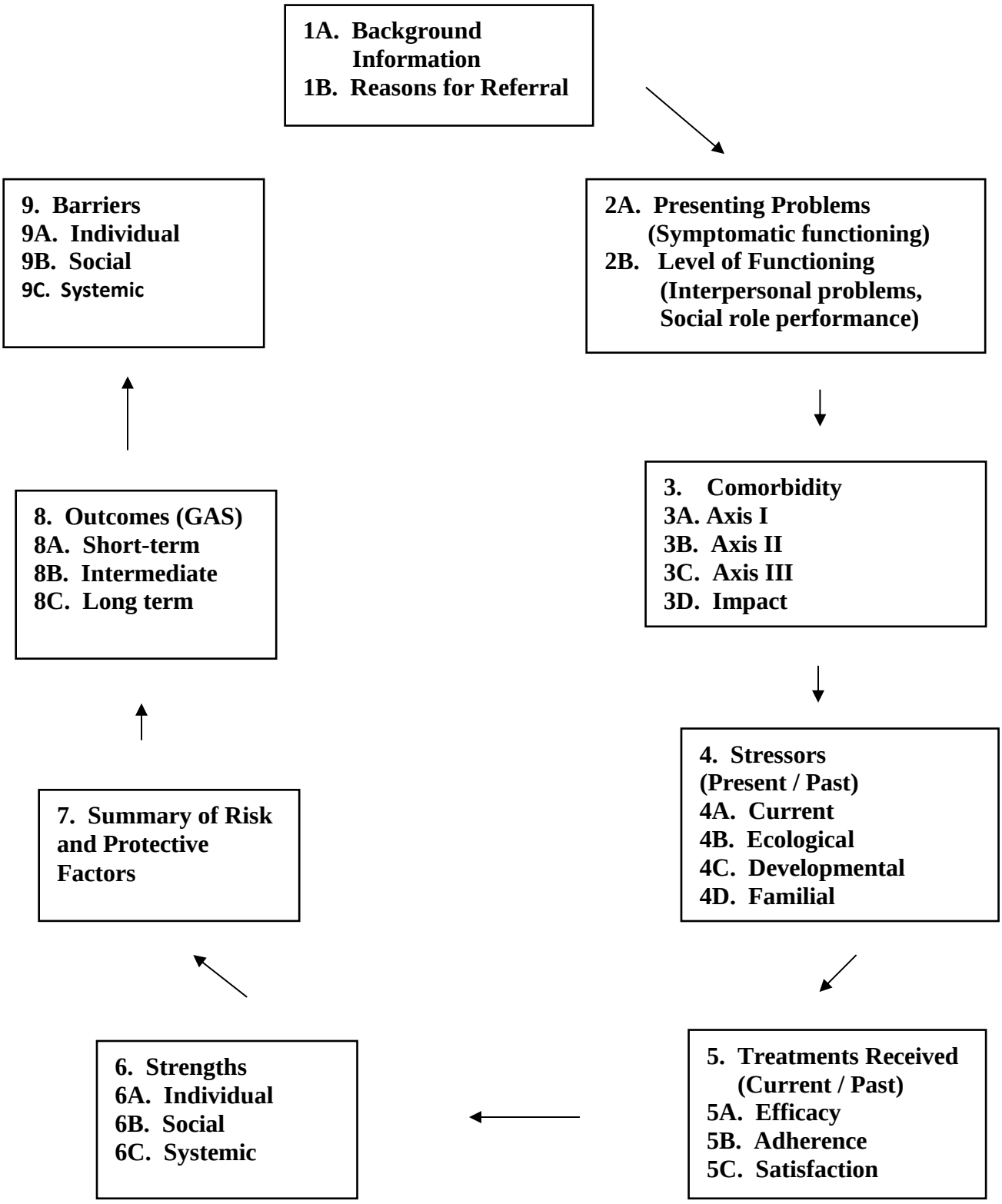
7. identify, anticipate and address potential individual, social and systemic barriers that may interfere with and undermine treatment long-term effectiveness;

8. provide a means to assess on a session-by-session basis the patient's progress and the quality of the therapeutic alliance on a regular basis;

9. consider how each of these treatment objectives need to be altered in a culturally, racially and gender sensitive fashion;

10.engender and bolster a high empathy therapeutic alliance, and one that nurtures hope in both the patient and the treatment team.

GENERIC CASE CONCEPTUALIZATION MODEL



FEEDBACK SHEET ON CASE CONCEPTUALIZATION

Let me see **if I understand:**

BOXES 1& 2: REFERRAL SOURCES AND PRESENTING PROBLEMS

"What brings you here...? (distress, symptoms, present and in the past)
"And is it particularly bad when..." "But it tends to improve when you..."
"And how is it affecting you (in terms of relationship, work, etc)"

BOX 3: COMORBIDITY

"In addition, you are also experiencing (struggling with)..."
"And the impact of this in terms of your day-to-day experience is..."

BOX 4: STRESSORS

"Some of the factors (stresses) that you are currently experiencing that seem to maintain your problems are...or that seem to exacerbate (make worse) are... (Current/ecological stressors)
"And it's not only now, but this has been going on for some time, as evident by..." (Developmental stressors)
"And it's not only something you have experienced, but your family members have also been experiencing (struggling with)..." "And the impact on you has been..." (Familial stressors and familial psychopathology)

BOX 5: TREATMENT RECEIVED

"For these problems the treatments that you have received were-note type, time, by whom"
"And what was most effective (worked best) was... as evident by...
"But you had difficulty following through with the treatment as evident by..." (Obtain an adherence history)
"And some of the difficulties (barriers) in following the treatment were..."
"But you were specifically satisfied with...and would recommend or consider..."

BOX 6: STRENGTHS

"But in spite of...you have been able to..."
"Some of the strengths (signs of resilience) that you have evidenced or that you bring to the present situation are..."
"Moreover, some of the people (resources) you can call upon (access)are..." "And they can be helpful by doing..." (Social supports)
"And some of the services you can access are..." (Systemic resources)

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

"Have I captured what you were saying?" (Summarize risk and protective factors)
"Of these different areas, where do you think we should begin?" (Collaborate and negotiate with the patient a treatment plan. Do not become a "surrogate frontal lobe" for the patient)

BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

"Let's consider what are your expectations about the treatment. As a result of our working together, what would you like to see change (in the short-term)?
"How are things now in your life? How would you like them to be? How can we work together to help you achieve these short-term, intermediate and long-term goals?"
"What has worked for you in the past?"
"How can our current efforts be informed by your past experience?"
"Moreover, if you achieve your goals, what would you see changed?"
"Who else would notice these changes?"

BOX 9: POSSIBLE BARRIERS

"Let me raise one last question, if I may. Can you envision, can you foresee, anything that might get in the way- any possible obstacles or barriers to your achieving your treatment goals?"
(Consider with the patient possible individual, social and systemic barriers Do not address the potential barriers until some hope and resources have been addressed and documented.)
"Let's consider how we can anticipate, plan for, and address these potential barriers."
"Let us review once again..." (Go back over the Case Conceptualization and have the patient put the treatment plan in his/her own words. Involve significant others in the Case Conceptualization Model and treatment plan. Solicit their input and feedback. Reassess with the patient the treatment plan throughout treatment. Keep track of your treatment interventions using the coded activities (2A, 3B, 5B, 4C, 6B, etc) Maintain progress notes and share these with the patient and with other members of the treatment team.

GENERAL QUESTIONS

How are things now and how would you like them to be?

What can <u>we</u> do to help you achieve what you want to have happen?

What have you tried in the past? I want <u>our</u> current efforts to be informed by what you have already tried? What has worked? What has not worked?

How could you tell if it was working?

What difficulties, if any, did you have in trying to change? (Get what you wanted?) How did you handle these difficulties (obstacles, barriers)?

If <u>we</u> work together, and I hope we do, how could we tell whether you are making progress? What specific changes should we expect to see? Who else would notice that you are changing? What would they see?

What obstacles or difficulties might you encounter (or likely experience) in seeking your goals? How might you anticipate or handle these obstacles should they arise?

What will you need to do or have happen in order for you to maintain these changes?

QUESTIONS DESIGNED TO ELICIT STRENGTHS

What do you see as your own personal strengths or abilities?

What things about yourself are you most proud of?

What do other people say are your positive qualities?

What do they say are the positive qualities of your community?

How have you used your personal strengths and abilities to achieve goals or deal with challenges in the past?

How do you think you could use your strengths to help you achieve your current goals?

What are things that give you hope that things can change for the better?

Where does this leave you in terms of your X (drinking)? What is your plan?

How do you think you might be able to do X? What else can you try? What might get in the way of your doing X?

You would have to be pretty creative (strong, clever, resourceful) to find a way around that. I wonder how you could do it?

Let me see if I understand where you are…

Let me see if I understand what you are committing yourself to doing?

So some benefits of making a change are…and some of the consequences of inaction are…Is that the way you see it?

Does this make sense to you?

So you are telling me, and telling yourself, that you will be (were) able to… That's impressive. How did you handle it this time compared to how you handled it in the past? Where else did you do X (resist social pressure to drink)? How did that make you feel? Are you saying to me, saying to yourself, that you were able to "notice, catch, interrupt, use your game plan, resist" etc. (therapist/trainer should use active transitive verbs)? What does this tell you about yourself and about your ability to achieve your goals?

TREATMENTS THAT WORK

Dialetical Behavioral Therapy (DBT)	Marsha Linehan
Collaborative Assessment and Management of Suicidality (CAMS)	David Jobes
Cognitive Behavior Therapy (CBT)	Aaron Beck & Gregory Brown
Brief Cognitive Behavior Therapy	Craig Bryan & David Rudd
Mindfulness-based Cognitive Behavior Therapy	Hayes, Teasdale, Williams & Segal
Problem-solving therapy	Nezu, Nezu & D'Zurilla
Attempted Suicide Short Intervention Program (ASSIP)	Konrad Michel & L. Valahn

Other interventions with suicidal patients include:
Motivational Interviewing, Teachable Moment Brief Intervention (TMBI) -- a one time intervention offered two days after a suicidal attempt and other interventions offered in Emergency Rooms, Crisis Response and Safety Planning, Telephone Hotlines and Internet -based interventions. For example, since its launch in 2007, the Veterans Crisis Line has received 644,000 calls resulting in 23,000 life savings rescues. There are Veteran Chat services and Website www.veterancrisisline.net. Also. Suicide hotline 1-800-273-8255 (TALK) In the future, a 988 line (like 911) will be established for suicide prevention purposes.

For a description of these programs visit the following Websites www.care-cams.com. Jobes http://www/texassuicideprevention.orgwp.content/uploads/2013/06/BCBT_workshop-slides.pdf

When evaluating such interventions, keep in mind that some 45 % of treatment outcome studies exclude severely suicidal patients and they do not include long-term follow-up assessments.

COMMON FEATURES OF THE EVIIDENCE-BASED INTERVENTIONS

1. Treatments focus on establishing, maintaining and monitoring the quality of the therapeutic alliance. They use the art of questioning or Treatment Informed Feedback on a session by session basis to monitor the therapeutic alliance. They provide ongoing contact with the suicidal patient in the form of intermittent call, texts and Active follow-up interventions. They convey their ongoing availability to the patient, nurturing a sense of belonginess, A nonjudgmental supportive and caring collaborative social discourse is maintained throughout treatment.

2. The patient's suicidal behavior is the initial treatment focus independent of any other psychiatric conditions. They conduct a detailed chain analysis of the most recent suicidal attempt identifying risk factors, warning signs and protective factors. They conduct both a "deep dive" life-span and a functional assessment. These programs work to avoid hospitalization.

3. These interventions engage suicidal patients in Safety Planning and Crisis interventions early in treatment They are particularly attentive to the patient's "suicidal mindset" and ways to ensure a safe environment for the patient. They address the patient's impulsiveness by engaging the patient in "delay" commitments in order to give treatment a chance. "If you could get some relief, would you still want to die?"

4. They conduct psychoeducation providing a treatment rationale, discuss issues of confidentiality, agenda setting, and explore the impact of co-occurring disorders. The treatment programs ask patients to participate in various forms of self-monitoring such as keeping mood and thought diaries and to perform various inter-session activities (personal experiments or "homework").

5. Interventions use a variety of procedures to nurture hope including collaborative goal setting the use of Hope Kits, and the use of Time-Lines to help identify evidence of the patient's strengths and resilience.

6. Interventions are skills-oriented in such areas as emotional tolerance and regulation and cognitive rethinking, problem-solving and interpersonal skills. They may also use acceptance and mindfulness training procedures. They often involve significant others in the treatment regimen in order to ensure a safe environment and ways to be supportive to the patient.

7. The various treatment approaches actively encourage suicidal patients in taking responsibility for their treatment improvement.

8. They employ Relapse Prevention procedures to address possible lapses or reoccurrence of suicidal ideation. They focus on possible triggering events and on ways to bolster the patient's self-efficacy in having a coping repertoire. They may use some form of future guided imagery as part of their intervention. The therapists employ self-attribution

training, ensuring that patients "take credit" for any changes.

9. They convey a "life-affirming" message, not only a suicide prevention message.
10. These intervention programs provide support for the therapists in the form of self-care and the use of team approaches.

COGNITIVE BEHAVIOR THERAPY WITH SUICIDAL PATIENTS

1. ESTABLISH AND MAINTAIN AND MONITOR A THERAPEUTIC ALLIANCE WITH THE SUICIDAL PATIENT

(See Below for Specific Examples of "HOW TO" Implement these Core Psychotherapeutic Tasks)

> ***"The importance of establishing a strong relationship with the suicidal patient cannot be overstated. Even the best therapeutic techniques are of little value when an adequate relationship has not been formed with the patient" (Rudd, 2006. P. 19).***

> **"*It is clear that the therapeutic relationship serves as the foundation for the entire treatment. We cannot underscore enough the importance of attending to the relationship between the therapist and teen"* (*Brent et al., 2011, p. 97*).**

The first and most critical task in working with suicidal patients is the ability to develop and maintain a good therapeutic alliance (***see below***) which can act as an excellent safe-guarding protective factor (see Messer & Wampold, 2002). Ghahramanlou-Holloway, Brown and Beck (2008, p. 162) offer sage advise on ways to establish a good working alliance with suicidal patients. They advise that the therapist should:

> ***"Be attentive, remain calm and provide the patient with a private, non-threatening and supportive environment to discuss experienced difficulties. Do not express anger, exasperation, or hostile passivity. Be forthright and confident in manner and speech to provide the patient with a stable source of support at a time of crisis. Stress a team approach to the problem(s) presented; for instance, freely use the collaborative pronoun "we" when discussing suicidal behavior. Model hopefulness, but make sure to acknowledge the patient's distress and perspective on the problem. Do not avoid using the word "suicide" because this gives the impression that you stigmatize the concept. Most importantly, do not immediately suggest hospitalization. In our experience, patients are most agreeable if the therapist carefully explores various safety options, then plans for the most appropriate clinical response to an acute suicidal episode."***

Brent et al. (2011) highlight the need for the therapist to defer judgement, be flexible, collaborative throughout treatment, genuine, supportive, project self-confidence and appropriately use self while creating a safe, trusting, accepting therapeutic environment that is individually tailored to the needs of the suicidal client.

The following is a list of clinical activities that the therapist can include:

Have the patient tell his/her "story", at his/her own pace. Conduct a behavioral chain analysis of events of the proximal factors that triggered the suicide attempt. Involve significant others as a source of information concerning the suicide attempt. Ensure the patient's safety.

Help the patient define the suicidal crisis. Remember that the patient is communicating how badly he or she feels.

As noted, use "we" and convey a collaborative team approach in understanding the events (stressors) that triggered the thoughts of suicide. Use phrases such as "murdering yourself" or "self-annihilation" when referring to suicide.

Help the patient view suicide as an attempt to solve a problem (***see Section below for discussion of how to conduct problem-solving***).

Use Motivational Interviewing procedures. (See examples below for a discussion of ways to engage patients). Britton et al. (2011) and Zerler (2008) have discussed how to apply the principles of motivational interviewing of suicidal patients (AA, EE, DD, RR and SS). The five principles of Avoid Argumentation, Expressing Empathy; Developing Discrepancy between the patient's present behaviors and values; Rolling with Resistance as the therapist strives to understand and respect both sides of the ambivalence from the patient's perspective. The therapist can empathize with the needs that give rise to suicidal ideation, without approving suicidal behaviors. Finally, the therapist can Support the patient's Self-efficacy by acting as a guide or consultant, suggesting possible ways to proceed. Do NOT use "pep talks", lectures, nor discuss the pros and cons of taking one's life.

The therapist can instead tap the suicidal patient's ambivalence about wanting to die and his/her desire to live with less pain. For example, Rudd (2006, p.10) suggests

> ***"You've told me that you really don't want to die, but all of your behavior over the last few weeks suggest otherwise". (Therapist offers specific examples and solicits acknowledgment) "I need you to help me make some sense of this contradiction. It almost seems like your telling me one thing and doing another. Frankly, I am more inclined to consider your behavior as more important, since I'm very concerned about your safety and well-being."***

Use phrases such as "At the same time…", "On the one hand – but on the other hand…"

> ***"How could I help you to get some of what you need most?"***
>
> ***"What do you need from me as a therapist?"***
>
> ***"What can WE do together to help you fill up some of the holes in your life?"***

Address any barriers that may contribute to Therapy Interfering Behaviors.

Use collaborative agenda-setting and solicit the client's feedback about each aspect of therapy.

Brent et al. (2011) offer the following examples of how to collaboratively set an agenda:

"Is there anything on your mind you'd like to focus on today?"
"Do you have some ideas of what you would like to put on the agenda for our session today?"
"Did you have some experiences over the past week that you would like to discuss?"

Each session can include a summary and brief review of the last session so there is a continuity or flow to collaborative narrative of treatment, a solicitation of the patient's feedback on the last session, a review of "homework", a check-in regarding current mood, a suicidality check and a safety plan review.

Periodically summarize throughout the session and at the end of the session. As psychotherapy progresses, ask the patient to summarize what was covered in the session and what he/she plans to do between sessions and, most importantly, the reasons why he/she should conduct these activities ("homework" assignments). Build in reminders that the patient and significant others can take home.
Therapist should model hopefulness and "dogged determination" and convey a "team" approach. (I have often wondered why CBT is effective with depressed suicidal patients and one answer I have come to is that CBT helps to prevent depression in psychotherapists. The CBT therapist does not get depressed as he/she recognizes that the "story" that the depressed suicidal patient is telling is only "one story" -- tuned into the depressogenic channel. It is the task for the CBT therapist to help the suicidal patient tell (and act upon) the "rest of the story" of strengths, resilience and survival instincts. (For an example, see my recent APA film with Missy who attempted suicide seven times).

Earn the patient's and his/her families' trust and confidence. They have to feel heard, respected, taken seriously, accepted and liked.

Discuss the issue of confidentiality and indicate what you, as a therapist cannot keep private. Share rationale for this needed procedure and solicit the patient's feedback. As Brent et al. (2011, p122) highlight:

"Without the teen's buy in, even the best treatment, provided by the best therapist, will not succeed".

Solicit feedback regularly from the patient and significant others. Ask:

"***I want to check in with you about how you found our meeting today. Were there any things I said or did, or did not say or do, that you found particularly helpful? Or particularly unhelpful, or that bothered you? What can we do differently the next time we meet"?***

The critical importance of a therapeutic alliance has been highlighted by Joiner (2005) and Joiner and Van Orden (2008). Under the heading of **Belongingness Therapy,** they describe the study by Motto and Bostrom (2001) who sent high-risk patients "caring letters" reflecting brief expressions of concern and reminders that the treatment agency was accessible when patients

needed it. The "caring letter was personalized, signed by the person in charge of the person's care, and any note the patient sent in response to the previous letter was answered in the subsequent letter.

The "caring letter" that expressed caring and availability proved effective in reducing suicidality in patients who had refused further treatment after hospitalization. An example of the letter that was sent:

> ***"Dear_____: It has been some time since you were here in the hospital, and we hope things are going well for you. If you wish to drop us a note we would be glad to hear from you"***

Finally, there is value in conveying to the patient the need for open, direct communication and the critical importance of ongoing feedback. The following therapist message that was adapted from Miller et al. 2010 (p. 192) provides an example:

> ***"I think I am a pretty good therapist, however, I'm <u>not</u> perfect. I make mistakes and I'll probably do something over the course of our working together that will bother or upset you, maybe even piss you off and may cause you to consider dropping out of treatment. Now, let's be clear. I expect you will also make mistakes. You may do things that upset me and piss me off. The point I am making here is that if you are going to get help we need to be sure that we keep the therapeutic relationship strong and working. This requires <u>BOTH</u> of us to be <u>HONEST</u> with each other if we feel there is a problem; if one of us upsets the other, even accidentally, we have to say to the other person, "Hey, when you said that, you upset me, you pissed me off." We have to tell each other exactly what they did that was upsetting. Does this make sense and is it something we can agree on from the outset that we can work together as a team?"***

There is a need for therapists to monitor the quality of the therapeutic alliance and also the patient's evaluation of his/her progress on a session by session basis. The following two scales use a Feedback Informed Treatment approach developed by Scott Miller and his colleagues (2002).

FEEDBACK-INFORMED TREATMENT (FIT) SCALES

OUTCOME RATING SCALE

This Scale should be administered at the beginning of each session.

Looking back over the last week including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels

INDIVIDUALLY
(Personal well-being)

INTERPERSONALLY
(Family, close relationships)

SOCIALLY
(Work, School, Friendships)

OVERALL
(General sense of well-being)

SESSION RATING SCALE

Please rate today's session by placing a hash mark on the line nearest to the description that fits your experience.

RELATIONSHIP :

I did not feel heard understood and respected ---------- I feel heard understood, and respected

GOALS AND TOPICS:

We did not work on or talked about what I wanted to work on and talk about ---------- We worked on and talked about what I wanted to work on and talk about

APPROACH or METHOD:

The therapist's approach is not a good fit for me ---------- The therapist's approach is a is a good fit for me

OVERALL:

There was something missing in this session today ---------- Overall, today's session was right for me

2. PSYCHOEDUCATION

- Conduct assessment procedures. Provide feedback from the assessment and use the Case Conceptualization Model to help the patient and significant others better understand risk and protective factors.

- Use "stuckness" metaphor to convey that what the patient may have used once to survive and cope (e.g., dissociating, withdrawing, self-medicating using substances) may no longer be effective.

  "When someone is exposed to extended bouts of stress, it can take a toll on the body and nervous system. As a result, they may stay on alert or sentry duty, even when there is no longer an immediate threat. Individuals can act out as if they are a faulty smoke detector".

  "Many things that you learned in the military served you well in your combat zones, but some of these same strategies may cause difficulties in your life now. Let's figure out what is working and what is not working."

- Educate the patient and significant others about the disorders and the cognitive model of depression and suicide and the proposed treatment plan.

- Help the patient and significant others to appreciate the role of warning signs and the role of setting factors that may potentate suicide attempts (e.g., discontinuance of medication, sleep deprivation, substance abuse behaviors, manic episodes, disengagement and social withdrawal behaviors).

- Use self-monitoring, Clock metaphor, downward spiral explanation, ***as described below.***

- Negotiate a Safety Plan that prevents and manages risk factors that contribute to suicide risk and ways that the patient can obtain help, as described below. Determine the appropriate level of care and document this in terms of risk, protective factors and intervention steps.

- Provide bibliotherapy for both the patient and significant other. See Ellis and Newman (1996) ***(Choosing to live: How to defeat suicide through cognitive therapy)***

- Use "urge" metaphor to describe suicidality.

- As part of the ongoing psychoeducation ensure that the patient ***(as described below)***
  - Has reminders of what went on during sessions and shares this with significant others
  - Has a self-help note-book that summarizes coping activities
  - Has a safety plan
  - Has crisis coping cards
  - Has an Anti-suicide Kit or Hope Chest with reminders of accomplishments and Reasons for Living (e.g. Scrapbook with pictures, mementos, Time Line 2 information, as described below)
  - Specific information about ways to contact health care providers

USE CLOCK METAPHOR

In order to help patients appreciate the interconnections between their thoughts, feelings, and suicidal behaviors, the therapist can use the following CLOCK metaphor.

12 o'clock - - external and internal triggers
3 o'clock - - primary and secondary emotions
6 o'clock - - automatic thoughts, thinking processes such as ruminating, schemas and beliefs
9 o'clock - - behaviors and resultant consequences

1. Place hand at 9 o'clock and move around imaginary clock and say "It sounds like a vicious…". Allow client to finish this sentence with "cycle" or "circle". Explore how his/her account fits a "vicious cycle".

2. Treat 3 o'clock primary and secondary emotions as a "commodity". What does the client do with all these feelings. For example, "stuff them", "drink them away", "act out".

3. If that is what he/she does with such emotions, ask, "what is the impact, toll, price he/she and others pay, as a result? If the client answers, "I do not know", then the therapist should say "I do not know either, how can we go about finding out? Moreover, how will finding out help you achieve your treatment goals of X (be specific)?"

4. Encourage the client to collect data (self-monitor) when the vicious cycle, as the client describes, actually occurs. Explore with the client when he/she engages in such behavior and the impact, toll, price. "If it has this impact, then what can the client do?" It is not a big step for the client to say, "I should break the cycle or circle". The therapist can then explore how the client now goes about breaking the cycle - - thus view present symptoms and behaviors as their attempt to "break the vicious cycle". (Use dissociation, substances, avoid, act out).

5. Explore alternative more adaptive ways "to break the cycle".

PROCEDURAL CHECKLIST FOR CONDUCTING SELF-MONITORING AND OTHER EXTRA-THERAPY ACTIVITIES

Another form of psychoeducation is to have patients collect "data" between sessions using a Mood Diary and various Worksheets. There is also a need to have patients engage in "personal experiments" between sessions. The following set of treatment guidelines provide ways to increase the likelihood that patients will indeed engage in these extra-therapeutic tasks.

1. Provide opportunity for patient to come up with suggestion for self-monitoring. Use situational analysis.

2. Provide a rationale. Highlight the connection between doing "homework" and the patient achieving his/her therapy goals.

3. Keep request simple (Use behavioral tasks and "foot in door" approach and build-in reminders).

4. Ensure patient has the skills to perform the task. Give the patient a "choice" as to how best to conduct the assignment.

5. Use implementation intention statements ("When and where", "If …then," "Whenever" statements).

6. Clarify and check the patient's comprehension (use role-reversal, behavioral rehearsal).

7. Use desirable rewards and peer/family supports.

8. Anticipate possible barriers and collaboratively develop coping strategies.

9. Elicit commitment statements and patient-generated "reasons".

10. Inquire about self-monitoring (other "homework" activities).

11. Nurture patient self-attributions ("take credit" for change).

12. Reinforce effort and not just product.

13. View failures as "learning opportunities".

14. Keep record of patient's compliance.

3. NURTURE HOPE

"Suicide is about despair and the cure for despair is HOPE" Joel Dvoskin

- Interventions need to help suicidal individuals transform their hopelessness to hopefulness.
- Engage in collaborative goal-setting. (Hope has been equated with goal-directed thinking). Focus on concrete attainable goals. Use SMART goal. (Smart, Measurable, Attainable, Relevant, Timely0.
- Use a Scaling Procedure 0 to 10 of Hopefulness. Importance of Living Ruler (***see below***).
- Administer a Reason for Living Scale (Adolescent and Adult versions).
- Engage the patient in generating an Antisuicide HOPE KIT (***see below).***
- Introduce the patient to coping models.
- Involve significant others and adjunctive interventions.
- Assess and build on "strengths".
- Use Time Lines.--One can trace collaboratively with the suicidal patient and significant others ***three Time Lines***. (See below for a detailed description of how to use these Time Lines as ways to nurture hope and begin the co-construction of a new narrative or "story".

  Time Line 1- traces from birth to the present, the list of stressors and interventions

  Time Line 2- traces evidence of individual, familial and cultural resilience and strengths

  Time Line 3- engages the suicidal patient in collaborative goal-setting. This time line begins in the present and extends into the future

- Use Future Time Imaging Procedures (***see below***)
- Encourage the patient to reconnect with supportive and prosocial significant others and reengage in life tasks and undertake unfinished life projects.
- Convey that psychotherapy is concerned with "life-promotion" and not just suicide-prevention. It is designed to help patients develop a life worth living.
- Help the patient appreciate the progress that has been made.

4. TEACH COPING SKILLS

- Help the patient develop internal and external compensatory strategies.

- Address the patient's impulsiveness ***(see below)*** and nurture emotion-regulation and distress-tolerance skills.

- Build in Behavioral Activation and Activity Scheduling **(*see below*)**.

- Engage in problem-solving and communication training with a focus on the problems that triggered the most recent suicidal attempt ***(see below)***.

- Conduct cognitive therapy of depression **(*see below*)**.

- Increase the patient's adaptive use of social supports and develop ways to broaden social support network (***see below***).

- Use cognitive behavior skills training procedures (e.g., Self-instructional training, Stress inoculation training).

- Use mindfulness and acceptance treatment strategies, willingness to experience thoughts, feelings and situations fully, in a non-judgmental fashion. (See Hayes et al., 2004; Hofmann & Asmundson, 2008 and Ost, 2008).

- Use cognitive rehabilitation procedures (e.g., memory and attentional pictorial reminders and supports) in order to build in self-efficacy trials for suicidal patients with Traumatic Brain Injuries and other such patients (See Hogan, 1999, and Meichenbaum, 2002 as ways to apply CBT procedures with TBI patients).

- Help foster positive, supportive, "cognitive prosthetic" social environments.

- Increase the patient's use of and compliance with adjunctive services to be conducted in an integrated fashion (e.g., use of medication). Brent et al. 2008 recently demonstrated that depressed suicidal adolescents who do not have a clinical response to an initial trial of SSRI, (some 40%), benefit most from a switch to a combination of CBT plus another medication regimen, as compared to being switched to only another medication alone. There is a need to provide integrative treatments. When psychotropic medications are used it is helpful to discuss with the patient how the medication allowed the patient to behave differently (e.g., notice warning signs, seek help, play a different CD in his/her head). There is value in having the patient attribute improvement to what the medication has allowed him/her to achieve or do differently.

- Where indicated, treat PTSD symptoms (e.g., hypervigilance and hyperarousal symptoms, reexperiencing symptoms, restricted affect, detachment from others).

- Follow generalization guidelines such as using "homework" assignments, involving significant others, build in reminders, behavioral rehearsal, self-attribution or "taking credit" and relapse

prevention procedures. Put the patient in a consultative role of showing, explaining and teaching. Use telephone consultation and home visits.

5. ADDRESS ISSUES OF COMORBID DISORDERS

Given the high incidence of suicidal behavior with such other disorders as Anxiety, Major Depressive Disorders, Bipolar Disorders, PTSD, Psychotic Disorders, Eating Disorders, Substance Abuse, Personality Disorders and Medical Disorders, there is a need to provide integrative treatments. The psychotherapist has a choice to provide sequential, concurrent, or integrative treatments.

- Integrative treatments highlight for suicidal patients how their suicidal ideation and suicidal behavior developed (see the use of Time Lines below) and how such suicidal acts fit within a "vicious cycle" process and how they are interconnected with triggering events, emotional reactions, thinking processes, and behavioral acts and resultant consequences (***see the use of a Clock metaphor, discussed below)***.

- Evidence-based interventions should be employed to address comorbid psychiatric disorders. For example, Prolonged Exposure procedures with PTSD patients, Cognitive and Interpersonal Therapies and Behavioral Activation Procedures for suicidal patients with comorbid Major Depressive Disorders, Relapse Prevention Interventions with Substance Abuse Disorder suicidal patients, Dialectical Behavior therapy Procedures with suicidal patients with Borderline Personality Disorder and Active After-Care Interventions.

- The challenge is how to maintain communication and a common message to the suicidal patient when there are multiple therapists. This is highlighted when psychotropic medications are combined with psychotherapy. Not only is there a need to provide adherence counselling to the suicidal patient across treatment agents, but there is also a need to provide a <u>common psychoeducational</u> <u>model</u> of suicidal ideation and behavior (See Meichenbaum, 2005, 2020).

6. RELAPSE PREVENTION PROCEDURES

- Need to equip the patient on how to deal with possible future adversities, lapses and reoccurrences, mood fluctuations and possible set-backs. ***("If I suffer a set-back, this does <u>not</u> mean that I am back to square one").***

- Help the suicidal patient to decrease cognitive constriction and rigidity by learning how to engage in problem-solving in order to consider a wider range of possible options. Help the patient to chart a possible new course, accepting less-than-perfect solutions. (See Clum & Lerner, 1990; Salkovskis et al., 1990).

- Have the patient learn to use mindfulness acceptance skills as a means to reduce relapse (See work by Kabat-Zinn, Hayes and the book on Mindfulness-based cognitive therapy for depression as a form of relapse prevention training).

- Have the patient and significant others recognize how far he/she has come-- taking credit for improvement.

- Need to help the patient develop Reasons for Living and reclaim a life that is worth living.

- Have patients view lapses as “teachable moments” when suicidal ideation reoccurs.

- Use relapse prevention tasks. Have patients visualize themselves in a future suicidal crisis. Use guided visual imagery of their employing their coping skills in dealing with the events leading up to suicidal crisis and ways to handle suicidal urges.

- Help the patient make good choices in response to “bad feelings”. Such imagery rehearsal procedures can be used as relapse prevention tasks involving past and potential stressful scenarios that might trigger suicidal ideation and suicidal behavior in a kind of stress inoculation fashion (see Meichenbaum, 2007). Successful accomplishment of such tasks can be used to determine whether gradual termination of treatment is required or whether further treatment is warranted. In this fashion, the length of the treatment is performance-based, rather than arbitrarily set ahead of time.

- Imagine possible obstacles and how these can be addressed.

> ***" This time see if you can change the outcome. Can we go through this image again, but this time see if you can imagine coping with each problem as it arises? This time you are aiming for ending up with the best possible outcome. Imagine using the coping tools we have worked on"***

- Raise such questions as:

Let's review our work together and the things we have figured out that tend to make you suicidal. What are you going to keep in mind at that time?

What kind of situations are triggers for you?

When you encounter W, you feel X, and you have the thought Y, and you do Z. (Use Clock metaphor of 12 o'clock being internal or external triggers; 3 o'clock being primary and secondary emotions; 6 o'clock being various cognitions; and 9 o'clock being specific behaviors and resultant consequences- -all of which contribute to a "vicious cycle").
You get a picture in your head of …..

Your brain tells you .....

You're telling yourself ...

Let's talk through the chain of events that led up to the suicidal attempt. Let's think of this as a video camera and in slow motion we can go over this and begin to change the sequence.

- Involve significant others like family members. The Family-based Cognitive-behavioral (FISP) interventions, as described by Asarnow, Huey, Rotheram-Borus, highlight the value of engaging parents to step-in and protect, while the suicidal youth develops coping skills. **FISP** works on enhancing family communication and problem-solving skills.

- Gradually taper treatment- once every two weeks, then once per month. Build in booster sessions every 3, 6, and 12 months.

NEGOTIATE A SUICIDE SAFETY PLAN

Do NOT use a Suicide Contract. Freedenthal reports a series of students that indicated psychiatric inpatients who agreed to a No Suicide Contract were significantly more likely to attempt suicide than those who did not sign a No Suicide Contract. Moreover, arranging a No suicide Contract with patients does not protect therapists from legal liability.

Instead, creating a Safety Plan with patients on how to cope with suicidal thoughts is more effective. See ***www.suicidesafetyplan.com.***

Brent et al. (2011) provide a detailed discussion of how to negotiate a tailor-made Safety Plan in order to help suicidal patients "buy in", so they can get through suicidal thoughts and urges without acting on them. Brent highlights the need to have the suicidal patients write out the steps of the Safety Plan as they create the Plan together with the therapist. The Safety Plan should include an assessment and elimination of any available lethal means in the patient's environment, a list of key adult contact people who can be approached for help, trouble-shooting any roadblocks that might interfere with implementation, a set of Coping Cards that enumerate both internal (coping strategies) and external (help-seeking) strategies and ways to involve significant others like parents.

The suicidal patient's **Safety Plan** should include the contact information (telephone numbers) for

1) therapist or care worker
2) on-call therapist who can be reached after business hours
3) psychiatric emergency evaluation center
4) other local support services who handle emergency calls
5) significant others
6) also, record the reasons why it is important to make these contacts and seek assistance

Joan Asarnow and her colleagues (2007) have developed a **Safety Intervention Plan** for suicidal patients that highlights the need to create **SPATS.**

S a) **Safe Setting--**restrict access to dangerous and lethal methods. Increase time in safe settings.

P b) **People**--increase contact with safe people and improve interpersonal relationships

A c) **Activities**--increase safe activities, actions and behaviors

T d) **Thoughts**--increase hopeful problem-solving thoughts: decrease suicidal thoughts

S e) **Stress Reactions**--strengthen abilities to regulate emotions, tolerate distress, and improve coping skills

SAFETY PLAN
(From Brown et al. 2006)

When I notice the following warning signs:	Anxious, irritable, signs can't cope
That lead to:	Thoughts of suicide; withdrawal
I plan to do the following:	Try my breathing exercises; call my husband
When others notice the following signs:	Crying a lot; agitation
I would like them to:	Be understanding: be patient
I know that I am in serious trouble when I or others notice that:	I have impulsive thoughts; my outlook becomes gloomy
When I am in serious trouble I will	I will ask my mom to come by; I will go to the ER; I will call my therapist

The therapist can supplement the use of these Safety Plan Checklists with the following questions:

"How have you managed to stay alive in spite of tour suicidal thoughts?"

"What have you done that has prevented your situation from getting even worse?"

"Think back to when you had suicidal thoughts, what helped you get through?"

CRISIS RESPONSE PLAN

"When I am acting on my suicidal thoughts by trying to find a gun (or another method to kill myself), I agree to take the following steps:

Step 1: I will identify what's upsetting me.
Step 2: I will write out more reasonable responses to my suicidal plans
Step 3: I will remind myself of the Reasons To Live
Step 4: I will _____

These various steps can be tailored to the specific patient and include the location and phone number of Emergency Room services.

The Crisis Response Plan can also include various other Affective Coping and Distress Tolerance Coping Skills. (See Marshal Linehan's Dialectical Behavior Therapy for examples of mnemonic-based emotion-regulation skills).

Physical self-soothing- relaxation methods

Cognitive self-soothing- distraction techniques (e.g., do enjoyable activity, recall positive memories, imagine a pleasant scene)

Acceptance- urges of self-harm often come in waves. Help the patient develop techniques to "ride out the wave of suicidality". Teach mindfulness skills.

Sensory self-soothing- use smell, sound, touch, warm baths, listen to music, scented candles, massage

Following the negotiating of the **Safety Plan** and the **Crisis Response Plan**, the suicidal patient can be asked:

"On a scale of 1 (not at all likely) to 10 (very likely), how likely do you think you would be to follow your Safety Plan (Crisis Response Plan) during a time of crisis?"

DESCRIPTION OF VARIOUS INTERVENTION PROCEDURES

CONDUCT A BEHAVIOR CHAIN ANALYSIS

"We believe that people do things for really good reasons. I am wondering if you and I could get curious together and try to figure out what those reasons may have been on the day you tried to kill yourself?"

Thus, begins Brent et al. (2011) suggested approach to invite the suicidal patient to become a co-detective in discerning the sequence of events that led to his/her suicidal behavior. A similar chain analysis can be conducted with the patient's parents.

The therapist can use Socratic questions that focus on "**What**" and "**How**" questions such as:

"What was different that day?"
"What made it more likely that you would engage in suicidal behavior on that day, than the day before?"
"How did you come to the decision to try and kill yourself?" Walk me through the steps, if you can of what specifically happened that day and your thoughts and feelings."

The therapist can use an imagery reconstruction procedure and what Wexler (1991) calls a Freeze Frame method in order to have the patient replay the sequence of events, in slow motion, (chain analysis) that contributed to the suicidal behavior. In this way, collaboratively the patient and therapist can begin to identify vulnerability factors, as well as the possible presence of predictive factors (associations, coping resources, religious beliefs, aspirations) that are also part of the chain. In this way, the therapist can begin to explore the ambivalence that suicidal patient's experience. The therapist can also employ pictorial representative (empty chain link circles) that can be filled in by the patient.

USE TIME LINES

The psychotherapist can collaboratively generate **3 Time Lines** with the suicidal patient.

Time Line 1- traces from the time of birth to the present time, the variety of major stressors and when they occurred and the various treatment interventions (hospitalization, medication trials, psychotherapeutic efforts)

Time Line 1-

Birth	**(*Note type of stressors and when*)**	**Present**
	(*Note year, types, and duration of treatment*)	**Time**

Time Line 2- traces the signs of resilience and strengths that the suicidal patient, family and cultural group have evidenced. This Time Line 2 constitutes the "**rest of the story**" and "**in spite of**" events that were characterized in Box 6 in the Case Conceptualization Model. Note that Time Line 2 can also extend back in time prior to the suicidal patient's birth by referring to the signs of "cultural resilience" of the patient's forefathers and previous generations. **"How did they survive and cope? What are the lessons to be learned that have been passed down?"** Remember Brewin's (2006) proposal that psychotherapy helps patients retrieve, attend to and find meaning and hope in alternative "positive" memories. The use of Time Line 2 is a useful way to help suicidal patients co-construct a new, more hopeful story".

Birth	***(Note Signs of Resilience)***	**Present**
	Strengths, Accomplishments, Coping Efforts	**Time**

Survival		***Present***
Skills of	***Birth***	***Time***
Forefathers		

Time Line 3- is designed to help the suicidal patient to establish future-oriented goals and to engage in a problem-solving set. The Time Line begins now and extends into the future. The use of these Time Lines helps the patient to accept the "good and the bad" in his/her history and provides an opportunity and context to become freer of old conflicts so that he/she can develop more adaptive ways of coping and begin to "restory" his/her life.

Present	***Problem-Solving Steps***	**Future**
Time		**Time**

USE SCALING PROCEDURE AND IMPORTANCE OF LIVING RULER

Britton et al. (2011) discuss how to use Motivational Interviewing procedures with suicidal patients. They use a Scaling procedure of asking the suicidal patient.

> ***Therapist: I have a question for you. On a scale of 0 to 10, where 0 is not strong at all and 10 is extremely strong, how important is living to you right now. (Use Importance of Living Ruler)***
>
> ***Suicidal Patient: I do not know, I'd say a 5.***
>
> ***Therapist: What made you choose a 5 and not a zero?***
>
> ***Suicidal Patient: (Provides answer)***
>
> ***Therapist: It sounds like there are times when X occurs (solicit elaboration and acknowledgement) and <u>at the same time</u> you have thoughts about killing yourself, you also think about what life might be like if you could resolve some of your problems and reduce your emotional pain.***

The following **IMPORTANCE of LIVING RULER** was offered by Britton et al. (2011, p. 22).

Step 1: Provide the client with the following instructions.

> **On a Scale of 0 to 10, where 0 is not important at all and 10 is extremely Important, how important is living to you right now?"**

0	1	2	3	4	5	6	7	8	9	10
Not at all Important										**Extremely Important**

Step 2: After the client responds, ask the client:

> ***What made you choose a (client's number) and not a zero?***

Note: It is critical that the clinician ask the client why a higher number and not a lower number was chosen. When clients are asked to compare a higher number to a lower number, they begin to talk about reasons for living, which is the goal of this exercise. When clients are asked to compare a lower number to a higher number, they will talk about reasons for thinking about suicide, which would be counter to the goal of the exercise.

OPTIONAL

Step 3: If the client gives a zero ask:

What would have to change for you to choose a (higher number, i.e. 5)?

Note: Clients who give a zero have difficulty identifying reasons for living. When clients are asked what would have to change for the client to choose a higher number, they begin to talk about areas that they need to make changes in, which is consistent with the goals of motivational interviewing.

EMOTIOAL TOLERANCE, REGULATION and ACCEPTANCE SKILLS

Teaching the suicidal patient the ability to tolerate, regulate and accept intense distressing emotions is a critical task of therapy. Strong emotions can interfere with the ability to think clearly and result in maladaptive high-risk choices.
Brent et al. (2011) and Miller et al. (2006) discuss a variety of skills training steps that include:

1. Educating the patient about emotions.
2. Teach the patient how to identify, label emotions ("If you can name emotions, you can tame the emotions").
3. Teach the patient how to monitor his/her emotions using an Emotional Thermometer, including a "Boiling Point" of "no return". Highlight warning signs- Also use the Clock Metaphor (***See below***).
4. Brent et al. (2011) use the metaphor of emotions are like a "Snowball rolling down a mountain" and that the patient needs to learn a variety of coping strategies.
5. Emotion regulation skills include the use of distraction procedures, self-soothing techniques, deep breathing and progressive muscle relaxation procedures, pleasant imagery, mindfulness skills, taking a time-out, communication and assertive skills training.
6. The inclusion of significant others such as parents in the training program.

BEHAVIORAL ACTIVATION AND ACTIVITY SCHEDULING

Behavior Activation (BA) involves encouraging the patient to engage in behavior that is reinforcing and enjoyable and that will entail the patient's sense of mastery, accomplishment and self-esteem and to counteract avoidant behaviors including rumination. Brent et al. 2011; Dimidjian et al. 2008; Martell et al.2010; Ritschel et al. 2011; have discussed specific ways to conduct Behavioral Activation. The length of BA varies and may entail some 15 sessions over 12 weeks. The BA includes:

1. A functional analysis of the types of activities that the patient finds rewarding. Martell (2009) suggests that the therapist raise the following questions:

   "What is your family like?"

"What kind of things have been fun for you in your life?"
"What is your life like when you are depressed?"
"Are there things that you are not doing now that you typically do when you are not depressed?"
"Are you taking steps to accomplish these things?"

When discussing these varied activities, carefully and sensitively determine if the patient freely chose these activities or whether they were imposed by others (e.g., parents pressuring adolescents to engage in certain activities).

2. Provide a Rationale for BA and how it relates to the patient's personal treatment goals.

3. Help the patient to generate a List of Past Enjoyable Activities and help them to identify and choose tasks and activities that are likely to prove pleasant, reinforcing and can engender a sense of mastery and accomplishment.

4. Help the patient break tasks into smaller, manageable pieces.

5. Help the patient identify avoidant behavioral patterns and learn ways to "break free" from ruminative thinking.

6. Have the patient practice, mentally rehearse and role play ways they will implement behavioral activities. Discuss possible obstacles and roadblocks and how these can be anticipated and addressed.

7. Encourage the patient to engage in such activities even when he/she does not feel like it and at the onset of depressed moods learn how to use Opposite Actions. Derive benefits even when one does not feel like it.

8. Have the patient use a Daily Activity chart with the hours of the day, noting his/her activity scheduling. Use a gradual task approach and mood diaries and problem-solving worksheets.

9. Discuss with the patient how engaging in such activities impacts his/her mood, sense of mastery and accomplishment. "How enjoyable was this?" "To what extent did you feel a sense of accomplishment?"

10. Involve significant others such as parents in the discussion and implementation of the BA.

11. Use various Acronyms to provide reminders of when and how to implement BA activities. Three Acronyms that have been used are **ACTION, TRAP** and **TRAC**.

Martell (2009) and Ritschel et al. (2011) have used a Handout with an acronym **ACTION** to summarize the Behavioral Activation procedures.

Assess behavior. "What does this behavior do for you? Will you feel better or worse after you try this behavior? Are there other alternatives? Is the current behavior avoidant?"

Choose a behavior to try. List the specific actions you will take.

Try out this behavior that you have chosen. Take careful notes about how the behavior affected you.

Integrate the behavior into your regular routine. If this is a new behavior for you, how can you make it part of your daily life?

Observe the results of the behavior. Do you feel better or worse after you try this behavior? How does doing this activity affect your mood?

Never give up. Sometimes new behaviors take a little while to feel natural, and you may have to try again.

A second set of Acronyms used in Behavior Activation are **TRAP** and **TRAC**.

Trigger or some event (Antecedent)
Response or emotional reaction
AP- - avoidance behavior

Trigger
Response
AC - - alternative coping activity

These Acronym reminders help patients recognize and "break free" of avoidant patterns and empowers them to reengage.

ANTI-SUICIDE "HOPE KIT"

The HOPE KIT serves as a memory aid to be used at a time of crisis. It can be a Box in which the patient puts items that remind him/her of the Reasons to Live (e.g., pictures of loved ones, Bible verses, information gleaned from Timeline 2 of "in spite of" behaviors and survival skills). The patient may include a Checklist of personalized self-management strategies to use during suicidal emotional crises. A list of ways to ensure that his/her environment is safe. Patient can GOOGLE Apps for Hope Kit and find a list of items to include in their Hope Kit.

USE FUTURE TIME-GUIDED IMAGING

Have the patient imagine a time in the future, noting the date, how old he/she will be and describe what is happening in his/her life. Where are they, what do they see around them, who are they with? Involve all senses. How do they feel about the image? Anything they can do to improve the image or anything that they would like to change? Discuss with the patient specific ways they can use their HOPE KIT and Guided Imagery technique to prevent a future suicidal crisis.

ADDRESS PATIENT'S IMPULSIVENESS

Some suicide acts are impulsive and interfere with effective problem-solving. There is a need to slow down impulsivity.

Teach the patient how to "procrastinate" suicide and how to "stretch out time".

Ride out suicidal urges. Use a riding the wave metaphor of emotions rising and then coming down. Help the patient recognize that suicidal urges are not constant and will pass with time.

Delay acting on impulse to self-harm using one's coping card so they learn how to ward off impulsive acts and maintain an emotional balance.

Compile and practice delaying strategies such as talking to someone, telephone therapist, engage in distracting tasks, sleeping, calling the suicide Talk line 1-800-273-8255 (TALK) or calling or visiting Emergency Center if needed.

Safeguarding one's environment so it is unfriendly to suicide. Collaboratively engage in safety planning. Involve significant others.

One way to help suicidal youth delay acting on their suicidal impulses is to use the quality of the relationship with the therapist as a means of delaying a suicidal response. Rotheram-Borus in the Imminent Risk Assessment asks the suicidal individuals to make a promise for "no suicidal behavior" for a specific period of time.

> ***"Promise me that if you feel suicidal you will call_____and/or call _____ (last) about your feelings before you try to hurt yourself."***

Brent et al. (2011) offer the following example as a way to address the suicidal patient's impulsiveness.

> "***If <u>we</u> can work together for the next X weeks, I am going to ask you <u>not</u> to hurt yourself. If <u>we</u> are going to work together, I need a commitment from you today that you are going to give therapy a chance. I know what I am asking is not easy. Working together we can help you <u>create a life that feels worth living</u>."***
>
> ***"Getting help is <u>not</u> a sign of weakness, but rather a sign of strength and courage. A willingness to honestly think aloud about one's problem's."***
>
> ***"I want to empower (enable) you to become your own therapist, so you can handle whatever comes your way in life."***

Rudd (2006) recommends the use of a time-limited <u>Commitment To Treatment Statement</u> (CTS) which is an agreement between the patient and clinician in which the patient agrees to make a commitment to the treatment process and to living. The CTS identifies the roles, obligations and

expectations of both the clinician and the patient in treatment and the need to communicate openly and honestly about all aspects of treatment including suicide and ways to access identified emergency services during periods of crisis. (See Rudd 2006, p. 52 for example of CTS). For example:

Commitment To Treatment Statement

"I (patient's name) agree to make a commitment to the treatment process. I understand that this means I have agreed to be actively involved in all aspects of treatment, including: (Clinician specifies the Treatment Steps).

"I also agree to make a commitment to living. This agreement will apply for the next X months, at which time it will be reviewed and modified.
Signed _____ Date _____
Witnessed _____

The Commitment To Treatment Statement is different from No-suicide Contracts that may give a false sense of security.

"The use of an oral or written "contract for safety" in the management of suicidality has been demonstrated to have serious limitations and to lack sufficient evidential basis for having a protective impact on acts of deliberate self-harm" (American Psychiatric Association, 2003, pp.5, 41-42).

"There is no empirical evidence supporting the effectiveness of no-harm contracts in preventing suicide." (Rudd, 2006, pg.50)

PROBLEM-SOLVING SKILLS TRAINING

55% of adolescents report that they attempt suicide as a method to escape from what they perceive to be an unbearable situation. The therapist should help the suicidal patient reframe suicidal behavior as a <u>failure in problem-solving</u>. Donaldson et al. (2010, p.218-219) provide the following example of therapist statements that can be offered to suicidal patients.

"So, basically, you felt stuck and decided that the <u>only</u> way you could get out of this situation was to hurt yourself."

"You couldn't think of anything else to do that you thought would be helpful. So you thought you would solve the problem by escaping it or hurting yourself."
"We can help you to learn how to get yourself 'unstuck' <u>without</u> having to hurt yourself."

The therapist should help the patient and significant others to prioritize problems.

What is upsetting you the most?

If you could change one thing about your life, that is changeable, what would it be?
If we could wave a "magic wand," what changeable problem would be different?
What have you tried in the past to solve this problem?
How did it work?
What difficulties did you have in working on this problem?
What do you think <u>we</u> could try differently now?
How would we know if we were making progress?
If you were changing, what would others notice?
What difficulties might we anticipate that we can plan for?
Why would working on this be important? What would change?
Are you willing to work with me on addressing this problem?

(In selecting a problem to work on, choose one that is potentially solvable and one that may have positive ripple effects)

Out of such social discourse, the suicidal patient can learn to:

1. Identify and list problems, discerning what are potentially changeable and unchangeable problems. Be very specific and concretely identify the problems.

2. Prioritize and specify problems worth working on and short-term, intermediate and long-term goals.

3. Explore the connections between perceived problems and suicidality.

4. Generate alternative plans and brainstorm all possible options and weigh the pros and cons of various solutions. (Use problem-solving sheets and Decisional Balance Sheets).

5. Decide on one solution and explore potential roadblocks. Break problem-solving into component parts and bolster self-confidence.

6. Implement and review consequences and evaluate progress.
   The goal of this problem-solving activity is to increase the likelihood that the suicidal patient will take the “therapist's voice” with him/her. The psychotherapist can ask the suicidal patient:

“Do you ever find yourself, out there, in your day to day experience, asking yourself the questions that we ask each other right here?”

COGNITIVE RESTRUCTURING/COGNITIVE THERAPEUTIC PROCEDURES

- Use the "art of Socratic questioning" which focuses on the patient's thinking processes. Use imagery reconstruction of behavioral scenes or chain analyses. Trace external and internal triggers that led to mood elevations, increased hopelessness, breakdown of problem-solving, suicidal thoughts and behaviors. (**Downward spiral)**

- Help the patient identify, monitor and decrease suicidal ideation. Help him/her collect "automatic thoughts." Explore with the patient the "internal debate" of the suicidal mind and the interpersonal aspects.

- Encourage, invite, entreat, persuade, convince and cajole the patient to consider alternatives to suicide. For example, the therapist could ask
  "If you could solve some of your family problems, would you want to live?"

- Help the patient reconceptualize "the cant's", "won'ts", the "absolutes" and the "negotiables", to widen fixed blinders, to think the "unthinkable" and to move beyond "only".

- Learn how to challenge thoughts, instead of having an "emotional knee-jerk reaction" to situations.

- Help the patient label and rate emotions and identify "cognitive road blocks."

- Help the patient to monitor mood shifts and learn to ask oneself***, "What just went through my mind?"*** Learn the link between feelings and "downer" thoughts and how to "jump start" adaptive thinking. Can collaboratively generate wallet size **coping cards**.

- Help the patient learn how to note mood shifts and develop plans for coping with trigger situations. If ...then plans so the patient is not "blind sided" by feelings and events.

- Educate about cognitive errors--all or none, black-white thinking, overgeneralization. Teach the concept of the "middle road".

- Help the client move from "either-or" thinking to "both-and" thinking. For instance, the therapist can observe:

  "I can see why you want both more independence and more respect, <u>and at the same time</u>, it is important to continue to have a close relationship with those you love in order to get support when you need it."

- Teach the patient how to question and challenge his/her thoughts and learn how to instill reasonable doubt. Thoughts don't always equal facts. Nurture the patient's sense of curiosity.

- Help the patient learn how to use a Dysfunctional Thought Record and collect data. Identify triggers, core beliefs and forms of "emotional reasoning".

- The therapist helps the patients examine their thinking patterns, their "If-then" assumptions, helpful and unhelpful automatic thoughts. Brent et al. (2011) use the metaphor of sledders going downhill who stay in the same pathway every time they go down the hill. "***Often, when individuals are depressed, their thinking patterns can get stuck in a pathway that maintains their depressed mood. They have to steer out of a pathway that is likely to lead to depression." (p. 179).***

- Address issues of denial and avoidance as a form of coping technique. Use a "stuckness" metaphor. The patient is "stuck" using a coping technique that worked in the past, but is no longer adaptive in the present.

The following QUESTIONS are designed to nurture a curious self-questioning mindset on the part of the patient.

> ***"You do not always believe everything that you read in the paper and everything you hear on the television. Help me understand what leads you to believe every thought that goes through your mind?"***
>
> ***"What is the evidence that what you are telling yourself is in fact true?"***
>
> ***"Is it possible that you are wrong about what you think will happen if you kill yourself?"***
>
> ***"Is there anything that you may be leaving out?***
>
> ***"Is it possible that there is a downside to that?"***
>
> ***"What is another way to look at this?"***
>
> ***"What would be different if you changed what you tell yourself?"***
>
> ***"Is there a way you can talk back to your Amygdala (your lower emotional part of your brain), so you do not allow it to HIJACK the thinking part of your brain?"***

An alternative way to help patients develop a different relationship to their suicidal mindset is to have them use an ACCEPTANCE approach. The therapist can say:

> ***"The mind loves to hang around in the past and be preoccupied about the uncertainty of the future. Is it possible that you can use your Mindfulness skills and stay in the present?"***
>
> ***"Instead of challenging each thought that you have, you could accept each thought and let them float away like a passing set of clouds, or like leaves being carried away in a floating stream."***

Finally, let me ask you a DIFFERENT QUESTION:

"Do you ever find yourself out there, in your day to day experience, asking yourself the type of questions WE ask each other right here?"

USE CLOCK METAPHOR

12 o'clock - external and internal triggers

3 o'clock - primary and secondary emotions

6 o'clock - automatic thoughts, thinking processes and core beliefs or schemas

9 o'clock - behaviors and resultant consequences

The therapist can use his/her hand to convey the **clock metaphor** by moving his/her hand slowly from 9 o'clock around to 6 o'clock. The therapist can say:

It sounds like this is just a vicious…(without completing the sentence), thus allowing the patient to interject- - "cycle or circle".

If you engage in such a "vicious cycle," then what is "the impact, the toll, the emotional price you and other's pay? Is that what you want to have happen?"

Moreover, what do you do with your emotions of X ?(3 o'clock).

(The psychotherapist can treat the patient's emotions as a "commodity" to do something with. For example, does the patient "stuff" his/her emotions, explode, drink them away, etc?)

If the patient responds to the question, "What do you do with your emotions? with a reply of "I do <u>not</u> know", the psychotherapist can say, "I don't know either. How can <u>we</u> go about finding out?" In this way the psychotherapist is <u>not</u> , what I call a "Surrogate Frontal Lobe", doing the thinking for the patient, but rather a supportive "detective" and collaborative guide.

WAYS TO INCREASE SOCIAL SUPPORTS

Have the patient make a list of possible social supports. Brent et al. (2011, p. 204) provide a Social Circles Exercise that can be used to assess the patient's social support network. They also describe how to enhance the patient's interpersonal skills including training in direct communication, active listening, assertiveness, ways to improve social success (grooming, hygiene, conversational skills and ways to maintain social supports).

Utilize family resources

Proactively develop healthy new social supports (e.g., join social club)

Teach the patient how to access and use social supports
Involve family members (significant others) in treatment with the patient's permission. For example, educate the patient's parents about the nature of depression and comorbid disorders and on ways they can provide support.

Help significant others understand that it is not dangerous to ask the patient how he/she is feeling.

Encourage the patient to let people know when he/she is suicidal.

Patients can be asked:

> ***"Who are three people you will call if you are feeling like hurting yourself? Which adult or helper (counsellor, therapist) do you feel comfortable calling? What is their name and telephone number?"***
>
> ***1.***
> ***2.***
> ***3.***

This activity is designed to challenge the patient's belief that "No one cares" and to ensure that the patient contacts "safe" supportive people (non-suicidal).

Ask the patient:

> ***"If you were considering suicide, what can you say to someone who cares for you to help you get through another day?"***
>
> ***"What do you most wish someone would say to you that could help you get through a tough day when you are having suicidal thoughts?"***

OTHER POSSIBLE INTERVENTIONS

- Freeman and Reinecke (1993) propose that the therapist adopt a phenomenological perspective in an attempt to understand and address the client's concerns. The therapist should convey empathy with the client's despair, explore the client's motives for considering suicide (e.g., desire to escape emotional pain vs. desire to communicate their concerns to others), acknowledge their belief that there is no other alternative. In order to nurture the client's sense of being understood and accepted the therapist can convey:

  I need us to focus on the problem or problems that are making you feel like there is no other answer but to take your life.

  The therapist needs to convey that while suicide always remains an option, it is <u>not</u> the client's only option, nor the best option. The therapist should also convey his/her availability and explicitly indicate that he/she does <u>not</u> want the client to commit suicide. See the client as often as needed. Give the client an emergency telephone number where help can be obtained 24 hours a day. The therapist can request that the patient call him/her or the emergency center for help before engaging in any self-destructive behaviors.

- In collaboration with the patient, develop and implement a plan to remove weapons and take appropriate safety precautions. This may involve contacting significant others, psychiatric consultation, or hospitalization, intensive outpatient treatment, medication, and develop a supportive and secure environment.

- Probe the patient's level of hopelessness (use Hopelessness Scale) and ask, "What, if anything, prevents you (the patient) from taking your life?" This question will provide an opening to explore reasons for living and move toward problem-solving (use Reasons for Living Scale). The objective is to help the client expand on his/her reasons for living (viz., "What has kept the client from suicide so far?"). Linehan's (1985) findings indicated that the absence of strong positive reasons to live is most indicative of suicidal behavior. Address the client's sense of hopelessness, demoralization and fatalism.

- Help "<u>normalize" depression</u> -- therapist might comment: "Given your (the patient's) life circumstance, I can understand that you might be depressed. (Cite specific examples.) Depression and disappointment should be viewed as a normal part of life rather than believing that such feelings should not exist. That does not make the emotional pain any less, but I can understand what might lead you to be so depressed. " Moreover, convey that it is understandable and natural that someone might consider suicide when he/she sees no other way to fulfill his/her desires. If someone felt that there is no other way to handle "the emotional pain", or if someone feels that "the emotional pain will never end", then suicide may seem to be the only or best solution.

- Reframe suicide as a possible solution to problems. For example: "Your feeling hopeless does not mean that your situation is hopeless. It simply means that you are depressed." Describe the effects of depression -- possibly, use metaphors such as, "depression acts as a prism (lens) that you see the world through", or use the metaphor of, "A horse that wears blinders (like depression) and as a result has its vision restricted." "A person who only tunes into one channel." Indicate that the client experiences the world through blinders of which he/she has no awareness. Have the client collaborate in citing specific examples from the client's experience (supporting data) for the applicability of each metaphor. Ask the client for his/her reaction -- Does this "ring true" with your experience? Convey to the patient that: "He/She is plain wrong in his/her belief that suicide is the only (emphasize only) solution, or for that matter the best (emphasize best) solution, to your problem(s). If you believe that suicide is the only or best solution to your problems, then that is 'depression speaking' "Why don't we see how you feel in a few weeks? Let's take one day at a time and see if we can't find a better way to deal with this situation." Discuss with the client how he/she can anticipate possible problems.

- Help the client engage in problem-solving by tracing how he/she came to the solution that suicide was the only or the best solution. Trace thinking process. Help the patient generate alternatives. Use imagery of various possible alternative solutions. Help the suicidal client create the perception of options and nurture the hope for change. Time projection can be used to encourage the suicidal client to adopt the notion that life could get better. Help the client break what appear to be numerous and overwhelming problems into smaller, behaviorally prescriptive units that can be addressed individually. Help the client develop more adaptive ways of coping instead of using alcohol, drugs, avoidance strategies. Since drugs and alcohol exacerbate an individual's suicidal intentions and render clients less likely to be receptive to help, the addictive behaviors need to be addressed directly.

- The therapist can help the "victimized" client reframe suicide as a way of giving away "power" and "control" to the perpetrator, instead of taking her own power back. View suicide as a way to "escape from oneself."

- Help the client to look for "gray areas" instead of employing black or white thinking. As one suicidal client concluded, "Gray can be a beautiful color." Cognitive restructuring procedures can be used to help the client to question the conclusions that he/she is "worthless" or a "failure" and that "life is futile", and that the future is "hopeless".

- Beebe (1975) suggests having the client image his/her completed suicide and then confront "illogical justifications" such as:

  "My family will be better off without me."

  "They will be sorry."

  "My family's pain will stop."

"I will remove the burden from my family and friends."

Discuss with the client the advantages and disadvantages of solving the immediate problem by means of suicide versus the long term effects on others such as family members (children when they grow up).

Ask what "legacy" the patient wants to leave his/her children? What does he or she want to be remembered for?

- Beck (1994) has offered additional clinical suggestions on how suicidal clients can be helped. He indicated that he assesses the client's level of hopelessness each session, since hopelessness is one of the best predicators of suicide. He will assess the client's level of hopelessness at the beginning of the session and then explore with the client what options exist beside suicide. Following this discussion, toward the end of the session the therapist would once again assess the client's level of hopelessness. Such assessments may be conducted by means of open-ended interview questions, or assessed by means of asking the client to provide a rating on a 0% to 100% or 1 to 10 point scale of the degree of hopelessness, or assessed by the Beck Hopelessness Scale. The change in the level of hopelessness from the beginning to the end of the session reveals the client's suicidal potential. But changes in a positive direction that are offered in therapy are not sufficient. As Beck observes, he is sensitive to the fact that the suicidal client may have a "relapse" during the coming week. In anticipation of this possibility he comments[1] to the client:

  "I can see that you seem more hopeful and feel better now than at the beginning of this session. But when you are home, it is possible that your feelings of hopelessness may return? Can you see that possibly occurring? ... Should your feelings of hopelessness return, I am wondering what you might do at that time? ... I also want you to know that your re-experiencing such feelings of hopelessness and thoughts of suicide are not all bad. At that moment it means that all your problems are present; that is, the time when you are having what we call "hot cognitions". It is critical to catch your cognitions when they are hot! At that very moment, you can call me on the phone if you need to or if you wish you can write down your thoughts and feelings, as well as what is happening. On the phone or when you come to our next session, we can go over them." (Note: Beck indicates that his clients have not abused the phone call privilege.)

  In short, Beck is proposing that the clinician help the suicidal client reframe his/her suicidal thoughts and feelings as a "learning opportunity" to be collaboratively explored with the therapist. Consistent with Beck's views that therapy is a "journey of exploration", he challenges his clients to adopt an attitude of "curiosity" and "inquiry". For example, if the suicidal client conveys a negative self-image, the therapist may wonder aloud, 'Where did all of these feelings of helplessness, hopelessness, and

[1] This quotation reflects a paraphrase of the essential clinical suggestions offered by Beck (1994).

thoughts of suicide come from?' The therapist may convey that therapy is like a jigsaw puzzle, a puzzle to be solved with its many pieces. If the client highlights developmental and familial factors that contributed to his/her distress, the therapist can encourage an inquisitive attitude by asking the client if he/she has any brothers or sisters. "Is there any way that the client could obtain information from his/her siblings that might help explain what was different about how they reacted versus how the client reacted? ... Would this help provide useful information, another piece to the puzzle?"

Clearly, there are many additional variations on the clinical suggestions offered by Beck and the others included in this handout. The important point is that the therapist is active in suggesting to the client ways that he/she can become his/her own therapist, viewing his/her thoughts and feelings as occasions to engage in self-reflection, as occasions for learning, as opportunities to collect data where one's thoughts are viewed as "hypotheses worthy of testing". The ways in which the therapist goes about accomplishing these objectives will surely vary depending upon the client.

A critical objective of the therapeutic process is to nurture hope and to ask clients to put this into their own words, "What prevents them from committing suicide?"; "How can they find meaning given what has happened?"; "How can they not only move on, but find ways to help themselves and others?"; "How does one find hope?" (Note, the use of "How" and "What" questions as a means of having the client **take ownership and responsibility for behavioral change and for staying alive**).

- These clinical procedures represent short-term immediate therapist interventions. For some traumatized clients who are suicidal, more long-term interventions are required. This is especially true of individuals who are diagnosed with Borderline Personality Disorders.

A major concern with clients who are diagnosed with Borderline Personality Disorders is the possibility of **self-mutilation**. There is a need to carefully consider each specific incident of self-mutilation. An important first step is to better understand the client's motivation for self-mutilation. As Fleming and Pretzer (1990) observe, there is a need to:

(a) Examine with the client the specifics about those occasions in which they have self-mutilated and occasions when they have been tempted to self-mutilate. Then to consider the commonalities evident across these situations. The following questions can be used to cover this information.

(b) <u>Consider precipitants</u>.

What led up to your wanting to hurt yourself?

When did you start feeling like hurting yourself? What was going on before that?

How were you feeling beforehand?

What other feelings did you have?

What was your immediate reaction when (the precipitating event) happened?

What thoughts ran through your head?

Consider goals

What did you hope to accomplish?

How did you expect to feel afterwards?

How did you expect others (be specific) to react? How would you like them to react?

Suppose you had not done (self-mutilation), what do you think would have happened? How would things have been different? How would you have felt then?

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WEBSITES SUIC IDE TREATMENT RESOURCES

www.cams-care.com

https://nowmattersnow.org

https://practiceinnovations.org/I-want-to-learn-about/suicide-prevention

https://www.crisistextline.org

https://zerosuicidecdc.org

www.helpingthesuicidalperson.com

http:/ www./texassuicideprevention.orgwp.content/uploads/2013/06/BCBT_workshop-slides.pdf

TREATMENT of INDIVIDUALS WITH PROLONGED and COMPLICATED GRIEF AND TRAUMATIC BEREAVEMENT

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COMPLICATED GRIEF versus TRAUMATIC BEREAVEMENT

There is value in drawing a distinction between individuals who experience Prolonged and Complicated Grief versus Traumatic Bereavement in response to the loss of a loved one or for someone for whom an individual has a strong attachment relationship. Survivors are likely to experience **deaths as traumatic** if the loss is sudden, unexpected, untimely, often violent, and perceived as preventable, unjust, and resulting from an intentional human act. If the death involved violence or mutilation, or if the survivor believes that his/her loved one suffered during his/her final moments, then there is a high likelihood of mental anguish, an overwhelming sense of loss and difficulty accepting the death. They often struggle making sense of what happened and may experience guilt, self-blame, manifest preoccupation with the circumstances of the death and the deceased experience of suffering. Such shocking deaths may cause survivors to question their faith and experience "spiritual struggles." (Pearlman et al., 2014). In addition, individuals who experience traumatic bereavement with accompanying PTSD are likely to experience intrusive thoughts, avoidance behaviors, cognitive and mood alterations, physiological arousal, loss of meaning, affect dysregulation, impaired concentration and being consumed by memories (rumination). They are prone to disengage from the present in favor of yearning for the deceased and focusing on the past. They evidence an avoidance of engaging in pleasurable activities and social contacts.

In terms of Prolonged and Complicated Grief, Prigerson et al., (2009) have proposed a **Prolonged Grief Disorder (PGD)** that is associated with intense, unremitting and disruptive impact on central roles and relationships and that contribute to enduring mental and physical health problems and that are slow to resolve and will persist if left untreated. At least 6-12 months following the loss, the individual with **PGD** experiences intense yearning or longing for the deceased, either daily or to a disabling degree, as well as 5 or more of the following symptoms on a daily basis, or to a disabling degree:

feel stunned, dazed or shocked by the death; avoid reminders of the reality of the loss; have trouble accepting the death; have trouble trusting others; feel bitterness or anger related to the loss; experience difficulties moving on with life; experience confusion about one's role in life or a diminished sense of self; feel that life is unfulfilling, empty or meaningless and feel numb (absence of emotion) since the loss.

In addition, they may also experience heightened levels of suicidal thinking and behaviors, impaired social functioning and more days of work missed.

The intense yearning for and preoccupation with the deceased, the accompanying pangs of grief in response to the evocation of the "echoes of the past", the avoidance of loss reminders, social isolation and avoidance of seeking help can contribute to difficulties with occupational and social functioning, self-care behaviors, poor health, impaired sleep, contribute to substance abuse, and in some instances, contribute to suicidal thoughts and acts. (***See Pearlman et al., 2014 - - pp. 42-43 – for a list of common responses to the death of a loved one***).

Bereaved individuals with Complicated Grief are more likely to seek professional services than individuals without Complicated Grief.

Thus, the circumstances of the death can influence the nature of the bereavement process, and the type of treatment approach that should be employed. Survivors of natural deaths rarely encounter the problems and challenges that bring about great distress for survivors of traumatic deaths.

INCIDENCE OF COMPLICATED GRIEF

The incidence of Complicated Grief varies depending on the circumstances of the death (e.g. traumatic death due to violence, homicide/suicide), death of a child (as high as 30% to 50%), or whether the death was expected due to natural age-related causes. Some healthy individuals do not show significant distress, nor impaired functioning even shortly after a recent loss (Wortman and Silver, 1989). Most bereft people advance through bereavement without any residual problems (Parkes, 2011).

For most individuals (75%), over time the severity of their grief reactions subside and they grieve adaptively over a period of a few months and evidence resilience (Bonanno, 2002, 2004; et al. 2005; Clayton et al., 1968; Currier et al., 2008; MacCallum & Bryant, 2013). Wortman and Boerner (2007, 2011) have reported that while most survivors improve symptomatically, but they may still have difficulty finding meaning after a sudden traumatic loss, than after a loss stemming from natural causes. Neimeyer and Sands (2011) indicate that the inability to find meaning is a significant predictor of post loss adjustment.

Anywhere from 5% to 20% of bereaved individuals evidence Prolonged and Complicated Grief (PCG) reactions and Complicated Spiritual Grief reactions, chronic depression and related adjustment difficulties. Psychiatric outpatients who are bereaved evidence a higher incidence of PCG (Hensley, 2006).

During the first weeks past the loss, grief-related reactions are normal (Clayton et al., 1968; Pearlman et al., 2014).

- 70% of bereaved individuals report depression, sleep disturbances
- 85% experience bouts of crying
- 50% evidence diminished interest in usual activities, loss of appetite, difficulty concentrating, withdrawal, and a sense of insecurity

Such behavioral patterns of grieving occur across cultures, but there are marked variability in expression.

For a discussion of the controversies concerning the inclusion of Complicated Grief in DSM-V see Boelen & Prigerson, 2013; Jordan & Litz, 2014; Pearlman et al. 2014; Prigerson et al. 2001; Prigerson & Jacobs, 2001; & Jacobs, 2001; Rando et al. 2012; Shear et al., 2011; and Wakefield, 2013. DSM-V has introduced the diagnostic category of Persistent Complicated Bereavement in

the Appendix. The diagnosis of Prolonged Grief Disorder (PGD) will be used in the International Classification of Diseases (ICD-11) (Maercker et al., 2013).

THE NATURE OF PROLONGED COMPLICATED GRIEF REACTIONS

Complicated Grief Reactions consist of a variety of components including how survivors perceive and appraise interpersonal, intrapersonal (reminders), situational triggers and the emotions they elicit, as well as the accompanying automatic thoughts, images, beliefs, schemas which contribute to how survivors behave (what they do and do not do) and how others react. This interconnective chain can occur in a variety of ways and can lead to a downward "loss spiral", or can lead to a "recovery process". The following **CLOCK** metaphor can be used to summarize and educate clients about the mourning process.

Use of a CLOCK Metaphor to Summarize Complicated Grief Reactions

12 o'clock - External and Internal Triggers

3 o'clock - Primary and Secondary Emotions

6 o'clock - Automatic thoughts and images, Thinking Processes, Schemas and Beliefs

9 o'clock - Behavior and Resultant Consequences

12 o'clock - External Triggers - Circumstances of the death
- Reminders of death, losses
- Other people's losses act as triggers
- Memorial events, routines

Internal Triggers – Reminders such as an anniversary and situational reminders (holidays, special times and events)
- "Echoes of other losses".

3 o'clock – Primary and Secondary Emotions and The Survivor's Attitude About Emotional Expression

Initially, stunned, shocked, disbelief, confused, emotionally numb, angry, enraged, sad, anxious, bitter, psychologically hyperaroused, devastated, sense of unreality about the loss, dissociated, disgusted, guilty, shamed, humiliated.

This may be followed by feelings of longing, yearning, emptiness, loneliness, fear that something else bad is going to happen, powerlessness, helplessness and hopelessness, separation distress and depression, "emotional anesthesia" and feelings of unreality..

6 o'clock – **<u>Automatic thoughts and images, thinking processes, schemas and beliefs</u>**

Initially, a sense of disbelief depending on the circumstances of the death, rumination on circumstances of the death, difficulty accepting the loss, disbelief, denial of the death. Subsequently, sense of purposelessness, ongoing rumination and increased vulnerability to intrusive ideation, hallucinatory experiences, sense of losing control, "going crazy", overgeneralized memories that contribute to not envisioning a future and that undermines problem-solving, mistrust of others, and identity confusion, enduring search for meaning, engage in contra-factual thinking (Ask "Why Questions" for which there are no satisfactory answers), engage in "Only if" type thinking. Continually replay circumstances of the death, self-blame and critical negative thinking, hold onto unachievable goals. (See Janoff-Bulman, 1989, 1992; Nolen-Hoeksma, 2001; Stroebe & Stroebe, 1999, 2006).

The following are examples of the **LOSS MINDSET** and the accompanying **METAPHORICAL NARRATIVES** that characterize individuals who experience PCG. Such thinking processes and the accompanying emotional reactions contribute to the perpetration of complicated grief. The thinking processes include:

1. **Inconsolable emotional pain.**

2. **A lack of a future outlook.**

3. **Guilt-engendering thoughts, self-blame, "hindsight bias" (judging something in the past on the basis of knowledge that one has now, but did not have then; "Monday Quarterbacking").**

4. **Ongoing search for meaning.**

5. **Ruminations and self-doubt.**

6. **Contra-factual "If only" and "If then" thinking processes.**

7. **Thoughts that undermine help-seeking.**

8. **Low self-efficacy statements**

<u>Examples of the Narrative of Individuals with PCG</u>

<u>1. Inconsolable Emotional Pain</u>

"I am (lost, adrift, bereft, a cry baby, entangled in a cascade of grief, a loop of unresolved grief)."
"I am experiencing a (fog of grief, bereavement overload, waves of grief)."
"I feel (alone in my suffering, stuck in the past, frozen in Time, an emptiness with a hole in my heart that cannot be filled)."
"I don't know who I am any more. The light in my life is no longer living."

2. A Lack of Future Outlook

"There is no future. My life is over."
"I will never get better."
"I am stuck in this forever."
"This will never end."
"There is no way to be happy again."
"I don't deserve to be happy, laugh, love again."
"His pain ended, but mine will be forever."
"Time has stopped for me."
"It feels like it just happened."
"I don't have confidence in the future."
"There are more yesterdays than tomorrows. I have nothing to look forward to."
"I feel an impending doom."
"I am waiting for the other shoe to drop."

3. Guilt-engendering thoughts: Influence of Hindsight Bias

"I killed him/her. His/her death was my fault."
"I was too busy and too self-absorbed that I overlooked (denied) the warning signs."
"I didn't do anything right when he/she was alive."
"I am a bad person for letting this happen."
"I must suffer like he suffered. It is not right to enjoy myself."
"This is God's punishment."

"I feel guilty about all of the unfinished business between us. I never got a chance to say 'I was sorry'."
"I never got a chance to say a proper goodbye."
"I was not there to comfort him when he died. He died alone."

4. Ongoing Search for Meaning

"I haven't been able to put the pieces of my life together since this event."
"I have trouble making sense of her death."
"How unfair that he/she died. It makes no sense?"
"His/her death was useless. What did he/she sacrifice his/her life for?"
"I am devastated. Since his/her death life has no meaning. It is purposeless."
"I feel cheated."
"I asked God to protect her, and He did not."
"I was betrayed."
"His/her death has robbed my life of meaning."
"Since _____ died, I feel worthless, directionless."
"Life has nothing to offer me."
"I am trapped. I am up against a wall."
"I keep asking why questions, but there are no satisfactory answers."

5. Rumination – "Not Let It Go"- "Reenactment Story; Desire for Retribution

"I keep thinking about how he/she died."
"I replay it over and over."
"I repeatedly think about how things could have been different."
"It is too painful. I do not want to think about it, but I can't stop thinking about his/her death."
"I keep asking, 'Why me?'; 'Why my child?'"
"I continually dream about revenge."
"I am suffocated by my anger."
"I can never feel completely safe again."

6. Contra-factual Thinking Processes: "If only" and "If then…" Thinking

"If only X (I had, or I had not), I could have prevented his/her death."
"Only if I had X, he/she would be alive today."
"If I did X before and things turned out badly, how can I ever trust myself to make good decisions?"
"If only he/she were here now."
"If I get better, then his/her death has no meaning."
"If I don't continue mourning, there is no one to hold onto his memory."
"My grieving keeps his/her memory in the public "eye."

7. Thoughts That Undermine Using Social Supports and Accessing Help

"No one knows how bad I feel."
"No one can help me."
"This is too painful to bear and share."
"This is the worst thing that could happen. If I talk about his/her death, I will go crazy."
"I cannot confront the reality of his/her death."
"Nothing and no one can ease my pain."
"No one will want to be around me when I am so miserable."
"I am not whole. I have lost an important piece of me and it is not reparable."
"I can't trust anyone."
"I feel shut out, a stigma over my head, like I had the plague."
"I avoid and limit contacts with others."

8. Lacking Ability to Cope: Low Self-efficacy

"I can't cope."
"I am emotionally worn out."
"I can't cope with anything that reminds me of him/her."
"I can't make myself better. I am trapped."
"I will never have someone this close again, this important."
"I don't want to have someone this close to me again, and have them die on me."

"Others will die and I won't be able to bear it."
"I was so dependent on _____. I cannot function without him/her."
"Here I go again. The same vicious cycle that I cannot stop."
"I don't mourn the way I should."
"I feel as if part of me has died."
"I can't trust my own judgment any longer."
"Drained my vitality. My life has no purpose and meaning."
"My life is now filled with never agains."

9 o'clock – **<u>Behavior</u> <u>and Resultant</u> <u>Consequences</u>**

Uncontrollable crying spells, sighing, fatigue, decreased appetite, difficulty sleeping, nightmares, neglect of self-care, increased use of substances, increased tobacco use. Difficulty concentrating, irritability, restlessness and difficulty reinvesting in life.

Proximity seeking behaviors- - wear deceased cloths, sleep in his/her bed, lie near the grave, hallucinatory experiences, hard to part with loved one's possessions.

Avoidance of emotions and reminders, withdrawal, disengaged from usual activities that give pleasure, engage in mindless self-distraction activities, keeping busy, lack of acceptance of death, denial. Attempts to control rumination by suppressing thoughts and engaging in avoidance behaviors.

Difficulty "moving on" with life, failure to engage in memorial, commemorative ceremonies, avoid seeking social supports and help/treatment.

Social withdrawal can contribute to feelings of isolation, estrangement, loneliness. Self-isolation is an important factor associated with health problems, PTSD and complicated grief. Not participating in leisure activities that one enjoyed with the deceased because they trigger bittersweet memories; not participating in religious-based activities because disillusioned with one's faith, engaging in overprotective behaviors with surviving loved ones can each contribute to PCG. Such reactions by survivors can be exacerbated by the social ineptitude of others who minimize the loss, or who offer "moving on" statements, or who avoid contact or fail to offer comforting supportive emotional and tangible assistance. (Dyregov, 2003-2004; Wolfert, 2006).

The grieving process can also be impacted by the legal system and media coverage in the aftermath of traumatic violent death of the deceased and by the need for victim impact statements.

Challenges of fulfilling new social roles and responsibilities (financial, parenting, role models). Loss of self-identity (e.g. being a "military spouse") can contribute to Prolonged and Complicated Grief.

ASSESSMENT PROCRDURES
(*See Neimeyer 2016 and Neimeyer et al. 2008 for a discussion of measurement of grief)*

1. **Guided Interview and the "Art of Questioning"**
2. **Self-report Measures**
3. **Self-monitoring Procedures**
4. **Risk assessment" Past and Present (Potential Suicidality)**
5. **Checklist of Coping Strategies with Grief**

A number of event-related and person-related factors have been found to contribute to the mourning process. In terms of event-related factors these include: the characteristics and type of death - - natural versus traumatic violent death (suicide, homicide, accident; finding or viewing the loved one's body after a violent death; death in a hospital versus home and not being present when one's loves one died); treatment related factors (perceived failure or negligence of treatment, perceived as a preventable death), caregiver burden, medical and related expenses; dissatisfaction with death notification; multiple deaths "bereavement overload"; threat to one's own life, or witnessed the death.

The person-related factors include: gender - - female (especially mothers), close kinship to the dying patient, especially spouse or child, being a widow/widower; high pre-loss marital dependency, vulnerability factors - - developmental adversities including trauma history and prior losses; insecure attachment history; current physical health and degree of self-care behaviors; coping strategies such as optimism and use of one's faith and spiritual/religious beliefs; supportive social network and kinship relationships. (See Pearlman et al. 2011 for a discussion of how event and person-related factors interact. For example, the loss of a spouse versus loss of a child interacting with the gender of the survivor and how Complicated Grief and Traumatic Bereavement overlap).

1. GUIDED INTERVIEW AND "ART OF QUESTIONING"

For a Guided Interview see Rando (1993) Grief and Mourning Status Interview and Inventory (GAMSII) that assesses the client's mourning process and areas that need to be addressed. Topics include:

- Circumstances surrounding the death
- Nature and meaning of what has been lost
- The mourner's reactions to the death
- Changes in the mourner's life since the death

- The history of the mourner's relationship to the deceased

- The mourner's self-assessment of how well he/she is coping with the loss. Has his/her symptoms worsened, maintained or reduced since the traumatic event or death of your loved one?

- The mourner's comprehension of the mourning processes and his/her expectations regarded the mourning process.

The following questions are designed to help identify the complex combination of grief, trauma and psycho-social problems (secondary losses) that clients experience. Clinicians should sample from this list of questions. Note that most of the questions are "**How**" and "**What**" questions. As Neimeyer and Thompson (2014) highlight, the interview should cover both the story of the events ("Event Story") and the "Back Story" about the changed relationship with the deceased, and an account of the lingering impact and accompanying coping abilities. The interview should begin with Permission Gathering Questions.

Permission Gathering Questions.

Would this be a good time to talk about _____ ?
How would it be for you if we talked about (the deceased- use name and relationship. "the death of your dad, husband")?
Is there at least one person you have (can) talked to about your grief? Who is that person?
Who would be a good person for you to share your grief?
Could we begin that conversation now?
You can stop at any time you want. Just share that which you feel comfortable with.

Questions about the circumstances of the death.

Follow the clients lead, but consider the circumstances - - violent traumatic death due to homicide, suicide, body mutilation, multiple deaths, suddenness, out of time death, death-child, death perceived as avoidable and unnecessary ("useless").

What do you recall about how you responded at the time of the event?
Put yourself back there now.
How did you hear about the death?
How did you respond at the time of notification? Who was there?
How have your feelings changed over time?
Did you have to bear your grief alone?
What was the most emotionally difficult part of the experience for you?
How did you make sense of the death at the time?

Query about a "proper goodbye" and funeral arrangements. "In your eyes, was this a fitting goodbye?"

Questions concerning how currently experiencing grief.

"I would like you to think about how the death of _____ has impacted (influenced) your life."
Please describe how your life has been since _____ died.
How are you doing with your grieving?
What impact has the death of _____ had on you?
How much does your grief still interfere with your life?
How much trouble are you having accepting the death of ____?
What has it been like for you to go through your daily routine without _____ ?
What has been going on in your life since the death of _____ ?
What changes have come about as a result of the death of _____ ? (Question pulls for possible secondary losses).
What has been lost since his/her death?
What lingers from this loss?
How have you dealt with your loved one's belongings?

Besides sadness and missing _____, what else are you feeling?
When you talk about these feelings, what else comes to mind?
Can you tell me more about that?
Is there anything you would like me to know about your past experiences?

Do you think it is possible that some of what you are feeling right now, might be related to earlier experiences you have had? (Question designed to assess earlier losses and developmental adversities)
Might some feelings be tied to your concerns (fears, uncertainty) about the future?
Are you struggling to make sense or find meaning in what happened?
What has helped you cope with this loss?
Are there people to support you in your loss?
What have you found helpful and what was of little or no help?
What areas of your life have not been influenced by your loss?
How are these coping strategies useful?

Questions Concerning Emotional Reactions

Litz et al., (2016, p. 106) offer the following questions:

"What are you most sad about?
What are you most troubled by?
How do you think this event has changed you?
Is there anything that could have been different?
What do you think will happen if you let yourself feel the intensity of your grief?

Have there been other times when you've lost someone? If so, how is this similar or different? How did you mourn/grieve in the past?"

In the aftermath of the death of a loved one, individuals may experience a mixture of different feelings? Some may feel sadness, anxiety about the future, anger, guilt, shame and other feelings. Some may even experience positive emotions of relief, gratitude, forgiveness, pride. Can we take a moment to discuss how you felt at the time of _____ death and what feelings linger now?
Can you tell me about your feelings and how they have changed over time?
When you have such feelings, what do you do with those feelings?
Do you ever feel like you have a need to suffer?
Do you feel that you need to live with your (guilt, shame, anger, sadness)?
What gets in the way of your sharing your grief with others or you getting help?
Do you have any goals at the present time?
What would you like to be doing if you were no longer grieving? How can <u>we</u> work on ways to meet these goals?
Can you describe something you did, or something that happened to you that made you feel good and that was meaningful to you and that helped you get through the day?

<u>Questions Designed to Tap Past History of Coping and Current Sense of Self-efficacy.</u>

Can we take a moment to discuss what challenges, setbacks, losses you have experienced in the past? What were these?
How did you handle (overcome) these challenges (losses)?
What coping skills and support from others did you use to handle these challenges?
What helped you then?
Who was most helpful? What did he/she say or do that was helpful?
Is there anything that helped you then that you can use now?
What contributed to your ability to "bounce back", be resilient, in spite of _____?
Could you answer the following question? "Although I am sad, I am still able to _____"
Can you mobilize your own self-healing?
Is it okay for you to be okay?

<u>Questions Designed to Tap Relational History (Past, Present, Future).</u>

(Assess for the importance of the deceased person(s) in the client's life and in terms of future adjustment - - see Magariel, 2016).

Is it okay if I ask you some questions about your past relationship with your _____?
Can you tell me about your relationship with the deceased? (Use the deceased husband, son, etc - - use the deceased name).
What did you most appreciate about him/her?
What do you think he/she most appreciated about you and your relationship?
If I was watching you earlier in your life, what moments would I have seen that would help me best understand the connection you two shared?

What were the challenges the two of you faced and how did you handle (overcome) them?
What was unique about your relationship?
When did you feel your closest connection with _____?
When did the two of you spend time together?
In what ways did you two care for each other?
Was your spouse (husband/wife) the person in your life who would encourage (help) you through difficult times?
If your _____ were here now, what advice (guidance), if any, would he/she offer?
Do you ever hear his/her words of encouragement in your mind?
How would he/she want you to remember him/her?
Do you think you could develop an 'internal' relationship with your _____?
What do you think _____ would want you to do now?
What would you like others to know about your relationship with _____?
What would you like others to know about the legacy (gifts) he/she has left you?
Is there anything you wish you would have said or done before he/she died? What was that?
Is there any "unfinished business", or any regrets that you have about your relationship with _____?
Is this the first time you shared this with anyone?
What was this discussion like for you?

Lichtenthal & Breitbart (2016) have proposed a set of questions "Who am I?" to help clients engage in collaborative goal-setting.

Who was I before my loved one died?
Who was I while my loved one was sick?
Who am I know?
Who do I want to be?

Assessment of Meaning-making, Spiritual and Religious Beliefs and Practices

For clients who believe in God, Pearlman et al. (2014), suggest asking, "***In dealing with the death of X, do you feel supported, abandoned, or betrayed by God?***"

For clients who attended religious services prior to the death, "***Has the death of X affected your participation in your religious community?"***

Do you think that for you this event holds meaning other than loss?
How have you made sense of the death at the time? How do you view the loss now?
What spiritual or religious beliefs help you cope now?
Are there ways that his/her loss has affected the direction of your life?
How in the long run, do you imagine that you will give this loss meaning in your life?

See Meichenbaum's Handout on www.melissainstitute.org for ways to assess spiritual/religious coping strategies. On the Home Page, click Resources on the top of the page. Scroll down to Author Index and then to Meichenbaum. See paper "Trauma, spirituality and recovery".

Assessment of any benefit -finding

Has anything good come of this loss (his/her death)?
Have you found any insight, benefits or gifts that came from your grieving? If so, what?
What qualities in yourself have you drawn on that have contributed to your resilience?
Has your loss affected your sense of priorities? What is most important to you now?
What lessons, if any, about loving and being close to others you care for, has this loss taught you?
Has this loss deepened your love, your gratitude for anyone or anything you have?
How has this loss contributed to a new outlook on your life?

2. SELF-REPORT MEASURES

Inventory of Complicated Grief (ICG) and Briefer Version ICG-13, Revised	Prigerson et al., 1995; Prigerson & Jacobs, 2001
Texas Revised Inventory of Grief (TRIG)	Faschingbauer, 1981
Two-track Bereavement Questionnaire for Complicated Grief (TTBQ-CG31)	Rubin & Bar-Nadav, 2016
Trauma and Attachment Belief Scale (TABS)	Pearlman, 2003
Continuing Bands Scale	Field et al., 2003
Hogan Grief Reaction Checklist (HGRC)	Hogan and Schmidt, 2016
Grief and Meaning Reconstruction Inventory (GMRI)	Neimeyer et al., 2016
Inventory of Complicated Spiritual Grief	Burke et al., 2014; Burke & Neimeyer, 2016
Moral Injury Questionnaire- Military Version (MIQ-M)	Currier, 2016
Post Traumatic Adjustment Scale	O'Donnell et al., 2008
Inner Experience Questionnaire	Brock et al., 2006
Inventory of Self-Capacities	Briere & Runtz, 2002
Inventory of Daily Widowed Life (IDWL)	Caserta & Lund, 2007; Caserta et al., 2016
Inventory of Stressful Life Experiences Scale (ISLES)	Holland et al., 2010, 2014; Holland, 2016
Inventory of Social Support (ISS)	Hogan & Schmidt, 2016

Perceived Life Significance Scale	Hibberd, 2016
World Assumption Scale	Janoff-Bulman, 1989
Affect Balance Sheet	Bradburn, 1969
Professional Quality of Life Scale (PROQOL)	Stamm, 2005
Meaning of Loss Codebook	Milman et al, 2016
Analysis of Narratives: Meaning of Loss	Gilles et al, 2014
Collaborative Goal-setting "SMART" Goals Specific, Measurable, Attainable, Relevant, and Time-limited	Meichenbaum, 2013; Sage et al., 2008
Use Time-lines of Chronological Losses	Neimeyer, 2012
Asses Genograms and Social Supports	Neimeyer, 2002; Wolfert, 2006

Follow up this assessment of Social Supports with detailed questions that probe for:

Who is in the client's social network? (Note names and relationships)
Which network members provide effective emotional, informational and tangible supports?
Which members were in the network prior to the loss, but have since backed away?
Which members (activities, settings) do you intentionally try to avoid? Why?
What "insensitive" comments and questions have you experienced?
What impact have these comments or actions had on you?
How have you coped with them?
Have you actively sought out social supports (church, work, school, survivor groups, internet)?
Have you gone online and used the Internet to connect with others who have experienced a similar loss; or visited Internet resources like griefnet.org, Memorial Groups or commemorated and memorialized X (the person you lost)?
What types of social support do you need now?
What are some barriers/obstacles that get in the way of your accessing such support?

3. SELF-MONITORING PROCEDURES

Grief Monitoring Diary - - Turret & Shear (2012)

Ask clients to rate their grief intensity on a 0 to 10 scale, where 0 is "no grief at all" and 10 is "the most grief they ever experienced." Record the highest and lowest level of grief experienced that day.

As Turret and Shear (2012) highlight, such Grief Monitoring serves several functions:

1. Helps clients map and observe the variability in their grief reactions, pinpoint triggers and "stuck points" and "hot spots."

2. Help clients figure out what feelings are grief and what other emotions are being experienced. "What is grief and what is not grief?"

3. Provides a basis for collaborative goal-setting and a consideration of alternative coping strategies.

Another form of self-monitoring involves having clients notice when they are engaged in a "vicious cycle". Use **CLOCK** analysis.

Activity Logs, Day Planners, Monitor engagement activities. (Check in with self and ask "**How am I doing**?") Record positive activities.	Neimeyer, 2012

4. RISK ASSESSMENT: PAST and PRESENT (Suicidality)

Lobb et al (2010) have identified the following factors as being potential risk factors for the development of Prolonged and Complicated Grief Disorder.

History of prior trauma and loss/History of mood and anxiety disorders/Insecure attachment style/Being a caregiver for the decreased/ Violent cause of death (e.g., suicide, homicide/Lack of social supports after the loss.

Current risk factors include the presence of comorbid disorders such as depression, PTSD, Substance Abuse and the presence of suicidal ideation and behaviors. (See Jordan and Litz, 2014 for a discussion of the distinctions between free-floating depression versus the focalized grief on the deceased that accompanies PCG).

PCG has been associated with 6 to 11 times the general rate of suicidality. For a discussion of ways to assess for the threat of suicidal behaviors accompanying Complicated Grief, visit the Melissa Institute Website ***www.melissainstitute.org.*** See papers on "35 years of working with suicidal patients, Lessons learned" and "Child and adolescent depression and suicide: Promising hope and facilitating change".

5. COPING WITH GRIEF CHECKLIST

Another way to conduct assessment is to ask clients with PCG to fill out a Coping With Grief Checklist and then reviewing their responses afterward. The following article describes such a Checklist and how it can be used. This Checklist should be given after several months have passed since the loss of a loved one. Implicit in having clients fill out this Checklist of Coping Strategies, and the subsequent clinical discussion of what coping strategies the client has used and found helpful, are suggestions of additional potential coping strategies that could be tried. The therapist can ask clients:

> ***"Of the Items that are on the Coping with Strategies Checklist, how did you come to choose those? How helpful were they? Can you give me an example? Of the remaining items that you did not check, are there any that you think would be worth trying, adding to your coping repertoire? Which ones? How did you come to choose those? Can you give me an example how you might use them? What would change? What would other people notice changing? Can you foresee anything that might get in the way or undermine your using these coping strategies? I am eager to learn if what you chose will indeed be helpful? Are there any coping strategies in your "tool box" that are not on this checklist that you think we should add and share with others?***

STRATEGIES FOR COPING WITH GRIEF CHECKLIST

(This article included in Neimeyer R.A. (Ed.) (2015). Techniques of grief therapy (Vol.2): Assessment and intervention. New York: Routledge pp. 117-124.)

STRATEGIES FOR COPING WITH GRIEF

Donald Meichenbaum and Julie Myers

CLIENTS FOR WHOM THE TECHNIQUE IS APPROPRIATE

Presenting clients with a history of trauma and loss with a list of coping strategies can help mobilize resilient and adaptive responses for a broad range of survivors. However, it is not intended as a stand-alone intervention for complex loss or trauma, and is restricted in its written form to adults with at least a 6th grade reading level.

DESCRIPTION

In the aftermath of experiencing traumatic events and personal losses, 5% to 20% of survivors evidence prolonged and complicated grief and traumatic bereavement, often with accompanying adjustment difficulties (Pearlman et al., 2014). Although the remaining proportion of survivors is affected, they evidence more robust resilience and are able to continue functioning (Meichenbaum, 2013).

One factor that distinguishes these two groups is the nature of the coping strategies that they employ. We have identified a list of coping strategies, taken from the treatment literature,

clinical experience, and focus groups with survivors and their mental health providers, and incorporated them into a self-report list of strategies (see Neimeyer, 2012; Rando, 1992; Shear & Gorscak, 2013). This list (see Appendix XX.1) can be used with all classes of survivors, including individuals experiencing prolonged and complicated grief reactions due to the loss of loved ones some time ago, as well as with individuals experiencing recent traumatic bereavement, as described in the case below.

First, survivors complete the list, indicating which coping strategies they have employed. This can be done either alone or with their healthcare provider. Then, they discuss with their provider the items they used and examine how, when, and in what ways they have proven helpful. A key aspect is to have survivors identify other list items that they might wish to try, and more importantly, what barriers might get in the way of using them.

This format may also be used when facilitating a group of survivors, by having each member review the list before the group meets, and then discussing which coping strategies they chose and how they used them. In this way, survivors can learn from their peers how coping strategies might be helpful and worth trying.

In this approach, assessment and suggestive interventions are interwoven. Filling out the list per se is not the most helpful feature, but rather it is the subsequent discussion and implementation that are critical to the recovery process. The list acts as a catalyst and a self-selected guide to negotiate the mourning process and to bolster resilience. The list helps the bereaved begin a healing journey whereby they can develop a new identity and narrative including examples of a number of "RE" verbs, such as re-framing, re-claiming, re-connecting, re-solving and re-building their lives (Meichenbaum, 2013).

CASE ILLUSTRATION

Tom, a 44-year-old mechanic, had always thought of himself as a happy person. He enjoyed his work and was dedicated to his wife Susan and their children. Susan had difficulty controlling her diabetes, which required that Tom be a caretaker of both his children and his wife, a role he took on willingly. One day, with no sign to her husband, Susan slit her wrists in the bathtub. When Tom found her several hours later, the blood-filled bathwater was still warm.

Tom's traumatic bereavement was such that he was unable to care for his children or return to work. After a month, he sought professional help and was diagnosed with PTSD. Tom had a particularly overwhelming sense of helplessness, so key to his recovery was instilling a sense of self-efficacy, which made him an ideal candidate for the "Strategies for Coping with Grief."

After stabilization, Tom was introduced to the list of strategies. He felt "safer" completing the list with someone, so he and his provider reviewed it together over the course of several sessions. Tom reported that some of the items he had tried were helpful, and he was encouraged to continue those activities. In particular, he found most useful the comfort and help from others such as his siblings.

He identified several new items he would like to try and possible ways to modify items that he thought might be helpful. The provider also suggested modifications that Tom might try, for example, as Tom's faith was shaken, he suggested new ways that he could reconnect with his spirituality, such as poetry and meditation.

As Tom went through the list, what emerged was evidence of resilience and fortitude, despite his traumatic loss. He had a "toolbox" of things he could use by himself, which empowered him, decreasing his sense of helplessness. He found that he turned to the list around anniversary dates and particularly troubling events, even years later. In essence, the list served as a relapse prevention tool.

Although Tom required professional trauma treatment, the list of strategies allowed him to take charge of his own recovery, bolstering his resilience.

CONCLUDING THOUGHTS

The list of strategies provides individuals who are at different phases of their mourning process an opportunity to "take stock" of their present coping strategies and to consider other potentially useful strategies. A discussion about the list with their provider can encourage individuals to ask themselves, "What can help with my grief *now*?" It can also help individuals identify coping strategies that can be employed "down the road," when emotional upsurges or sliding into negative self-talk with its accompanying dysfunctional emotions occur, or when preparing for high-risk situations such as anniversary events, thus minimizing being "blind-sided" by unexpected thoughts and emotions.

Research can be conducted to determine the potential usefulness of Strategies for Coping with Grief as a supplemental tool to varied interventions. We welcome feedback on the content and use of this list.

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STRATEGIES FOR COPING WITH GRIEF CHECKLIST

Donald Meichenbaum, PhD and Julie Myers, PsyD

The process of grieving is like going on a "journey." There are multiple routes and people progress at different rates. There is no right way to grieve, no one path to take, no best coping approach. These grief coping strategies list some of the pathways that others have taken in their journey of grieving. It is *not* meant to be a measure of how well you have coped or how you should cope, since there is no one way to manage the pain following the aftermath of the loss of a loved one, no matter what the cause of his or her death. Rather, the strategies listed are suggestions of things you might consider doing to help you on your journey.

We suggest that you look through this list and put a mark by the coping strategies that you've tried. Hopefully, these strategies have helped you. But if you feel that you could use a little extra help, we suggest that you look through the list and then choose some new items that you would like to try. You may find them helpful, and you can add them to the strategies that you've already tried. This list is intended to help you discover new ways that you can move forward on your journey through the process of grief. If there are things you have done that you have found helpful that are not on this list of coping strategies, please add them at the end so we can share these with others.

Sought comfort and help from others

___1. I examined the thoughts that kept me from seeking help from others, such as the beliefs that "I am a burden to others," "No one can help me, no one understands," "I have to do this on my own," "I should be stronger," "Listening to the grieving stories of others will make me feel worse," or "People are tired of hearing about my loss."
___2. I reached-out to family, friends, elders, or colleagues for comfort and companionship, but gave myself permission to back-off when I needed time alone.
___3. I took the initiative to reach-out to folks from whom I might not normally seek help. I looked for new friends in church groups, social groups, work, school, or I went on the internet to find others who experienced a similar loss. I made a list of these supports to turn to when I was struggling or experiencing pain.
___4. I forced myself to be with people and to do things, even when I didn't feel like it. I put something on my calendar almost every day, with back-up plans.
___5. I allowed myself to tell people how much I loved, admired, and cared for them.
___6. I hugged and held others, but felt free to tell people when I did not want to be touched.
___7. I learned to grieve and mourn in public.
___8. I shared my story with others who I thought would appreciate and benefit from it. I told anyone who would listen to the story of the deceased, even if they had nothing to say back.
___9. I gave and received random acts of kindness.
___10. I connected with animals and nature, for example, the deceased's pet, a beautiful sunset, hike, or garden.
___11. I cared for or nurtured others. For example I spent time caring for my loved ones or children.
___12. I found my faith or religion comforting. I participated in religious, cultural, or ethnic mourning practices, such as attending church services, sitting Shiva, participating in a Wake, celebrating the Day of the Dead, visiting a memorial shrine, etc.

___13. I sought help from organized *supportive* bereavement groups, hospices, religious groups, grief retreats, talking circles, or groups specific to the way the deceased died, such as cancer support groups or survivors of violent loss groups, such as suicide or homicide.
___14. I sought help from mental health professionals. For instance, attended counseling sessions or took medications as advised by my providers.
___15. I read books written by others who have coped with the loss of a loved one. I read about the grieving process, loss, and advice books about other issues that arose.
___16. I made a list of all the professional resources that I could use in a crisis, such as suicide hotlines, mental health crisis lines, mentors, clergy or imam, or mental health providers.
___17. I decided not to walk through the grieving process alone, so I visited websites that focus on the grieving process (***Refer to the list of websites at the end of this list.)***

Took care of myself physically and emotionally

___18. I examined the thoughts and feelings that kept me from taking care of myself physically and emotionally, such as guilt, shame, sense of lost self, and loss of the will to live.
___19. I established routines of daily living. Although things were different, I made new routines and did not berate myself when I was not "perfect." I maintained personal hygiene, medical care, healthy nutrition, and regular sleep.
___20. I reconnected with my body through exercise, yoga, Tai Chi, or expressive arts, allowing myself time to get stronger.
___21. I recognized that my brain needed time to heal and for things to improve, so I forgave myself when I made mistakes, became distracted, couldn't remember or understand.
___22. I avoided the excessive use of alcohol, tobacco, recreational drugs, and caffeine as a coping mechanism.
___23. I relinquished avoidance and learned to face my fears by engaging in life. I participated in activities that had meaning and kept me occupied, such as work, hobbies, crafts, singing or dancing.
___24. I allowed myself to pursue and feel positive emotions, such as compassion toward myself and others, expressions of gratitude, and emotions of love, joy, awe, and hopefulness.
___25. I recognized and labeled my feelings, viewing them as a "message" rather than something to avoid. I accepted and dealt with these emotions, understanding that the less I fought them, the more I was able to handle them.
___26. I regulated my strong negative emotions using slow smooth breathing, coping self-statements, prayer, or other mood-regulating techniques.
___27. I allowed myself time to cry at times and gave words to my emotional pain. I distinguished feelings of grief from other feelings such as fear, uncertainty, guilt, shame, and anger.
___28. I expressed difficult feelings through writing and talking to supportive others. I used journaling, reflective writing, letter or poetry writing, or other expressive arts of scrapbooking, dance or music.
___29. I engaged in gratitude activities, such as telling others how much I appreciate their love and support, reminding myself of the things that I am thankful for, and being grateful that I knew the deceased.
___30. I established a safe and comforting space for myself, either physically or through imagery.

Stayed connected to the deceased and created a new relationship, while recognizing the reality of the loss.

___31. I examined the feelings and thoughts that kept me from forming an enduring connection with the deceased, such as the fear of what others would think of me, guilt, shame, humiliation, disgust, or thoughts of anger, revenge or being preoccupied with my grief.
___32. I participated in practices, such as visiting the grave or memorial site, celebrating special occasions, prayer and candlelight vigils, public memorials, or commemorative services.
___33. I commemorated the deceased's life with words, pictures, things, or created a small place of honor for the deceased, which I could visit any time I chose.
___34. I thought about what I received from the deceased and the legacy and mission to be fulfilled. I became involved in a cause or social action that was important to the deceased or myself.
___35. I created a legacy such as planted a tree, started a scholarship or charity in the deceased's name, started an internet blog, or launched new family or community practices.
___36. I allowed myself to talk to the deceased and allowed myself to listen. I wrote a letter to my loved one and asked for advice.
___37. I asked for forgiveness, shared joys and sorrows, and constructed a farewell message.
___38. I accepted that sadness was normal and learned how to be with my grief. I learned how to contain my grief to a time and place of my choosing. However, I understood that intense upsurges of grief may arise unexpectedly and without warning, and I developed coping strategies to handle such events.
___39. I used imagery techniques, shared stories and photos of my loved one, or purposefully used reminders such as music or special routines to recall positive memories. I cherished and hung onto specific, meaningful possessions (objects, pets, etc.). I actively reminisced, holding onto our relationship in my heart and mind.
___40. I reached out to help and support others who are grieving for their loved ones. Helping others is a way to reengage in life and combat loneliness and tendencies to withdraw and avoid social contacts.

Created safety and fostered self-empowerment

___41. I examined the thoughts that fuel my fears, avoidance, and the belief that I cannot or should not feel happy and that things would never get better.
___42. I took a breather and gave myself permission to rest knowing that grieving takes time and patience, with no quick fixes.
___43. I identified memories that trigger or overwhelm me and disengaged and/or established boundaries by limiting people, places, or things that cause me stress or overwhelm me so that I could address them one by one, in my own time. I learned to say "no" to unreasonable requests.
___44. I identified important activities, places, or things that I was avoiding due to fear of my grief reactions. I slowly reintroduced them or allowed myself to choose those I never wanted to encounter again.
___45. I began to think of myself as a "survivor,", if not a "thriver" of my own story, rather than as a "victim." I reminded myself of my strengths and of all the hard times that I have gotten through in the past.

___46. I wrote out reminders of how to cope and put them on my fridge, cell phone, or computer. I looked at them when I was struggling and reminded myself of ways to be resilient.
___47. I created a plan about how to cope with difficult times. I learned to anticipate and recognize potential "hot spots" of when things are most difficult. I rated each day on a 1 to 10 point scale on how well I was doing. I asked myself what I can do to make things better and increase my rating. I worked on increasing the number of good days compared to the number of bad days.
___48. I avoided thinking "This is just how it is," realizing that I have choices no matter how hard life is. I came to recognize that emotional pain can be a way to stay connected with my loved one.
___49. When I was overwhelmed by negative memories of the past, I avoided "time-sliding" into the past. a) I "grounded" myself to the present by refocusing my attention on the environment around me, b) I changed my self-talk by telling myself "I am safe and that this will pass," c) I controlled my bodily reactions by slowing down my breathing, and d) I oriented to people's faces, voices or touch or called for help from a friend.

Moved toward a future outlook and a stronger sense of self

___50. I examined the thoughts and feelings that kept me from moving forward, such as "I am dishonoring the deceased by getting better," or "I am leaving him/her behind," or "Feeling happier means that he/she is no longer important to me," or that "My love for him/her is fading."
___51. I regained my sense of hope for the future. I worked to reestablish a sense of purpose, with meaningful short-, mid-, and long-term goals. I am creating a life worth living, taking control of my future.
___52. I worked on regaining my sense of self-identity, knowing that my life had changed, but that I am still *me*. I focus on what is most important. I developed new goals and action plans, consistent with what I value.
___53. I created purpose by keeping the memory of the deceased alive in others. I kept others aware of the circumstances of the death, so that some good could come from the loss. I transformed my grief and emotional pain into meaning-making activities that created something "good and helpful," for example Mothers Against Drunk Driving and the Melissa Institute for Violence Prevention.
___54. I use my faith-based and religious and spiritual beliefs to comfort me and move on. People hold different beliefs, such as "My loved one can continue to influence the lives of others in the world," or "My loved one is no longer suffering and is in a safe place," or "We will be reunited in the future."
___55. I examined the reasons why some of the activities that have been helpful to others in the grief process were not helpful for me, and what I can do to help myself further in the journey through grief.

Other coping activities or strategies I have used to cope with my loss

_____

_____

_____

_____

Please feel free to let us know if you have any comments about this list, so we can be of assistance to others like yourself. You can reach the authors by e-mail at dhmeich@aol.com or at Julie.Myers100@gmail.com

Helpful websites:
www.griefnet.org
www.compassionatefriends.org
www.dougy.org
www.taps.org
www.missfoundation.org
www.afsp.org/coping-with-suicide
www.opentohope.com

NEED FOR ECOLOGICAL ASSESSMENT: OTHER LOSSES

Hobfoll and de Jong (2014) highlight the impact of various resource losses (material, psychological, social, spiritual), according to Conservation of Resources (COR) theory. Such loses are a major predictor of PTSD and the negative consequences of trauma. They underscore that the loss of "social and cultural capital" is exacerbated by ecological, contextual, and systemic factors such as:

1. the degree of the material resource loss and the length of time to receive assistance (meet basic needs, housing, insurance);

2. the ability to activate and renew their life course;

3. the ease and support during a reentry and reintegration processes;

4. the degree of safety and access to sustainable supportive attachment relationships;

5. the enactment of cultural and societal recuperative processes.

Any interventions need to assess and address these losses that can lead to prolonged and complicated grief. There is a need to address more that the cognitive and emotional responses at the time of the trauma and its aftermath. See Meichenbaum (2013) for a discussion of ways to bolster individual, familial and community-based ecological resilience.

EVIDENCE-BASED PRINCIPLES AND PRACTICES FOR CLIENTS WITH COMPLICATED GRIEF AND TRAUMATIC BEREAVEMENT

(Guidelines gleaned from Allen, 2013; Dyregov & Dyregov, 2002; Foa et al., 2007;Holland et al., 2014; Klass et al., 1996; Meichenbaum, 2013; Neimeyer et al., 2011; Jordan & Litz, 2014; Pearlman et al., 2014; Rando, 1993; Shear et al., 2006, 2011; Shear & Frank, 2006; Stroebe & Schut, 1999, 2010; Stroebe et al., 2013)

1. Grief work or working through the loss may involve loss-oriented coping efforts that include experiencing the pain associated with the loss, reminiscing about life as it had been, ruminating about the circumstances surrounding the death, pining about the future. Restorative-oriented coping efforts include the survivor's efforts to replenish psychological resources, mastering new skills and engaging in new activities and pursuits, making new social contacts and relationships, and creating a new identity. Each of these restorative efforts provide a respite from the loss and mourning process. Individuals oscillate between loss-oriented and restorative coping efforts.

2. Positive emotions can facilitate the healing process, adjustment and sustain hope. Such positive emotions as happiness, forgiveness, gratitude, a sense of awe, can nurture coping with loss. Positive emotions can bolster resilience. Such resilience-building behaviors can increase affect management capacities by increasing hippocampal volume, decrease amygdala activity and size, increase serotonin and endorphin production and activate the prefrontal cortex (McEwen & Gianaras, 2011; Southwick et al., 2011).

3. The process of mourning in many instances can be viewed as a search for meaning, or an attempt to make sense out of what happened. For some, their faith can act as a coping resource in the attempt to find meaning. The search for meaning may occur at many levels from the material ("***How did my loved one die?");*** from the relational ***("Who am I now that I am no longer a spouse?***"); from the spiritual or existential ("***Why did God allow this to happen?***"). Holland, Currier and Neimeyer (2014) report that from a bereavement standpoint, more adaptive meaning made of a loss has been shown to be associated with greater physical and mental health, over and above complicated grief symptoms, circumstances of the loss, and demographic factors.

4. The failure to find meaning or some form of consoling explanation of what happened can contribute to prolong and complicated grief, for those who are seeking meaning (Kesse et al., 2008; Pearlman et al., 2014). But for some survivors, the search for meaning is not a priority, need or realistic goal and they may not be preoccupied with issues of meaning, or sense making. Some individuals may not need to engage in a quest for meaning.

5. Grieving individuals do not go through a universal, nor normative pattern of mourning consisting of phases of denial, anger, bargaining, depression and ultimately acceptance, as initially proposed by Kubler-Ross (1969). There is considerable variability in the kinds of emotional experiences after loss. Psychotherapists who convey a so-called stage model of emotional reactions to death and dying may inadvertently undermine the healing process. (Doka & Tucci, 2011; Wortman & Boerner, 2001; Wortman and Silver, 1984).

6. There is a need for therapists to be culturally sensitive when treating clients with prolonged and complicated grief. See the following references for varied cultural mourning practices - - Rosenblatt & Wallace (2005) for African American grief practices; Houben (2012) for Hispanic traditions; and Klass and Chow (2011) for other cultural variations.

7. For many individuals using some form of spirituality and religious faith practices may be comforting to address bereavement issues. For instance, Bryant and Anderson (2014) report that in the aftermath of the Asian tsunami local monks were employed to pray with the survivors in order to encourage adaptive responses and help them cope with multiple losses. Consider the following examples of spiritually-based coping strategies. A mother of a child, who was killed in the Newton school shooting, had the remains of her son cremated and placed in an urn that she keeps in her bedroom. She has a discussion each morning with these remains. The parents of a firefighter who died at the September 11 terrorist attack, but whose body was never found, discovered that he had donated blood before the tragedy. They had a formal funeral and buried his vial of blood as a proper farewell to their son. Many other examples could be offered including the Hispanic annual ceremony of the "Day of the Dead", Jewish mourners sitting Shiva, Irish wakes, New Orleans jazz send off, and the like.

8. Interactions in various forms between survivors and the deceased are normative and not a sign of some form of pathology or mental disorders (Klass et al., 1996; Klugman, 2006; Pearlman et al., 2014; Sanger, 2008-2009). In fact, encouraging bereaved persons to break the bonds with the deceased may actually be harmful. A continuing connection with the deceased can be beneficial. A symbolic bond can serve as a "safe haven" for the bereaved and have a significant presence in the survivor's life.

TREATMENT GUIDELINES AND OUTCOME STUDIES

1. The scientific basis for counseling for grief is weak (Bonanno & Lilienfeld; Currier et al., 2008; Jordon & Neimeyer, 2003; Neimeyer & Currier, 2009; Pearlman et al., 2014; Zhang et al., 2006). Interventions implemented shortly after death has limited effects (small effect sizes). Intervention between 6 to 18 months after the loss has proven more effective than those provided sooner. Moreover, there is a need to customize interventions to the different phases of mourning, and where indicated address the need to help clients cope with both trauma, as well as grief.

2. There is increasing literature on effective modes of treatment with Complicated Grief and Traumatic Bereavement (Boelen et al., 2007; Currier et al., 2008; Horsley & Horsley, 2011; Pearlman et al., 2014; Rando, 1993; Rosner et al., 2011; Rynearson, 2011; Rynearson & Salloum, 2011; Shear & Gorsack, 2013; Shear et al., 2005, 2011 Wittouck et al., 2011). Although, in some studies up to 50% of individuals failed to respond to treatment and the dropout rate is 20% to 30%. Self-referred clients respond more favorably to treatment.

3. Some individuals may not be ready for active treatment because of the competing demands of the acute posttraumatic phase, or due to a number of more pressing demands due to dislocation, financial, legal and physical individual needs. Until these immediate, more pressing psychosocial

needs are met, then psychotherapeutic interventions may be contra-indicated. (Hobfoll & De Jong, 2014).

4. Specialized forms of interventions have been developed for individuals who are trauma survivors (Barski-Carrow, 2010; De Leo et al., 2014); individuals who are grieving the suicide of a loved one (Jordan & Mcntosh, 2011); homicide (Armour, 2003; Barske et al., 2010); loss due to infertility interventions and pregnancy losses (Kersting et al., 2013; Shapiro, 2010), and for individuals who are trying to bolster their level of resilience (Meichenbaum, 2013).

5. A number of innovative forms of interventions have been employed with clients experiencing traumatic bereavement and prolonged and complicated grief. See Neimeyer (2012, 2016) for a summary. These include:

Treatment	References
Adaptive Disclosure	Gray et al., 2012; Litz et al., 2016
Behavioral Activation and Exercise	Steenkamp et al., 2011
Expressive writing through bereavement (diary work, journaling, letter writing)	Acierno et al. 2012; Addis & Martell, 2001; Dimidjian et al., Papa et al., 2013
Expressive arts such as visual arts, music, dance movement therapies, theatrical enactments and horticultural therapy	Adams, 1999; Neimeyer et al., 2009; Pennebaker, 1997; Thompson & Neimeyer, 2014
Physical therapy, massage	Neimeyer, 2012, 2016; and Thompson & Neimeyer, 2014
Acceptance therapy	Doka, 2012
Mindfulness Training	Hayes et al., 1999
Yoga, Tai Chi, Compassion and Loving Kindness Meditation, Engaging in repetitive tasks (woodwork, knitting), and other self-soothing activities.	Gupta & Bonanno, 2001 Stang, 2014, 2016
Companioning the bereaved	Wolfert, 2006
Various Narrative forms of treatment	Litz et al., 2016; Meichenbaum, 2015; Neimeyer et al., 2010,2014;

Neimeyer & Thompson, 2014; Rubin et al., 2012; Saakvitne et al., 2000; White & Epton, 1990; Young et al., 2000	
Spiritually-based and religious activities (Use of prayer and connections with congregants)	Dyregov & Dyregov, 2008; Horsley & Horsley, 2011 Wortman & Park, 2000
Imaginal conversations, or "chair work" (Restorative retelling) Bryant, 2013; Paivio & Greenberg, 1995; Rynearson & Salloum, 2011	Allen, 2013; Klass et al., 1996; Klugman, 2006; McCallum &
Family Therapy	Kissane & Hooglie, 2011
Group Therapy	Piper et al., 2007
Public and private Bereavement Ritual and creation of a legacy, Memorialize, create an online memorial	Caroll & Landry, 2010; Lewis & Hoy, 2011
Self-help Workbooks 1996	Rando, 2014; Saakvitne et al.,
Internet Therapies	Sofka et al., 2012; Wagner, 2013

6. Cognitive-behavior approaches have been used with children and youth who have experienced traumatic bereavement and complicated grief (Cohen et al., 2006; Currier et al., 2007; Murray et al., 2008, 2013). (See www.musc.tfcbt.edu for training).

7. Antidepressant medication has little impact on the symptoms and adjustment associated with complicated grief (Zhang et al., 2006), but in combination with CBT it has been found to have some benefits (Jordan and Litz, 2014; Simon, 2013).

8. Internet-based cognitive behavior therapy has been employed successfully with individuals experiencing prolonged and complicated grief (Dominick et al., 2009-2010; Gilbert & Horsley, 2011; Kersting et al., 2013; Litz et al., 2014; Wagner, 2006, 2007, 2013). Caroll and Landry (2010), Lynn and Roth (2012) and William and Merten (2009) have described the use of online social networking to help individuals grieve and mourn.

9. Finally, there is a need to provide "help to the helpers" in order to reduce secondary or vicarious trauma, compassion fatigue and burnout, and transform these reactions into "vicarious resilience." A number of authors have provided specific strategies to address Vicarious Traumatization (Bober & Regehr, 2006; Dalenberg, 2000; Elwood et al., 2011; Hernandez et al., 2007; Jordan, 2010;

Norcross & Guy, 2007; Pearlman et al., 2014; Pearlman & Saakvitne, 1995; Saakvitne et al., 1996; Stamm, 2005; Wilson & Thomas, 2004) (***Also see Meichenbaum, 2007 "Self-care for psychotherapists and caregivers-Individual social and organizational interventions" on www.melissainstitute.org - - under Author Index***).

CORE TASKS AND PROCESSES OF GRIEVING

Worden (2000) has described the core tasks of grieving as consisting of:

a) acknowledging and accepting the reality of the loss, (balancing denial and reality);

b) experiencing and processing the pain and grief, (externalizing emotional pain);

c) adjusting to the world without the deceased, (adapting life assumptions and meanings);

d) finding an enduring connection with the deceased in the midst of embarking on a new life, (continuing bonds with their deceased loved ones or other loss object).

These overlapping tasks are flexible, since they can be addressed in different orders depending on the client's needs and can be revisited and reworked over time.

Rando (1993, 2013, 2014) and Pearlman et al., (2014) have outlined the tasks of psychotherapy as the need for survivors to progress through six "R" processes:

1. Recognize the loss
2. React to the separation
3. Recollect and reexperience the deceased and the relationship
4. Relinquish the old attachments to the deceased and the old assumptive world
5. Readjust to move adaptively into the New World
6. Reinvest in life

Neimeyer (2002) has highlighted that the mourner needs to:

1. formulate a coherent narrative of the loss;
2. retain access to the bittersweet memories and emotions and cope with troubling feelings;
3. revise, rather than relinquish one's relationship with the deceased;
4. redefine one's life goals and experiment with new roles and relationships.

IMPLICATIONS FOR PSYCHOTHERAPY

An analysis of the grieving processes underscore the variety of core psychotherapy tasks that need to be incorporated in work with individuals who evidence Prolonged and Complicated Grief and Traumatic Bereavement. The Core Tasks include the need to:

1. Establish, maintain and monitor the psychotherapeutic alliance with the client and significant others;

2. Conduct initial and ongoing assessments and provide the client with feedback, using a Case Conceptualization Model of risk and protective factors. Be sure to assess for the client's "strengths" and for any evidence of resilience. Be sensitive to cultural, developmental, gender issues, and the presence of any co-occurring disorders. Also, assess for the client's implicit theory or belief about the potential to change, as being a member of his/her ethnic or religious group. How should one cope with loss and negotiate the mourning process in a culturally-sensitive fashion?

3. Ensure the client's safety (possible suicidal tendencies), and address self-care needs and the presence of any therapy-interfering factors. Do so on an ongoing basis;

4. Employ motivational enhancement procedures and involve significant others, where indicated;

5. Conduct psychoeducation about grief. Validate and help normalize the client's grief. Use the **CLOCK** metaphor to help clients learn how feelings, thoughts and behaviors are interconnected, and how the client may inadvertently, unknowingly, and unwittingly contribute to his/her adjustment difficulties. Help the client appreciate the nature and influence of their narratives and "story-telling" style;

6. Engage the client in collaborative goal-setting that nurtures hope. Help the client create concrete plans with **SMART** goals (Specific, Measurable, Attainable, Relevant, Timely). Help clients identify new aspirations and activities;

7. Encourage the client to reengage in pleasurable and reconfirming activities with others (seek new companionship). For example, use Behavioral Activation (exercise) with others. Promote social reengagement. Use the Strategies for Coping with Grief Checklist;

8. Conduct emotion-regulation and behavioral skills training in order to nurture self-efficacy and as a way to enhance social supports (networking). Build in generalization guidelines and reinforce any resilience-engendering activities. Include self-attribution ("taking credit") training;

9. Use Cognitive Restructuring procedures in order to help clients identify and correct any inappropriate self-blaming, mental defeating and unhelpful thoughts, and accompanying behaviors;

10. Have client engage in loss-focused restorative retelling and reconnecting exercises that may take various forms such as:

    A. Intentional repeated retelling that facilitates the acceptance and emotional processing of the reality of the loss. Vividly narrate with eyes closed, the loss and listen to the tape of the narrative account;

    B. Use the Gestalt empty-chair procedure, art expressive and journaling procedures, writing about positive and negative memories of the deceased;

    C. Use graduated exposure exercises in order to help clients confront people, places and events that they have been avoiding. Use imaginal and behavioral exposure activities.

11. Engage in meaning-making activities, including the client's use of his/her faith and spirituality, where indicated. Incorporate the client's cultural group's ceremonial rituals, as part of the grieving process;

12. Address specific bereavement issues such as "Anniversary" events, evocative reminders of the loss, lingering legal and medical issues, and the like. Conduct relapse prevention and provide ongoing follow-up contacts.

EXAMPLES OF THE CORE TASKS OF PSYCHOTHERAPY

1. **Establishing, Maintaining and Monitoring the Psychotherapeutic Alliance**

The psychotherapist should act as a non-judgmental, "compassionate guide" who uses empathetic attunement, encouragement, supportive collaboration, understanding and respect for the client's symptoms and struggles. For instance, validate the client's feelings so the client feels heard and understood.

> ***"I am so sorry this happened to your loved one."***
> ***"I think you are brave for seeking help in the midst of your grief."***
> ***"You seem connected to your experience and can still be able to talk about it."***
> ***"I wonder if you have allowed yourself to express and share the full (fear, anger, guilt) you experience?"***
> ***"What do you fear will happen if you allow yourself to feel (your emotions, grief, anger, fears)?"***
> ***"I can see that you are learning to express your feelings without trying to escape from them."***
> ***"There may be obstacles along your path, but we can address them in a way that frees you up."***

The therapist can also employ the language of possibilities, change and becoming. For example, bathe the social discourse with such evocative verbs as "notice, catch, handle, tolerate, confront, take control, choose" and a variety of "***RE***" verbs - - "regain, reclaim, redefine, reaffirm, reauthor, restore, reconcile, reengage, remind, reconnect." See Meichenbaum's Roadmap to resilience book (pp. 127-128 and 136-137 for a discussion of how psychotherapists can ask clients for examples for each "RE" activity, and moreover, what does this mean for the client's journey? In this way, the psychotherapist can use a Constructive Narrative strength-based approach to help client's develop a "coherent healing story."

As Perlman (2016) highlights, the therapist needs to explore collaboratively with the client, empathize, educate and encourage.

2. **Conducting Psychoeducation**

Psychoeducation may take various forms that include the art of questioning; client feedback on assessment; descriptive sharing of information about specific topics such as the nature and rationale of treatment; the role of avoidance, specific bereavement issues; "myths" about the mourning process; self-monitoring procedures, coping skills and self-attributional training and relapse prevention procedures.

Psychoeducation is not a didactic process, but a highly collaborative, discovery-oriented Socratic questioning approach. Psychoeducation is ongoing and occurs throughout the course of treatment. It

is not as if one does psychoeducation and then one does treatment. The two processes are highly interweaved, as in the case of the Coping with Grief Checklist.

Examples of Psychoeducation

1. Provide a description of what therapy entails and the rationale for each aspect of treatment. Check for the client's understanding throughout.

2. Discuss the nature of grief and the mourning process. Highlight the following:

    a) Grief is often accompanied with sadness, anxiety and uncertainty about the future, and feelings of yearning and longing;

    b) There is no one right way to cope with the death of loved ones. There is no timetable. The grief process unfolds naturally over time.

    c) There are no specific stages that individuals go through in the mourning process.

    d) Most individuals are impacted by the death of loved ones, but they go onto evidence resilience or the ability to "bounce back". Some individuals need the assistance (help) of others. Joy and sorrow can co-exist.

    e) Individuals can learn to contain their grief, like putting it in a "grief drawer" (see Harris, 2016). They can choose when and to whom to share their grief. They can put their emotional pain into words, or into some other forms of expression (painting, dance), and they can embed their loss into a life-time autobiographical history. Some individuals go back and look at photographs and cherish their memories and their legacy. They learn to support themselves in ways that no other person can. They come to live life fully, even in the wake of their losses.

    f) Highlight that relationships are not really lost when a loved one dies, and who is not physically present, but the relationship is "changed."

    g) Ask if the client can learn to leave a space in his or her life for their loved one's presence?"

3. Discuss the nature of avoidance and its impact. For instance:

"It is human nature for individuals to desire to avoid painful events, disturbing thoughts and distressing feelings about the loss and avoid any reminders that may trigger such emotional pain. But such avoidance actually prolongs the pain in the long run. Unfortunately, such avoidance usually does not work, and pain finds its way into our lives, one way or another" (with the therapist's assistance, have the client give examples).

Convey how treatment can help individuals, in a safe and supportive environment, develop the courage to express and share their emotional pain, without becoming overwhelmed, and even learn to view such "emotional pain" as a form of connection with the deceased (reframe the pain). Address the client's attitude toward expressing feelings and discuss and train emotion-regulation skills on how to tolerate and manage negative emotions and "broaden and build" positive emotions (See Meichenbaum, 2013).

4. Use a **CLOCK** metaphor to help clients better appreciate the interconnections, and links between how they appraise events, experience primary and secondary emotions, have automatic thoughts and beliefs, and behave and the consequent reactions from others.

5. Psychoeducation can also be used to have the client reexamine "realistically", the nature of his/her relationship with the deceased (both positive and any negative/disappointing aspects) of their relationships. The therapist can ask:

"What are some things you <u>most appreciated</u> in your relationship with your loved one (spouse, parent, friend, coworker)? What do you miss the most?"

"Permit me to ask, what do you wish could have been different in your relationship with X? Is there anything you did <u>not</u> appreciate or wish was different in your relationship with X?"

Such questioning reduces the likelihood of the survivor idealizing the past relationship and may help the client be open to developing new relationships. Also, conduct goal-setting that nurtures hopefulness and the language of becoming.

"What would you like to be doing if you were no longer grieving?" (See the Section on Questioning)

6. Psychoeducation should include a discussion of <u>possible</u> <u>barriers/obstacles</u> that may undermine the client's personal journey of mourning. Reinforce the client's development of a "New Identity", a "New Me." The therapist can convey:

"Each person is unique. Each person's situation is different. Each person negotiates the mourning process at his/her own pace and manner. What, if anything, might get in the way of your personal journey? How can you learn to anticipate these potential barriers and address them ahead of time?"

"How can you learn to reengage the most painful aspects of your account of loss (narrative), while also learning how to contain the emotional pain and come to terms with it?"

"Is there any way you can mobilize social supports?"

"Healing, in the case of grief, involves hearing. Is there someone in your life you

can count on, or with whom you can share your story?"

3. **<u>Restorative Retelling Procedures</u>**

Restorative retelling procedures may take many different forms (Neimeyer, 2002, 2012). Each of these procedures are designed to help the survivor to process grief and establish a new relationship with the deceased, but maintain the deceased person's presence in the life of the survivor. One prominent procedure is to use the Gestalt empty-chair technique ("chair work" Paivio & Greenberg, 1995). In Litz et al.'s (2016) Adaptive Disclosure therapeutic approach, they use the "empty chair" procedure as a vehicle to generate a conversation with the deceased person. It facilitates corrective information, especially when loss and guilt are entangled. They divide the imaginal dialogue into three sequential steps:

1. Preparing the client for the processing of the loss;

2. Engaging in this breakout procedure of loss in which the client has a conversation with the deceased person, in real time (right now);

3. Post breakout component discussion about the meaning and implications of the loss and the client's experience of talking to his or her lossed person.

As described by Litz et al. (2016, pp. 107-117), the following clinical guidelines should be followed. (A similar approach has been used with clients who have experienced "moral injuries" (See Litz et al., 2016 pp. 117-139). When clients experience moral injuries, the empty chair procedure may employ a "moral mentor", rather than a deceased person (Litz, 2004).

I. Preparing the client for the Breakout Imaginal Dialogue Procedure

The therapist should describe the "empty chair" procedure and address the client's questions, concerns and possible sources of resistance. The therapist should offer a rationale for the need to emotionally process the nature of the loss. Discuss the impact of avoidance behaviors. The therapist can ask the client:

"By focusing on the impact of the death of X, you will have an opportunity to understand and begin to recover and heal and master your grief. This can create a positive ripple effect in your life. Does this make sense? Do you have any questions?"

"What do you imagine may be any concerns you may have in engaging in this empty-chair activity? Can we discuss these?"

II. Imaginal Dialogue with the Deceased

1. The client is asked to have a conversation with the deceased person, in real time right now, as if the deceased person was sitting in the empty chair.

2. The conversation with the deceased uses the first person present tense and the client is encouraged to tell the deceased anything he/she wants, highlighting how the loss is affecting him or her. The client should be encouraged to provide a real emotional confession of how the client feels (haunted, guilty, unhappy). The client may wish to close his/her eyes when conducting the empty chair activity. The therapist may use prompts, as suggested by Litz et al. 2016, p. 108).

"Now I want you to go back to the image of [person who died]. This time, I want you to have an actual conversation with X. What would you like to tell him/her, here, now?"

"I know he/she is gone, but take this chance to talk to him/her and make it real."

If the client gets stuck, the therapist should guide him/her by suggesting:

"Why don't you start with what you remember from when he or she was alive?
Why don't you talk a bit about how much you miss him/her; how sorry you are and why?

After a period of time, the therapist can ask the client to tell the deceased person what has changed behaviorally in him/her since the loss. As suggested by Litz et al. (2016, p.108).

"Tell him/her what changed for you after his/her death, and tell him/her how his/her death has affected you. Tell him/her how his/her death has changed your views of yourself, others, and the world."

"Tell him/her how stuck you are, and be sure to describe any struggles you are now having."

To this imaginal dialogue, the client can be encouraged to share what efforts he/she has taken to honor the memory of the deceased and what coping activities he/she has taken. To facilitate level of resilience, Litz et al. (2016) propose that the therapist ask the client to share what the dead person would say to him/her right now, after hearing all of this.

"What is she/he telling you now, after hearing all you have said?"

"What advice would he/she have for you?"

If the client has difficulty coming up with positive forgiveness-type statements, the therapist can offer suggestions:
Does he/she want :

"You to carry on?"
"What is best for you?"
"You to live the fullest life possible?"
"You to claim your life and live it fully for <u>both</u> of you?"

The imaginal dialogue may be repeated during multiple sessions in order to help the client shift his/her perspective and contribute to benefit-finding, meaning-making narratives that nurture healing. This form of restorative retelling can contribute to the reconstructing, rather than to severing one's relationship with the deceased.

III. Post-breakout Component

The therapist starts this phase by asking the client to open his eyes and return to the here and now and then to discuss his/her experience of what just happened.

"What was that like for you?"

"What are you going to take from this session to think about throughout this week?"

"What really stood out for you?"

The therapist can also provide normalizing and reassuring comments, and encourage the use of coping behaviors should the client become emotionally upset. Litz et al. (2016, p.117) offer the following examples of possible therapist's comments:

"I know this was difficult, and more than likely you will continue to think about it from time to time throughout this week. This is normal."

"I often find that as clients start to look at difficult experiences, they sometimes have more unwanted thoughts about the experience. This usually goes away with time."

See work by Pearlman, Rando, Shear for additional examples of ways to conduct Restorative Retelling Procedures.

Restorative retelling and empty-chair interventions provide individuals with opportunities to reconstruct and reframe the "stories" they tell themselves and others. Making meaning through the construction of stories and the use of metaphorical language contributes to the healing process (Meichenbaum, 2013; Neimeyer et al., 2010).

4. **Exposure-based and Supplemental Interventions**

In order to address the lingering impact of trauma and to confront avoidance behaviors that undermine recovery, various forms of imaginal and in vivo exposure-based interventions have been developed. Foa et al., (2007), Pearlman et al. (2014), and Steenkamp et al., (2011) provide specific treatment guidelines on how to conduct such exposure-based interventions so clients learn to purposefully tolerate and manage their fears and overcome any avoidant activities. In the case of imaginal exposure, clients are asked to tell and retell their "story" in the first person using the present tense and to listen to the tape recordings of these sessions as "homework". The in vivo exposure activities are arranged along a gradual hierarchy of increasing demanding challenges. Such exposure exercises should be conducted for at least 45 minutes, three times a week to the point where the client can learn to tolerate his/her fears. The exposure activities may be learning to use coping skills such as breathing retraining and cognitive restructuring.

Jordan and Litz (2014) raise questions about the use of imaginal exposure therapies of having clients repeatedly retell (relive) memories of the moment of death, or related scenes. Such exposure-based interventions follow from trauma-focused treatment approaches that embrace a conditioning model that targets fear-based memories. They note that PCG is not characterized by such fearful memories and

"therapeutic rationale for repeated and sustained reliving of the traumatic moment is unclear. Moreover, there is no evidence that 'working through' a loss by sustained focus on it is necessary for healing for all individuals" (Jordan & Litz, 2014, p. 186).

Restorative retelling and exposure-based interventions may be supplemented by cognitive restructuring procedures that address the client's Automatic Thoughts and beliefs (shattered "Assumptive World"). Another procedure is the use of Activity Scheduling that provides a means to address the client's depression, inactivity and withdrawal by means of physical exercise and related engaging social activities (exercise with others).

The therapist should encourage the client to reengage in pleasurable activities, reattach with others, and pursue various wellness activities. As suggested by Litz et al. (2016, p.114), the therapist can ask:

"What type of pleasurable or healthy activities are you keeping yourself from doing since the death/loss of X?"

"Of those who care about you in your life, who are you not spending quality time with?"

"Are there new challenges you might attempt or activities you might devote specifically to the memory of X? Are there life experiences that you might plan to honor X?"

"Are there ways to memorialize (remember and honor) X?"

The therapist can use the Coping with Grief Checklist (see pages 21 to 25) as a way to review possible coping activities. In a collaborative manner, the therapist should elicit specific client commitments and discuss possible barriers that may interfere with the client implementing specific "homework" activities between sessions.

"What do you think would be useful for you to do before our next session?"

"What would you be willing to try to work on for next week?"

"What kind of practice assignment seems doable in the next week?"

Neimeyer (2012) has proposed another cognitive restructuring activity that asks clients to share "stories" of their relationships with the deceased as a way to reaffirm and reorganize their attachment with their loved one. He proposes the use of the following set of questions as a way to initiate such accounts:

Could you introduce me to _____ ?
What did knowing _____ mean to you?
Are there particular times, places, or ways in which you recall _____ importance to you?
What kind of things did _____ teach you about life, and about how you could manage the challenges you now face?
What might _____ say he/she appreciated most about you?
What strengths did _____ see in you?
In what ways might you strive to grow closer to _____ across time, rather than more distant?
What difference might it make to keep _____ stories and memories alive?
What has _____ given you that has had enduring value?
What do you want _____ to know about you and your relationship?
Can you describe the lasting impact, of _____ on your life?

Litz et al. (2016, pp.115-116) have offered the following exercises as a way to help clients express their grief and develop possible coping strategies. They ask the client to:

"Think or write about the following:

- ***How has losing _____ affected me?***
- ***How would ____ say I impacted him her?***
- ***How did ____ impact me? How have I grown as a person because of ____?***
- ***How can I honor _____now and move forward in my life?***
- ***What are some of the positive memories I have of ____?***

The therapist may ask the client to "write a goodbye letter to ____. Include how the loss has changed you; what you will miss most about the person lost; how do you want to remember him/her; and how will you continue to honor him/her?"

The average length of this comprehensive treatment program for clients with Complicated Grief and Traumatic Bereavement is 19 sessions, as described by Pearlman et al., (2014) (See ***www.guilford.com/pearlman-materials*** for a collection of client worksheets). Also see Harris (2011) and Jeffreys (2011) for examples of additional supportive activities.

5. **Addressing Bereavement Specific Issues**

Bereavement-specific issues focus on reawakened intense waves of grief when one least expects it. Rando (1993) have termed these acute grief responses to varied triggers that underscore the absence of the deceased, as Subsequent Temporary Upsurge of Grief (**STUG**) reactions. These triggers, may occur in social settings, at cyclical times like anniversaries, holidays or in response to particular occasions such as weddings, graduations. The **STUG** reactions, or powerful unexpected waves of grief that trigger a crisis of memory and undermine adaptive functioning, can lead to feelings of losing control, embarrassment, and result in withdrawal and avoidance that reinforces a loss grief cycle.

Psychotherapists need to "validate and normalize" such **STUG** reactions as part of the mourning process. Such emotional pain can be viewed as one way of staying connected to the deceased. In a collaborative fashion, the therapist should help clients anticipate and prepare (have coping strategies in place) in order to handle such episodes or "rough patches". Role plays and exposure activities can be employed to address **STUG** reactions. There is also a therapeutic need to address any accompanying self-critical automatic thoughts. The therapist can use the **CLOCK** analysis to help clients cope with **STUG** reactions, as well as conduct relapse prevention stress inoculation interventions (Meichenbaum, 2013).

6. **Self –attribution training or helping clients "take credit" for changes**

A key aspect of relapse prevention interventions is to help clients develop coping skills for bereavement-specific upsurges ("rough patches") and to ensure that clients monitor their progress and attribute any positive changes to their own personal coping efforts. Psychotherapists can facilitate this process by using Client Checklists, engage in discussions of how clients have handled tough situations, and ways they can anticipate and address future potential challenges (anniversary dates, reminders, and the like). The therapist can "go public with the data" of reported or observed changes. For instance, ***"It sounds like you have learned to:***

"Draw upon your resources."
"Identify warning signs."
"Tolerate strong feelings."
"Move back and forth (oscillate) between your loved one and beginning your life again"
"Reach out for help."
"Do so many of the things your spouse used to do."
"Trust your judgment."

"Express difficult feelings."
"Catch and challenge your negative automatic thoughts."
"View your emotional pain as a way of remaining in touch with your loved one."
"That <u>in</u> <u>spite</u> <u>of</u> your fears, you were able to be courageous and not withdraw."

The therapist should provide specific examples and have the client offer specific examples of each of these changes. This should be followed up with queries of "How" the client was able to accomplish each activity?

There is also value in discussing what the client has gotten out of treatment and what, if any, "unfinished business", and issues remain to be addressed. Discuss the possibility of seeking future help if the need arises. "What was the client like when he/she entered treatment and what has changed?" How has the client's "story" changed and the accompanying new skills and new identity developed?

Two additional ways to bolster the client's level of self-efficacy and resilience is for the therapist to:

1) share examples of coping observations that other clients have offered;

2) ask the client for examples of "**RE**" based activities that he/she may have engaged in.

I. The therapist can say to the client:

"We have asked other clients, like yourself, to share with us some of the things they have learned over the course of treatment. With their permission, they have offered the following examples and given permission to share them with other clients, like yourself:

LIST OF COPING OBSERVATIONS OFFERED BY INDIVIDUALS WHO HAVE LOST LOVED ONES

"I now recognize that pain is inevitable, but suffering is optional."

"I unburdened myself by disclosing/sharing my loss with people I can trust and respect."

"I benefited from the feedback and advice I received."

"I reached a turning point, when I began to let go of some of my grief."

"I am having more good days than bad days."

"I am in a better place now."

"I found a new normal, a footing in the world."

"I have become more buoyant in dealing with the waves of grief."

"I have learned to compromise with life."

"I can engage in heart-mending activities."

"I have been able to transform my pain into compassion for myself and for others."

"I have learned to invite my emotional pain to tea."

"I have hope for the future."

"I cherish life more now. I don't take life for granted."

"I now value more of what I have, like my remaining children."

"I give myself permission to close the lid on my loss and grief in order to turn my energy elsewhere, as needed."

"I can use my spirituality. I have found God again."

"I believe they are watching over me."

"They are in a better place."

"I can create a space for my loved one to fill in the future."

"I have chosen <u>not</u> to wrench out of my life, my _____ (loved one), but instead to include him/her to be with me and continue to share my challenges, alongside me."

"I have a sense of peace."

"I mastered my grief."

II. A second intervention strategy that psychotherapists can use is to ask the client to provide examples of behavioral changes they have made, using "RE" verbs. The therapist can say:

"It seems to me, and correct me if I am wrong, or if I am misreading the situation, that you are [Insert one of the following "RE" observations]?...
Can you give me an example when, where and how you were able to do that?"

With regard to the Past

Retell your story of loss
Reframe what happened (engage in benefit finding)
Reconcile the past
Revisit your positive memories with _____

With regard to the Present

Regulate your emotions
Reengage emotionally
Relax and release your tension
Regain a sense of control
Rewire your brain
Relinquish old habits
Reestablish your routine
Revisit the places you have worked hard to avoid
Readjust to the loss
Retell your "story" when and to whom you choose
Reevaluate how you think
Restory your life
Redefine yourself
Reclaim your life
Reengage life
Reconnect with others
Rebuild and reestablish connections with others in your life
Repair your relationships
React to the separation in a positive way
Reengage in pleasurable activities

With regard to the Future

Reset your priorities and goals
Rewrite your list of Reasons for Living
Rewrite your "story" of the future
Recognize both the losses and gains in your life and look to the future with hope
Reinvent a "new identity". Who am I, now? Who do I want to be in the future?
Restore your dignity
Reconstruct a world of meaning
Reaffirm your life
Restore your resilience

Keep in mind that the critical feature of this intervention is to use discovery-oriented processes to help clients generate examples of each "**RE**" activity that is discussed. There is a need for the client to take "ownership" for behavioral changes that they have brought about.

There is a need for therapeutic aftercare contacts and booster sessions, where indicated.

INTERNET WEBSITES

Violent Death Bereavement Society
www.vdbs.org

Bereaved By Suicide
www.bereavedbysuicide.com

Grief Net
www.griefnet.org

The Australian Palliative Care Network
www.caresearch.com.au

The Kindness Project
www.projectkindness.org

Compassionate Friends
www.compassionatefriends.org

Miss Foundation
www.missfoundation.org/forums

Dougy Center
www.dougy.org

Treating Traumatic Bereavement: Client Worksheets
www.guilford.com/pearlman-materials

Tragedy Assistance Program for Survivors (TAPS)
www.taps.org

Trauma-focused Cognitive-Behavioral Treatment for Children and Youth Who Experience Complicated Grief
www.musctfcbt.edu