Suicide Prevention with a Focus on the Treatment of Suicidal Patients

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Learning Objectives
At the end of this program the participants will be able to:

- Describe the Interpersonal Theory of Suicide
- List the steps necessary to treat suicidal patients
- Identify quality enhancement strategies

Major Concepts
Interpersonal Theory of Suicide

Acute Suicidal Affective Disorder (ASAD)
aka Suicidal Mode

Fluid Vulnerability Theory

Facts About This Presentation
Although discussions of suicide are usually split into three major sections (Assessment, Management, and Treatment), there is an underlying unity in the presentation—

That unity occurs through the Interpersonal Theory of Suicide (ITS)

The Interpersonal Theory of Suicide (ITS)

Suicide involves

1. Acquired capacity to kill oneself
2. Thwarted belongingness
3. Perceived burdensomeness (hopelessness underlies these)

Developed by Thomas Joiner and colleagues

Acquired Capacity
Higher suicide rates among patients with anorexia, police officers, physicians, sex workers, veterinarians (those who are exposed to violence or human suffering).

They (a) gradually lose their fear of death and (b) develop higher tolerance of pain
Thwarted Belongingness

The person does not feel close connections with others, or does not identify with any valued group of people.

May be a recent loss of a valued relationship through relocation, divorce, family conflict, or death

Perceived Burdensomeness

The world is better off without me.

People may perceive themselves as an emotional, physical, or financial burden (may have illness or functional limitations)

Hopelessness often co-exists with thwarted belongingness and perceived burdensomeness

Acute Affective Suicidal Disturbance

Suicidal behavior likely to occur if
1. Desire to die– thwarted belongingness, perceived burdensomeness, self-disgust
2. A belief that 1 cannot be changed (hopelessness)
3. Emotional state (insomnia, nightmares, agitation, irritability) that increases rapidly (geometrically)

ASAD and Suicidal Mode

The ASAD corresponds closely to the suicidal mode from cognitive therapy—the interaction of emotions, behaviors, thoughts, and motivations that interact with each other and lead a person to think that suicide is the only solution to their problems.

Three Steps of Assessment

1. Specific questions about ideation, plans, attempts
2. Static (fixed), acute (changing), and protective factors
3. Screening or brief suicide inventories (if needed)

Relationships and Assessment

The assessment is also the first part of building a relationship with the patient. Be calm, nonjudgmental, sympathetic, interested. Use open-ended questions that encourage people to say what is on their minds.

Patients should have had the opportunity to tell their story. Patients should feel that their psychologist really cares about them
### Interpersonal Theory and Interviewing

Remember that thwarted belongingness is one of the features that predict suicidal behavioral according to the Interpersonal Theory.

Creating a good relationship with the therapist, in and of itself, reduces the risk of suicide.

### Does My Psychologist Care About Me?

When asked what was the most important factor that kept patients from killing themselves, the factor that received the most endorsements was the knowledge that my therapist cared about me.

### Psychotherapist Feelings

Often psychotherapists fear of having a patient die from suicide OR fear of litigation in case something goes wrong

Ideally, those with a good background in suicide assessment, management, and treatment will have the confidence to keep their fear in check

### Information from Screening

- **Suicidal ideation**: frequency, duration, and intensity
- **Past attempts**: multiple attempters increase risk
- **Suicidal plans**: including secondary, dormant
- **Passive suicidal beliefs**

### More Thorough Assessment

- Patient’s history
- Social connections
- Life stressors
- Physical health
- Religion/values
- Mental illness/ emotional states

### Diagnosis and Suicide

The major factors to look for in assessing suicide risk would be the factors found in the ASAD regardless of diagnosis: acquired capacity for harm, thwarted belongingness, perceived burdensomeness, hopelessness, self-disgust, insomnia, nightmares, agitation, irritability, social withdrawal
Consider Cultural Factors
Do patients, because of their background have different ways to express distress?

Does minority status aggravate isolation? Are there microaggressions or micro insults?

Among patients from collectivist cultures, consider the importance of family discord

Protective Factors
Identify with a social group
Intimate, caring relationships
Religious beliefs
Psychological Resilience

Develop Risk Using Fluid Vulnerability Theory (FVT)
The FVT posits a baseline of distress. Patients with a higher baseline can move more quickly into the suicidal mode (ASAD) and take longer to return to baseline.

The assessment should establish a baseline and the foreseeability of moving into a suicidal mode.

Responses to Suicide
Historically, across all of health care professionals, the most common responses to suicide are:

Medication
No-suicide contracts
Seeking hospitalization

Responses to Suicide-2
No suicide contracts—no evidence of effectiveness

Medication—except for bipolar or schizophrenia, no evidence that it reduces short-term risk

Hospitalization—no evidence of long-term benefit

Part Two: Management
Four M’s
Motivate
Means
Medicate
Monitor
Management as Early Therapy

1. Direct intervention designed to stop suicidal behavior
2. Gathers information about patient in developing crisis plan
3. Designed to motivate for treatment and first step of informed consent process
4. Building a good treatment relationship

Types of Treatment

Direct interventions - designed to reduce suicidal behavior – often called suicide management

Indirect interventions – designed to address mental illness

Direct interventions can reduce risk of suicide by up to 80% over indirect interventions only

Myth One

Myth: When working with suicidal patients, the most important thing is to treat their mental illness and then the suicidal plans will go away

Truth: When working with suicidal patient, it is essential to develop plans to manage the suicide risk in addition to treating the mental illness

Myth Two

Myth: No-suicide contracts have value

TRUTH: No evidence shows that they save lives. Patients who sign such contracts are just as likely to die from suicide as patients who do not sign such contracts. They do not provide additional legal protection. They are often used in a clinically contraindicated manner.

Management-Motivate

Commitment to Life (Treatment) Agreement

1. Reasons for living
2. Coping: Situations to avoid, situations or people to seek out, ways to self-soothe
3. Crisis response: numbers if needed

Interpersonal Theory and Management

Since thwarted belongingness is a major factor in suicide, management techniques should try to incorporate social connections with the patient.

For example, cooperative and caring relationship with therapist
Seeking out natural social networks for support
Cooperative Work Together

The commitment to life document is a product of active collaboration between the psychotherapists and their patients.

The psychotherapist can make suggestions about reasons for living or soothing activities, but ultimately the patients decide what to put down.

Myth Three

Myth: If you take away their guns (or pills, etc.) they will kill themselves by another method

Truth: Taking away guns or medications reduces the likelihood of a completed suicide. The goal is to delay action until the suicidal crisis passes.

Medication

A management strategy for schizophrenia or bipolar disorder

Its effectiveness in reducing short-term suicide risk in other patients is unclear

Increased risk when starting or getting off medication

When to Refer for Medication?

Refer for medication when it is clinically indicated to do so. Just do not think that medication will be especially helpful in reducing suicide risk for most patients.

Antidepressants often take several weeks to become effective.

Myth Four

Myth: medications will reduce suicidal risk

Truth: except for schizophrenia and bipolar disorder, medications do not appear to reduce suicidal risk in the short run.

“A pill does not remove a gun from the home”

Management: Monitor

Continue to measure suicidal ideation and plans

Day-to-day check ins or monitoring with patients consent may be indicated for some patients

Hospitalization in extreme cases
Family Involvement
With patient’s permission, solicit involvement of family with patient in the form of social support and monitoring.
Rely heavily on patient in managing this.
May need to educate family so that they will not overreact or "support" in punitive or shaming ways

Myth Five
Myth: No one can stop a patient who really wants to die from suicide
Truth: Although no one can MAKE a patient refrain from suicide, almost all patients are intensively ambivalent and good management and treatment techniques will greatly increase the chance of living

Management Techniques
Breaking confidentiality—do so only as a last resort
Involuntary hospitalization—do so only as a last resort
ER: what was your last ER visit like?

Hospitalizations
No data on its effectiveness. Use it when no other way to ensure safety.
Patients recently discharged from hospitals are at a very high risk to die from suicide.
Discharge planning needs to be done very carefully and conscientiously

Treatment of Suicidal Patients
Based on data gathered in screening, assessment, and management stages
Assessment not only predicts risk, but also provides information that will guide management and treatment and establishes a baseline to monitor progress

Overview of Treatment
Effective Treatments in General
Suicide-Informed Treatments
Addressing the Suicidal Mode
Problems in Treating Suicidal Patient
Effective Treatments in General

Patient outcomes do not vary by: age, gender, professional affiliation or years of experience by psychologists

Patient outcomes do vary if psychotherapists are: good at relationship building, show humility, practice craft deliberately, and monitor progress vigilantly, and have skill in specific techniques.

What is Effective?

Relationships: Convey empathy, repair alliances, respectful and likable

Deliberate Practice: Working on improving skills through collective feedback

Humility: accurate understanding of skills, including limitations

What Is Effective-2?

Monitoring outcomes: being vigilant about patient progress such as using outcome measures or systematic measures to ensure adequate progress

Psychotherapists can underestimate risk of treatment failure

Monitoring Treatment

Psychotherapists estimate that about 4% of their patients deteriorated during psychotherapy (Walfish et al., 2012), although Castonguay’s review showed that about 8% of patients deteriorated.

Specific Techniques

Especially relevant here include

Teaching ways to reduce emotional turmoil (e.g., mindfulness, relaxation, cognitive restructuring)
Helping patients problem-solve
Motivating patient (e.g., motivational interviewing)
Knowledge of sleep hygiene

Harmful Behaviors

Increases risk of patient deterioration

Confrontational
Dismissing patient concerns
Premature interpretations

Any behavior that patients interpret as diminishing their importance
Culturally Informed Treatment
Culturally competent psychotherapists have better outcomes
Matching on patient demographics alone does not consistently improve outcome
Intersectionality: culture interacts with age, gender, SES, religion, and other factors

Religiously-Infomed Treatments
Outcomes not sufficiently clear to make generalizations EXCEPT
Religious-informed treatments tend to be no worse that conventional treatments
No evidence that matching psychotherapist or patients on religion leads to better outcomes.

What Are Effective Treatments?
Evidence-based for reducing suicide
Rudd et al. (2015) CBT
Linehan et al. (2015) DBT
Jobes (2016) CAMS
Others may be effective as well

Why So Little Data on Effective Treatments with Suicidal Patients?
Most outcome studies (including studies with medications) exclude patients with suicidal ideation.
Few studies collect data on suicide attempts or completions.

Suicide-Informed Treatment
Contains elements of effective treatments AND
Continue to focus on managing and treating suicide, i.e., remember the psychological issues that commonly occur among suicidal patients

Suicide Informed Treatment and Suicide Management
From the standpoint of Fluid Vulnerability Theory:
(1) keep the patient from moving into a suicidal mode (if they do move into the suicidal mode keep them safe) and
(2) Reduce baseline
**Keep Management Strategies in Place**

1. Help patients understand the sequences that lead to a suicidal mode
2. Prepare to minimize risk of harm through means restriction
3. Teach them how to circumvent the suicidal mode
4. Instruct them on procedures for crisis intervention

**Self-Determination Theory (SDT) Informs Effective Treatment**

Psychological well-being improves with people have

- Connectedness with others
- Mastery over activities important to them
- Autonomy- control over decisions

**Applying SDT to Treatment**

- **Connectedness**— build good relationship with psychotherapists or others in natural environment
- **Mastery** – learn skills to control emotions, thoughts, etc.
- **Autonomy**— control treatment process as much as is clinically indicated- patients are more committed and persistent in addressing goals that they picked

**Informed Consent**

Especially important—

- address expectations of treatment
- what patients need to do to get well
- shows respect for patient and patient decision making

**Topics to Emphasize in Informed Consent Process**

- Expectations of patient in therapy
  - sharing information with other treatment providers
  - attending sessions, completing assignments, and participating in treatment

**Informed Consent and Adherence to Treatment**

One of the major reasons for failure of treatment is the lack of treatment integrity— including the failure of patients to participate fully-

- anticipate this by motivating patients, anticipating obstacles to compliance, and addressing non-compliance quickly
Informed Consent and Candor

With ambivalent parents: “If you fail to follow through with treatment, your child may die.”

With highly ambivalent adult patients: “if this does not work you an always kill yourself” (use selectively)

Motivating for Treatment

1. What are your values?

2. What would be the impact of your suicide on others?

Values

Values motivate for treatment– people can tolerate much pain and discomfort for values (Values are the general direction of life– Not the same as a goal which is an outcome)

What are your values?

Refer to “reasons for living” in commitment to life document.

If Patients Are Too Discouraged to Identify Values

“What used to be your values?”

“What would be your values if you were not so depressed?”

“If you were to have values, what would they be?”

Activities to Facilitate Discussion of Values

What would you like to be written on your tombstone?

What would you want your children (friends, spouse) to say about you?

Who has had the greatest positive impact on your life? (i.e., What values did they demonstrate?)

-- derived from Acceptance and Commitment Therapy

Motivation- Impact of Suicide on Others?

The average person has 6 to 10 people who are deeply impacted by a suicide.

When a spouse dies from suicide the family suffers more than if the spouse died from natural causes or an accident-stigma-guilt
If You Were to Die from Suicide.

Family members suffer guilt at not being able to prevent the suicide.

Family members suffer the stigma of a suicide.

“What kind of parent would. . .”
“What kind of spouse would. . .”

Impact on Others of Adolescent Suicide

When teenagers die, one of three of their friends develop a clinical depression.

Most experience distress up to 6 years later.

Some develop post-traumatic symptoms.

Those who had contact with decedent the day of their death suffer more.

Lived Experience

After listening to the story of a parent who lost a child from suicide, a suicidal person wrote, “For the first time in my life I understood the full scope of devastation and loss a survivor experiences.”

Medeiros, 2017, p. 6

Suicide Informed Treatment

Understand the interpersonal theory, the suicidal mode (ASAD), and fluid vulnerability theory.

Incorporate information from assessment and management identify problem areas and protective factors.

Interpersonal Theory and Treatment

Focus on desire to die (not acquired capability)

Allow for flexibility in schedule

Continue suicide management strategies as long as needed (e.g., updating commitment to life agreement, monitoring patient, means restriction)

Monitor Risk

Remember one of the goals of assessment is to provide a baseline by which progress can be measured.

Here the brief suicidal screening instruments may be used for that purpose.

Even one brief question is something
Focus of Treatment-1

Topics identified from the assessment could include:

1. Physical illness, pain or disability? coordinate with health professionals
2. Social isolation (thwarted belongingness or perceived burdensomeness); focus on building relationships- may mean cognitive restructuring or skill acquisition

For Patients Who Feel Too Worthless to Seek Out Others

- How would you respond if someone asked you for help?
- Have you ever helped anyone else?
- How can you help others?

Focus of Treatment-2

3. Stressful life events– teach problem solving
4. Emotions such as Insomnia, nightmares– (sleep hygiene)

Focus of Treatment-3

Emotions such as Agitation: “A time limited state of both psychological and behavioral over arousal often characterized by restless and/or repetitive behaviors coupled with expressions of emotional turmoil and/or mental anguish or unrest” (Ribeiro et al., 2014, p. 26).

Agitation or irritability– relaxation, cognitive re evaluations, or other activities to lower baseline of arousal or to interrupt downward spiral into ASAD

Focus on Treatment -4

5. Suicidal permitting thoughts such as self-disgust and hopelessness— cognitive re evaluations, self-forgiveness

Religion and Values

Religion can be protective to the extent that it involves participation in a social group

Religion and values and important if they involve life promoting or life protecting values

Self-forgiveness (self-compassion) can occur through religious or spiritual language, addresses shame and self-disgust
### Religiously Informed Psychotherapy

Use religiously informed interventions if consistent with desire of patient, avoids assuming you know what the patient believes, accepts that the content of the belief may be state dependent and change depending on the totality of the patient’s personality, immediate stressors, and other life circumstances.

### Religious Coping

Negative religious coping—life events occur because of alienation with God (e.g., “I am condemned,” “This happened because God wants to punish me.”)

Positive religious coping—God, religion or religious community is a source of strength during crisis.

### Moral Injury

Mental health symptoms and suicidal thoughts may persist because of moral injury or past behaviors that violated deeply held religious or moral beliefs.

### Avoid in Treatment

Avoid using group therapy as the primary treatment modality until suicidal risk is well under control

Avoid treatment of trauma until suicidal risk is under control

### Special Issues in Treatment

Problem relationships
Aggression
Time contingent suicide
Attempts during psychotherapy
Lack of adherence to treatment
Web sites and social media
Telehealth
Supervision

### Problem Relationships

“You are such a rotten therapist that I just might kill myself.”

Some patients who feel they are a burden to others or are unwanted have difficulty accepting or maintaining a good treatment relationship

Intimacy may frighten them.
Aggression
Statistically, those who harm themselves are at a greater risk to harm others.
The most common targets of violence are within the family
Screen for violence towards others— if no risk, then move on

What is Time/Event Contingent Suicide?
“If my wife dies, I intend to kill myself.”
“If it turns out that the tumor is malignant, I just might kill myself.”
“If my husband decides to leave me, then I will kill myself.”

Time/Event Contingent Suicide
1. Consider suicidal— do not let the event distract from the possibility that they could be suicidal even without the event
2. Acknowledge your position on suicide— cannot prevent it unless patient gives information, but will intervene
3. Do not argue or plead
4. Consider impact of patient threats on the treatment relationships

Suicidal Blackmail
“Unless you do not take my phone calls every day, I just might kill myself.”
“If you do not let me run up large debts I just might kill myself.”
“If you do not indulge my curiosity into your personal life, I just might kill myself.”

Handling Suicidal Blackmail
Are requests reasonable?
Do not accede to clinically contraindicated requests
Refer back to informed consent agreement
Address early in treatment

Suicide Attempts While in Treatment
Suicide attempts in by patients in psychotherapy are far more likely that a completed suicide.
32% of PPA members reported having at least one patient attempt suicide in the last year (Knapp & Keller, 2004).
First: Anticipate Crises
Based on information obtained in assessment-
What leads patient to the suicidal mode?
can patient identify warning signs
can patient prevent the suicidal mode?

Second Instruct Patient on How to Respond: Crisis Plans
Define crisis for patient– intense thoughts that the patient do not believe they can control
Crisis Card- rehearse the
1. Activity
2. First line emergency (2 numbers)
3. Emergency room

Prepare for Noncompliance
Ask patients, “If you did get into a crisis, how likely are you to follow through with the crisis plan”
“What are the obstacles in your way?”
(e.g., “I am too much of a burden on others anyway.”)

Aftermath of Attempts
Statistically, the risk of another attempt is high
Secure immediate safety
What can be learned from the attempt? Modify crisis plan as needed
Be attuned to shame, self-disgust,

Attempts in Progress?
Intervene if necessary
send ambulance
send police
send crisis service, etc.

Lack of Adherence to Treatment
Patient arrives late or misses appointments (without a good reason), does not complete home work assignments, is not open while in treatment, etc.
Remember that a major reason for treatment failure is the lack of treatment integrity
Is Patient Benefitting from Treatment?
Psychotherapists should not continue to treat patients who are not benefitting or who are unlikely to benefit from a treatment.

Benefit is not the same as progress. Sometimes keeping a patient stable is a meaningful benefit of treatment.

Addressing Non Adherence
Explore and document thoroughly efforts to motivate patient. For example:
- Not opening up because of shame
- Not arriving on time because of transportation issues
- Not taking medication because cannot afford it
- Not working in therapy—demoralized

Terminating for Non-Adherence
If patient is not benefitting nor likely to benefit, psychotherapists may terminate with patient IF

Patient not in acute suicidal state
Patient given referrals
Efforts to motivate patient have been exhausted and documented in the patient record

Balancing Reasons for Termination
Sometimes it means weighing the benefits (to the patient) against the risks (to the patient).

Despite objections of the patients, are they better of if treatment ends?

Remember, keeping patients involved in an ineffective treatment can be harmful to them

Telehealth
Even assuming you know the mechanics and legality of delivering telehealth services, do not do long-distance service with patients whom you do not know well—UNLESS you have professional back-up in the patient’s locality

Websites
Ask patients what websites they go to

Many pro-suicide sites that are thinly veiled examples of cyberbullying and exploitation under the guide of being “pro-choice.”
Supervised Services
Are trainees adequately trained in suicide prevention?
   training programs vary in training
Do trainees know state laws, agency policies, etc.
Is there a sentinel event process in agency?

Professional Liability and Suicide
Relatively low risk in outpatient treatment, higher for in-patient treatment
Follow standard of care: what a reasonably prudent practitioner would do.
Determined for a court by expert testimony informed by professional literature

Quality Enhancement Strategies
These are procedures designed to reduce legal risks to the psychologists by improving the quality of services the patients receive
They used to be called “risk management strategies”

Ethical Foundations of Quality Enhancement Strategies

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Implementing Quality Enhancement Strategies
Consultation: look at diagnosis, treatment choice, relationship quality
Empower Collaboration: agreement on treatment goal, legitimate patient preferences
Redundant Protection: routine monitoring of patient progress

Quality Enhancing Strategies
As the legal risks, the possibility of treatment failure, or patient complexity increases, the attention given to quality enhancing strategies should also increase
Benefits of Consultation

- Technique oriented information
- Emotional reactions (counter transference)
- Reduction of emotional turmoil
- Thinking through solution together

Empowered Collaboration

- Respect for Patient Autonomy
- Evidence based relationship-agreement on treatment goal accommodation to reasonable preferences explaining rationale for treatment recommendations

Empowered Collaboration-2

Empowered collaboration builds upon informed consent and attempts to maximize patient involvement in all essential elements of treatment

The patient becomes more actively involved in the process of psychotherapy. Greater commitment leads to better outcomes.

Application of Empowered Collaboration

- Because of the importance of empowered collaboration, psychologists should be reluctant to overturn patient preferences for Involving family members in treatment Choice of treatment goals
- Of course alternatives can be explored, but done with respect for patient control.

Documentation Purposes

- Required by insurers, State Board of Psychology, APA Ethics Code, etc.
- A record of treatment for future providers
- Useful risk management tool
- Dialogue with self and patient regarding process and goals of treatment
- Means to identify pertinent clinical issues
- Procedure to document progress

Routine and Risk-Focused Documentation

- As the level of risk increases, the detail and specification of documentation should increase.
- Most patients are routine and the documentation is mundane.
- Suicidal patients should trigger more detailed documentation.
What Should be Recorded?
Record the information obtained about risk including patient responses to questions, background especially related to risk factors, protective factors, and scores on screening instruments (if any).

The thinking process used to integrate this information, including cost/benefit analysis of major decisions.

Mistakes on Documentation
Failure to record thought process
Opening an issue without closing it
Imprecise use of terms, e.g., “manipulative”

Mistakes in Documentation-2
Failure to justify therapeutically indicated deviations from protocols
Over reliance on checklists—using checklists to replace—not supplement—narrative on patient

Monitoring Progress
Beneficence/Nonmaleficence
Additional source of information for a difficult patient
Routine procedure with high risk patients

Application of Monitoring
Include data on patient progress (see “four session rule” below)
Also, include scores on screening instrument in the record.
Represents productive vigilance on patient progress.

Protective Nature of Monitoring
Castonguay et al. (2010) found a deterioration rate of 8%, yet psychotherapists tended to predict a deterioration rate of LT 4%
So, 1 of 25 patients are identified as getting worse, but on the average 2 of 25 patients will be getting worse.
Monitoring Progress Informally

Routinely ask patients if they had a chance to talk about what was important to them?

If there were things that they did not get a chance to talk about?

How they would like the next session to be different? Etc.

Four Session Rule

Always monitor progress, BUT be especially vigilant if progress has not occurred by the fourth session

Why? Good indication of prognosis at fourth session, yet most psychologists persist on treatment up to an average of 10 sessions

Prompt List

1. rethink diagnosis and goals- do you need a consultation
2. discuss issues with patients
3. are there second sources of data to explore?

Prompt List- Additional Reflections

Do YOU think you and the patient have a good working relationship?
Is your assessment of the patient adequate?: Are there unresolved ethical issues?
Do unresolved clinical issues impede treatment?
What does your System I say about the patient? System II?

Self-Care

How sick are psychologists?
Neuroticism scale about average
rates of suicide and involuntary psychiatric hospitalizations approximate national averages

BUT- demands of the profession are unique

Apply the FVT to Yourself

What is your emotional baseline?

A high baseline makes you more vulnerable when stressors occur.
chronic stressors
unique work events
work-life spill over
Psychotherapy is an Emotional Contact “Sport”

“You have to be it to see it?”

“You have to name it to tame it”

“You have to share it to bare it”
From Dr. Jeff Sternlieb

Importance of Social Networks

A protective social network will

1. Help you keep up to date on developments
2. Provide informal monitoring of your behavior
3. Provide a check on idiosyncratic errors on your part
4. Give you an emotional reserve

Thank You!!

Questions?