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Helping Parents Cope with Suicide Threats: An Approach Based on Nonviolent Resistance

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Parent training in nonviolent resistance was adapted to deal with situations of suicide threat by children, adolescents, and young adults. The approach aims at reducing the risk potential and the mutual distress surrounding the threat-interaction. Parent training in nonviolent resistance has been shown to help parents move from helplessness to presence, from isolation to connectedness, from submission to resistance, from escalation to self-control, and from mutual distancing and hostility to care and support. Those emphases can be crucial for the diminution of suicide risk. Parents show good ability to implement the approach and report gains on various areas over and beyond the reduction in suicide threat. A particular advantage is that the method can be used also in cases where the young person threatening suicide is not willing to cooperate.

Keywords: Suicide Threats; NVR; Parents; Nonviolent Resistance; Violence; Suicidal Ideation; Suicide Risk

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Research on suicide gives support to a multi-level and multi-systems preventive network with a broad capability of detecting risk cases and providing a variety of interventions (U.S. Department of Health & Human Services, 2012). Advances in the understanding of suicide risk add new meshes to this net, allowing for better identification and management of cases also in areas that were previously disregarded. In this paper we present a parent-based model—parent training in nonviolent resistance (NVR)—for dealing with an area of suicide risk that suffers from relative and perhaps surprising disregard: suicide threats that young persons pose to their parents.

A suicide threat, explicit or implicit, presents parents with a major challenge. Their reaction and the ensuing exchange can profoundly influence the suicidal dynamic and the parent–child[1] relationship (Daniel & Goldston, 2009; Hooven, 2013; Kidd et al., 2006). Parents and child alike can suffer deeply in such situations. The goal of the present program is to help parents in ways that reduce both the risk and the mutual suffering associated with suicide threats.

Our program focuses on threats that are voiced in a context of intimidation. The threat can be made explicitly (i.e., the child threatens that unless the parents act in a given way

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[1]Throughout the paper "child" refers to the young person making the suicide threat, whether an actual child, an adolescent or a young adult.

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he or she will commit suicide) or implicitly (i.e., the child alludes to the possibility of suicide in a more oblique manner). Both explicit and implicit threats can serve to intimidate. Intimidation can be detected when the threat is voiced in the course of an argument or as an attempt to manipulate the parent to give in to certain demands. The child communicates an "either... or..." message. The presence of intimidation does not necessarily mean that the threat is merely "demonstrative." We believe that any threat represents a risk and that dismissing threats as "demonstrative" may actually heighten risk. NVR helps parents cope with suicide threats in ways that do not label them as "demonstrative" and yet counter their coerciveness.

A suicide threat has a unique coercive power: It threatens to stop not only the present interaction, but all interactions. It is the ultimate "last word." Due to this power and its potential destructive consequences, we view suicide threats as a form of violent communication (Qvortrup, 1999). The fact that the intended object of physical violence is the child who emits the threat does not, in any way, diminish the violent implications of the message: In one breath, the child threatens to destroy his or her own and the parents' lives.

Parents often react to suicide threats ineffectively, by panicking, responding aggressively, dismissing the threat, or remaining passive (Huhman, 2002; Owens et al., 2011; Owen et al., 2012). These reactions have several negative aspects: (a) panic reactions often increase arousal and dis-control (Lebowitz & Omer, 2013); (b) reacting to the perceived aggression by lashing back or giving in usually escalates the interaction (Omer, 2004); and (c) remaining passive, ignoring, or minimizing the threat leaves the child alone and unsupported. Those parental reactions are not only ineffective. They typify relational patterns that have been linked to suicide risk (Daniel & Goldston, 2009; Dube et al., 2001; Fergusson, Woodward, & Horwood, 2000; Johnson et al., 2002; Wagner, Silverman, & Martin, 2003).

Most suicide prevention programs concentrate on directing youth to sources of assistance (Klimes-Dougan, Klingbeil, & Meller, 2013). Despite this, it is rare to find prevention programs including families of vulnerable youth (Hooven, 2013). This can pose a serious problem in the identification of risk as, especially with young persons, parents are often the first and sometimes only people to be aware of the threat (Luoma, Martin, & Pearson, 2002; Owens et al., 2011; Owen et al., 2012; Pikris et al., 2003).

Most programs that do involve parents are usually geared to improving family communication, increasing positive interactions and strengthening the parent–child bond (e.g., Diamond et al., 2010, 2011; Hooven, 2013; Stanley et al., 2009). These goals are of high importance, as the literature has shown that suicidal children and their parents often suffer under serious liabilities in those areas (Kashani, Goddard, & Reid, 1989; Wagner et al., 2003). However, we think that some major problems remain unaddressed by most programs: (a) in many cases, suicidal young people are not willing to seek or accept treatment (Carlton & Deane, 2000; Wyman et al., 2008) and over half of those who completed suicide have never been in contact with mental health services (Booth & Owens, 2000; Nada-Raja, Morrison, & Skegg, 2003); (b) parents are in deep distress and should be considered as clients in their own right and not only as treatment agents; and (c) little attention is given to the threat-interaction as a risk factor in itself and to the question of how parents can reduce its destructive potential.

Based on the socio-political doctrine of NVR (Sharp, 1973), the present approach to parent training aims to resist violence and self-destructive behaviors in strictly nonviolent and nonescalating ways (Omer, 2004). The reason for systematically eschewing escalation is not only moral, but also practical. The basic assumption of NVR is that individuals and groups who act violently are not all of one cloth; rather, that there are voices within them that might favor a positive solution. NVR's practical rationale is to strengthen the internal voices in favor of a positive solution and reduce those in favor of extreme ones. Resisting violence while also avoiding provocation and escalation would, in all probability,

strengthen those positive voices. In contrast, lashing back, stonewalling, or giving in would, in all probability, strengthen the voices that favor violence.

Within the mind of a young person who threatens suicide, there is probably a debate between some inner voices favoring life and other voices favoring suicide. Shneidman's (1985) seminal theory of suicide is based on this premise. He referred to this inner dialogue as taking place within "the parliament of the mind," and assumed that as long as suicide is not completed, the voices in favor of life are still active and probably dominant. Attacking the child, giving in to threat-backed demands, remaining passive, or ignoring the threat might strengthen the suicidal faction.

In NVR, resistance and support are two sides of the same coin: Parents support the child and resist the threat at the same time. Support and resistance can be bound together because NVR is essentially an increase in parental presence. The message of decided parental presence can be paraphrased as follows: "We are your parents and will remain your parents! We will not leave you alone! You cannot discard us or paralyze us! We are here at your side and will resist the threat to your life and to ours!" This stance of support and resistance turns NVR into an approach that fosters both parental authority and the development of a secure bond between parent and child (Omer, Steinmetz, Carthy, & von Schlippe, 2013). This combination has been linked to lower suicide risk (Donath, Graessel, Baier, Bleich, & Hillemacher, 2014). On the supportive side, NVR joins hands with attachment-based family treatments (Diamond et al., 2010, 2011); on the resisting side, with programs designed to strengthen parents against inappropriate accommodation to dysfunctional demands (Lebowitz, Omer, Hermes, & Scahill, 2013). The essence of NVR is the commitment to achieving both goals using the very same means.

Nonviolent resistance has been shown to be effective in reducing children's aggressive and destructive symptoms, parental helplessness, parental impulsiveness, and parent–child escalation (Lavi-Levavi, Shachar, & Omer, 2013; Ollefs, Schlippe, Omer, & Kriz, 2009; Weinblatt & Omer, 2008). The program was also adapted for the parents of children with anxiety disorders (Lebowitz et al., 2013) and of dysfunctional young adults (Lebowitz, Dolberger, Nortov, & Omer, 2012). A special feature of NVR that makes it relevant for cases of suicide threat is its applicability even when the child refuses treatment (Lebowitz et al., 2012, 2013). In addition, NVR has shown high potential in recruiting and keeping in treatment parents who are otherwise refractory to professional help (Lavi-Levavi et al., 2013; Weinblatt & Omer, 2008). This is probably due to the fact that NVR addresses the parents' own distress, viewing them as clients in their own right (Omer, 2004, 2011). This characteristic helps to turn NVR into a potentially important mesh in the multi-level network of suicide prevention: Through NVR many parents, who might otherwise have remained isolated or detached, may become connected to the network, allowing thereby for the detection and treatment of many cases of suicide threat that would otherwise have remained hidden. NVR also promotes other elements of positive connectedness that have been strategically linked to reduced suicide risk (Center for Disease Control & Prevention, 2008): (a) connectedness between the suicidal person and his or her parents, as well as with other potential supporters; (b) connectedness between the family and a support network of relatives and friends; (c) connectedness between the family and the professional network (teachers, therapists, psychiatrists, social workers); (d) connectedness between the members of various professional and institutional agencies. This emphasis on connectedness is one of NVR's major sources of strength (Omer, 2004, 2011; Sharp, 1973).

NVR and the Interpersonal Dynamics in Suicide-Threat Situations

We believe that the urgency of suicide threats requires a two-phase approach: (a) a *containment phase* in which parents learn to cope with the acute crisis and (b) an *anchoring*

phase in which parents learn to widen and consolidate the steps activated in the containment phase, anchoring themselves in their parental role and support system in ways that may increase family and individual stability. NVR fosters containment and anchoring by promoting the following processes:

From helplessness to presence

Parents often feel paralyzed, have an emotional outburst, submit to the child's demands, or try to ignore the threat. The helplessness reflected in those reactions may have very negative effects: (a) the child feels left alone, (b) the conflict escalates, and (c) dysfunctional patterns are perpetuated. However, if parents are able to act in ways that convey presence instead of helplessness, the crisis can be contained and the fundaments can be laid for further improvement.

The containment phase is launched by an *announcement* in which the parents communicate to the child their decision to remain present in his or her life and resist suicide to the best of their abilities. The announcement is delivered solemnly, both orally and in writing. This quasi-formal delivery positions the announcement as a transition rite to a new form of dealing with the threat. The following is a typical announcement:

> Dear Daughter,
> We have decided that we will do all in our power to resist suicide and to support you in your trouble. We know you are suffering and we will do our best to stand by your side. We will no longer keep ourselves distant, but will be as close as we can. We will no longer keep this a secret, and will get help from anybody who is willing to help us. We feel that getting help is our utmost duty, for life and death are not private issues. We know that we will go through a very difficult period, and we will be together in this. Your loving parents.

The announcement affects the parents no less than the child. It signals the passage from helplessness to presence and restores the parents' sense of agency. Importantly, the announcement is a one-way parental initiative and its value is independent of the child's willingness to cooperate. Parents are prepared in advance to cope with a variety of reactions to the announcement. For instance, if the child rejects the announcement or throws away the written page, they are prepared to say: "We don't expect you to agree. We are doing this because it is our duty as parents!" If the child tries to provoke the parents, they are taught to withstand the provocations without escalating. If the child runs away, parents are prepared to launch a search action, leaving messages with the child's friends and their parents. Parents also learn to cope with the fear and stress that the child's reactions induce in them.

The shift from helplessness to presence is also manifested by an increase in contact with the child. If the threat is especially urgent (e.g., if there are signs of actual preparations or an attempt was already made), parents are required to set up a suicide watch, not only as a measure to impede the attempt, but also as a manifestation of presence. The suicide watch conveys the message, "We are here and will stay here to the best of our abilities!" Parents often object that they cannot keep the watch forever and that once the child is left alone, the risk of suicide will increase again. Indeed, impeding suicide continuously is all but impossible. However, even without being able to fulfill this goal, the suicide watch conveys a message of care and involvement that reduces the child's isolation. This experience is intensified when the people who set up the watch include also a group of relatives and friends, who take turns to maintain the watch. An adolescent or young adult who experiences the devotion of a group of people who are willing to stand by his or her side for hours and days will feel less abandoned. The sense of connectedness that is engendered by this experience can be a powerful antidote to the wish to die.

The gradual transition from containment to anchoring can be illustrated by the passage from an intense suicide watch into a more virtual manifestation of presence (e.g., by means of constant telephone contacts or text messages). As we argued elsewhere, when parents succeed in becoming present to the child's mind in situations of risk, risk may diminish (Omer, 2011). We believe that by becoming present to the child, either personally, virtually, or through other supporters, parents strengthen the child against the temptation of suicide. The intense presence of the first phase conveys containment. The presence achieved by multiple caring messages from different sources conveys anchoring. Indeed, an anchor may still fulfill its function even if the ship is connected to it by a long rope. Thus, the transition from containment to anchoring may be likened to a progressive lengthening of the rope: The child remains connected to the anchor, but in a manner that is less immediate and leaves more room for autonomous action.

From isolation to support

The negative aspects of the suicide interaction are deepened by isolation. Many parents keep the suicide threat secret, either out of shame, in order to protect the child, or because they are afraid of the child's reaction. Keeping the threat secret drastically reduces connectedness, enclosing the suicide interaction within the boundaries of the parent–child relationship. Secrecy is detrimental for both child and parents because (a) the parents remain maximally vulnerable to emotional blackmail, (b) help possibilities are restricted, and (c) the recursive aspects of suicide interaction are perpetuated. For these reasons, we believe that secrecy and isolation provide the ideal environment to aggravate suicide threats. In contrast, lifting the veil of secrecy and creating a network of supporters by involving relatives, friends, and professionals may lead to a deep change in the conditions that maintain suicidal dynamics.

Some parents may feel that involving others would constitute an unacceptable breach of the child's rights of privacy. In our experience, parents who were initially reluctant to disclose the threat agreed that, when the child's life is at stake, privacy rights should take the back-seat. Indeed, with proper coaching, most parents are willing and capable of mobilizing support. In our treatment, we have a supporters' meeting as soon as possible after the first session. In preparation for that meeting, parents are helped to prepare a "message for the supporters", briefly describing the problem and asking for their help. The message is delivered by word of mouth, but parents are encouraged to deliver it also in writing. The following is a typical text:

> Dear John,
> As we told you today, our daughter Mary has threatened to commit suicide, if we insist that she returns to school. Though this is not the first time that she has mentioned suicide, this is the first time we have decided to ask for help, not only from professionals, but also from family and friends. We are now in parent-therapy, where we learn to overcome our helplessness and isolation. We understand that in remaining alone and keeping the problem secret, we are making it worse. So, we would like to invite you to a supporters' meeting. In the meantime, we are setting up a suicide watch so as not to leave Mary alone. We are also developing a plan how not to give in to Mary's threat, but to help her go back to school as soon as possible. We would be very glad if you could visit us at home sometime during this week and, if Mary agrees, have a short conversation with her. If she doesn't agree, you could leave her a short written message. In any case, your visit will be enormously important for us. Your friends Silvia and Jack.

Parents should be helped to cope with their fears about the child's possible reaction to the involvement of supporters. It is crucial to address parents' fear that disclosing the secret might push the child into attempting suicide. We tell parents that more than anything loneliness and isolation deepen despair and suicide risk. Once parents dare to reach out for help, loneliness is reduced, which makes support and new solutions available. We

make it clear to parents that their child may react in anger to the involvement of others, perhaps attacking them or refusing contact with the supporters. However, the very involvement of supportive others opens new horizons for parent and child alike.

Parents are also helped to withstand the child's anger. Supporters echo the message that life and death issues overrun privacy rights, and this helps children to gradually accept it. The supporters are encouraged to tell the child, "If your parents kept this secret, it is as if they were giving you up! Neither they nor we are ready to give you up!" Lifting the veil of secrecy and involving supporters may change the entire ecology of suicide interaction in a matter of days.

The creation of a supporters' network is crucial not only for the containment phase, but also for facilitating the transition to the anchoring phase. The involvement of supporters in the suicidal crisis makes it more likely for parents to seek help in other contexts. The availability of a support system is a basic factor that enables parents to anchor themselves in their parental role. In this respect, the anchor metaphor is especially apt: A small anchor can stabilize a relatively large ship on account of its spikes (the supporters); an anchor with only one spike (the isolated parent) would be much less effective.

From submission to resistance

In many cases, a suicide threat is the culmination of a long chain of interactions based on patterns of coercion and dysfunctional demand. Fearing that the child may otherwise collapse, run away, or commit suicide, parents accommodate to the child's dysfunctional needs and demands, provide age-inadequate services, and relieve the child from routine obligations (Lebowitz & Omer, 2013). Each step in the sequence paves the way to the next in what becomes a loop of fear and despair. Over time, the very possibility of resisting the child's demands becomes all but inconceivable to the parents. Especially in the case of children with social anxiety, parental giving-in tends to increase withdrawal, as parental accommodation creates a totally protected space within the house, in deep contrast to the menacing challenges of the outside environment (Lebowitz & Omer, 2013). The child, in turn, becomes increasingly convinced of his or her own inability to function. Suicide threat is the logical conclusion of this interactive pattern. The message, "If you don't do this for me, I cannot live!" often paraphrases an entire relationship.

It may sound counterintuitive that, precisely when a child threatens suicide, parents should learn to resist demands they have become used to meet under relatively less stressful conditions. However, our experience has shown that a suicide threat situation—extreme as it is—can offer a unique window for change through resistance. Its very extremeness legitimizes breaking the patterns that led to it, by demonstrating to parents how destructive accommodation can be.

A chief goal of our work with parents is to help them deal with the suicide threat as a lever for changing the coercion-submission cycle. Any attempt to cope with the threat without changing the pattern paves the way for the next threat. For this reason, we find it central to describe the suicide threat as an act of violent communication. This description makes it clear that resisting the threat means resisting the violence and coercion that have often come to characterize the relationship.

Parents are able to resist, if they are supported, and support becomes more readily available because of the suicide threat. Helping parents to contact supporters and tell them they are being threatened and coerced makes parents more resilient to both threat and coercion. Some supporters are requested to contact the child soon after the parental announcement. Sometimes, one or more supporters are already present in the house at the time of the announcement. Parents may tell the child candidly as they deliver the announcement: "We have already notified some people who are close to us. Uncle Steve is now in the dining room and is aware of what is going on here." Thus, supporters may serve

as direct or indirect witnesses and validators of the transition rite created by the announcement. In cases where a suicide attempt has been made, supporters can come to the hospital or visit the child at home, conveying by their very presence the message that the situation is changed and that misused privacy rights have been abrogated.

Resistance is also manifested against the suicide intention itself. To be effective, this resistance should not take the form of a moral admonishment, which, in all probability, would leave the suicidal child indifferent or worse, but that of an existentially engaging encounter. The therapist asks the parents about the people who matter to the child. Those people are then asked to visit the child, openly discuss the suicide intention with him or her, and if the threat is concrete, "beg for his or her life." Those "supplicants" tell the child how important he or she is to them and how the suicide would cause them unbearable pain.

Typical candidates for the role are grandparents, uncles, the child's siblings, and the child's friends. We do not refrain from involving children among the supplicants, especially if an actual attempt has been made and if the children in question are important to the suicidal child. In our view, the objection that this would be psychologically cruel for the helping child is not valid. Suicide is the worst possible outcome for that child as well. In addition, siblings are often witnesses to the threats or to the interactions surrounding them. Therefore, involving them in the solution attempt helps them no less than the parents to go from helplessness to agency. We believe that including siblings by providing them with clear and age-appropriate information helps them fulfill a constructive role in the suicidal crisis and improves their coping abilities, much better than keeping them in the role of presumably uninformed bystanders.

The parental experience of being able to withstand the child's dysfunctional demands and expectations in a suicidal crisis can be of deep value in helping them break free of a long-standing accommodation and submission pattern. However, gains are not automatic; many parents revert to the usual routine once the crisis is over. To prevent this, care must be taken to transform containment into anchoring. Parents must be helped to recognize the connection between their accommodative and submissive behaviors and the suicidal crisis. Their ability to manifest resistance to the suicidal behavior and the suicide-linked demands should be underscored. The message to the parents is: "If you could avoid submitting under the threat of suicide, you definitely can do it under less extreme conditions!" Thus, the suicide crisis can become an opportunity to discontinue a host of inappropriate services. Learning to withstand the pressure to submit and accommodate becomes a self-anchoring experience for parents, by which they become able to stabilize themselves against the pull of unsettling emotions (Omer et al., 2013).

From escalation to self-control

Suicide threats do not usually arise out of nothing, but are preceded by an emotional crescendo that is unwittingly fanned up by parental reactions. Parents often get caught in *reciprocal escalation* by reacting to screams with screams, to aggression with aggression, and to suicide threats with suicide baiting; or in *complementary escalation*, in which giving in to the child's threats reinforces dysfunctional demands (Omer, 2004). Often, the two kinds of escalation co-exist. NVR helps parents recognize and avoid both traps. During sessions, situations of escalation are examined and reactions that manifest self-control are formulated and rehearsed (Omer, 2004; Weinblatt & Omer, 2008). We coined three bywords that are easily remembered and illustrate the nonescalating stance of NVR: "Hit the iron when it is cold!", "You can't control the child, but only yourselves!", and "You don't have to win, but only to persist!" These sayings carry a special meaning in a suicidal situation.

The first expression ("Hit the iron when it is cold!") was originally designed to help parents overcome the urge to react immediately to a child's unacceptable behaviors. The rationale was that immediate reactions come about at the height of arousal and increase the risk of escalation. In the suicidal interaction, this saying gains special meaning: Instead of frantically searching for an immediate response, parents are helped to exercise self-control and reduce escalation. Parents learn to take a deep breath, hold off the pressure for immediate solutions, and remain present in a supportive way. Their ability to do so under the pressure of a suicide threat can be readily generalized to less intense situations. Thus, containment lays the foundations for anchoring.

The second expression ("You can't control the child, but only yourselves!") aims to modify dominant attitudes that often turn the parent–child relationship into a destructive zero-sum game (Bugental, Lyon, Krantz, & Cortez, 1997). The shift from attempting to control the other to exercising self-control is a major NVR de-escalation skill (Lavi-Levavi et al., 2013; Weinblatt & Omer, 2008). A controlling, dominant attitude in the suicidal interaction can lead to highly inappropriate reactions, chief of which is suicide baiting ("You want to jump?! Go ahead, jump!"). The motivation behind suicide baiting is probably the wish to defeat the suicide threat once and for all. However, even if the child refrains from executing the threat, the parental provocation causes damage as the child feels rebuffed instead of supported.

In contrast, emphasizing self-control rather than control over the child may foster a positive change in the suicidal tug-of-war. In our program, parents are encouraged to tell the child (and themselves), "We will do all in our power to prevent you from killing yourself! But we know we cannot control you!" The compulsion to control is thereby replaced by the duty to resist. In resisting, we know that we do not have control over the other. Parents who take NVR measures convey the message that they are doing their best to resist suicide. The positive strength conveyed by these acts more than outbalances their candid acknowledgment that they have no ultimate control over the child.

The third expression ("You don't have to win, but only to persist!") is actually a synthesis of the other two; it unifies the factor of time (the duty to persist) with the renunciation of control. The message of persistence is a good antidote to the sense of absolute urgency that fans suicidal dynamics. The parents react to the child's overwhelming demand ("Act now or I'll kill myself!") by conveying the message, "We will stand by you today, tomorrow, and the day after!" In treatment, parents learn to develop a long breath, and to think not in terms of hours or days, but of weeks and months. Actually, NVR acts at both time ranges; parents are helped to act decidedly here and now, but in ways that convey endurance and self-control. In learning to do so, they offer the child an anchor that the child may learn to use gradually.

In a typical escalating interaction, the child's sense of urgency is multiplied by that of the parents. Instead of an alliance between the child and parents, we have an "alliance-of-urgencies," a mutual spin of suicidal panic. In NVR, in contrast, the suicidal urge is no longer viewed as a fire that must be put out immediately, but as a pain that should be endured until it diminishes. However, the parents should not tell the child, "You can endure the pain!" It is far better if they say: "We will stay with you and endure this together with you!" In this way, they lend the child some of their own power of endurance. This new focus and message come to characterize the parents' attitude regarding other conflicts with the child. In this way, strategies learned during the containment phase lay the foundations for the anchoring phase.

From distancing and hostility to care and support

Nonviolent resistance does not limit itself to struggling determinedly against violent, oppressive, and destructive acts, but involves expressions of respect and care. This is true

even in the socio-political sphere and infinitely more so in the application of NVR to suicidal children (Omer, 2004). Helping parents express care and respect can have a life-enhancing influence on the child's "parliament of the mind" (Shneidman, 1985). Often, however, parents feel inhibited in their ability to do so because the process of mutual distancing and hostility may have *blocked the caring dialogue* (Jakob, 2013). A common reason for parents' inability to express positive feelings is their expectation that the child will ignore or blatantly reject them.

In our program, parents are helped to take steps that express care, respect, and reconciliation, even while expecting a probable rejection by the child. For instance, parents are encouraged to deliver one-sided positive messages in writing, give the child symbolic gifts, mention to the child positive events in the past, or propose a joint activity that was once pleasant to the child. The parents are explicitly prepared for the child's negative reaction, in which case they may say, "That's how I feel, but I can't force you to accept it!" In one case, a mother baked a cake for her 15-year-old son who had threatened to kill himself if she dared disturb him while he was engrossed in the computer game to which he was addicted. She knocked on his door, and said, "I've baked you a coconut cake!" When he expectedly cursed her and her cake, she said, "I made it for you because I love you, but I can't force you to eat it!" She then put the cake in the fridge, leaving her son in the dilemma of whether to prove himself tough and forgo the cake, or enjoy the cake at the price of his toughness. This interaction repeated itself weekly and, in the third week, the boy ate the cake clandestinely. We believe that a piece of mother's cake in the stomach can perform a positive emotional service, even if the child refuses to acknowledge it.

In treatment, the parents learn to view those and similar events as interactions that strengthen them, because their care is no longer dependent on the child's acceptance. The child, in turn, learns that the parent's care is no longer obliterated by his or her hostility. In one case a mother smuggled into her son's school bag bonbons wrapped in pieces of paper with messages of appreciation of a rather unexpected kind (e.g., "I know no one can defeat you!" and "I know that what you did last week was out of loyalty to your friends!"). We believe he might have experienced the smuggled "care-bonbons" as miniature injections of reasons to go on living (Jakob, 2013).

The Treatment Frame

Our programs for parents of children with externalizing or anxiety disorders usually take 10 weekly sessions (Lavi-Levavi et al., 2013; Lebowitz et al., 2013). Our experience with parents of young adults showed that we need a broader time frame (Lebowitz et al., 2012). The same is true about cases of suicide threat. On the average, we need 15 sessions (with a wide range from 10 to 25). In all cases involving suicide threats, the child is offered individual therapy, although this help is sometimes refused. When there is an individual psychotherapist or psychiatrist (or both), close cooperation must be established involving mutual updates. Sometimes, the child's therapist feels unable to share information because of the commitment to absolute therapeutic discretion. We then request permission from the therapist to inform him or her about our work with the parents so the therapist is only a receiver and not a provider of information. We have found that under these conditions, even therapists who are guarded initially eventually agree to a collaborative relationship. However, we expressly advise parents not to agree to stop the measures of NVR if the child sets this as a condition for going to therapy. We feel that therapy carried out under those auspices might actually perpetuate the conditions that led to the suicidal crisis.

The issue of collaboration with other professionals and agencies probably presents special challenges in Israel as the mental health system tends to be rather fragmented and compartmentalized, compared for instance with what we have witnessed in our work with

colleagues in Germany, Switzerland, Belgium, Holland, and the United Kingdom. The fact that NVR includes special measures for establishing and maintaining contact with the family (nuclear and extended), school personnel, social workers, psychiatrists, and psychotherapists helps in countering this compartmentalization. In our experience, those measures proved helpful in considerably increasing connectedness also when the method was applied in other countries (e.g., Newman, Fagan, & Webb, 2013; Ollefs et al., 2009; Van Holen, 2014).

The therapeutic sessions are not preprogrammed according to a strict manual, but they do obey a typical sequence. The initial meetings are devoted to an analysis of the suicidal interaction, with special attention to the issue of escalation. At the end of the first session, parents are asked to formulate an announcement and consider who should be included in the supporters' network. The delivery of the announcement usually occurs after the second session. In cases of acute risk, the first and second sessions take place a couple of days apart. The supporters' meeting usually takes place in the third or fourth session (it is often a longer session; 90–120 minutes long). A mail list is compiled that includes all of the supporters. At different times during the treatment, the therapist provides parents with a message to send to the supporters' group. In this way, parents remain the gatekeepers of communications with the supporters. At times, the parents or therapist may make specific requests from a supporter; for example, the one who has the closest relationship with the child.

Gradually, the treatment focuses on how the strategies learned during the containment phase may be applied to other interactions with the child. Optimally, parents become better able to manifest presence, involve supporters, reduce escalation, resist destructive behaviors, increase self-control, and act in ways that convey care and appreciation. At the final session, parents are given a letter summarizing the chief events and learnings of the therapy. Many parents have reacted very positively to this summary letter, stressing that it gave them a "bird's eye view" of the therapeutic process and of the tools with which they can face future threats.

Case Example

Martha and Eli came to therapy 2 months after their son (Roby, 21 years old) sent them a text message telling them that he could not go on living after his girlfriend left him. They had gone to the dorms where he lived (he was in the first year of college) and found him drunk. At first, he rejected their offer to take him home and blamed them for destroying his life. However, after some persuasion, he agreed. In the following weeks, Roby alluded repeatedly to the possibility of suicide, especially when the parents tried to make demands regarding his functioning. Martha became depressed and was deeply afraid when Roby was away from home. Eli felt paralyzed by Roby's threats. The parents' plight was worsened by the fact that at this stage Roby refused to see a therapist or psychiatrist.

Roby would go out at night, return early in the morning, and stay in bed for most of the day. He would also take his parents' car. When he once found the tank was empty, he blamed and humiliated Martha. He complained that his parents had interfered with his decision to put an end to his life, and added that the next time he would not be so dumb as to give them notice.

The parents told the therapist that their relations with Roby had always been stormy. When they made demands on him, Roby would silence them with a tantrum or threaten that he would vanish from their lives. He had had three courses of individual therapy in the past, but the stormy patterns had not improved.

The parents were asked to list the services they provided for Roby that, to their minds, were not adequate for a 21-year-old. It turned out that they had a characteristic division of labor: Eli took care of all the practical demands (he had helped Roby register at the university, had arranged for the dorm, was in charge of the money transfers, reached an agreement with the bank when it threatened to cancel Roby's credit card, and so forth). Martha was in charge of Roby's emotional needs, talking to him over the phone, sometimes for hours on end. The conversations, which Martha characterized as "blaming orgies," were deeply painful for Martha, but she was afraid to stop them.

With the therapist's help, the parents summarized the coercive and escalating patterns between Roby and themselves. All services connected to Roby's threats or to their fears of Roby's negative reactions were described as links in the cycle. Also the parents' dire warnings and Martha's endless attempts to placate Roby were represented as links in this chain. The connection between inappropriate services, escalating patterns, and misguided help attempts on the one hand, and Roby's extreme threats and reactions on the other, became clear to the parents. Eli and Martha agreed that the goals of therapy should be to help them manifest decided presence, while, at the same time, cease giving in to Roby's inappropriate demands or invitations to escalate. They were assisted in writing an announcement and were asked to build a list of potential supporters.

The second session took place 3 days after the first. In that session, the parents discussed how to deliver the announcement, and prepared for Roby's reactions. Eli raised objections to the involvement of supporters, but the fact that a number of family members (Roby's and Martha's brothers and the two remaining grandparents) knew about the suicide threats helped the father accept that discretion was not a viable or helpful course. A supporters' meeting was scheduled for a week later. In the meantime, the grandparents and Roby's uncles became involved and were available by phone when the announcement was delivered. In the announcement, the parents declared they would do all in their power to stay in touch with Roby and not stay passive in the face of his suicide threats or his disappearances. They declared that they would reduce their inappropriate services, for they now understood that they were deeply damaging. They said that they would be very willing to help with any constructive plans, but they would no longer maintain his present lifestyle.

Unexpectedly, Roby remained silent and even reread the announcement after the parents finished delivering it orally. Roby remained in his room until the evening, then left the house without a word, as he usually did. The parents sent him a text message asking him to tell them when he was coming back. When Roby did not respond, they called three of his friends and asked them to tell Roby that they were anxious about him. Roby called Martha back and asked her if they had gone crazy. Martha said they did not wish to disturb any of his friends and would not do so if Roby notified them of his plans. Roby hung up the phone angrily; Martha did not call him back. The next day, his grandfather called him and told him he had also been updated and that, if Roby disappeared, he would support the parents in looking for him, for neither he nor they were ready to give him up. He also invited Roby to stay with him for a couple of days. Surprisingly, Roby agreed.

There were 12 people at the supporters' meeting. The supporters agreed to be on call in case Roby made any extreme action or threat. A couple of close friends of the family who lived abroad were also included among the supporters (they would support Roby via phone and mail), though they were obviously not present at the meeting. Their contribution was deemed important for Roby thought highly of them and had had a positive relationship with them and their children in the past. A friend of Eli, who was a financial advisor, agreed to talk to Roby about money issues. He made it clear to Roby that the parents would no longer rescue him from losing his credit card. He told Roby that he knew he had run into debt with his friends and that he would be glad to help Roby develop a financial plan.

During the next week, Roby threatened suicide twice. On both occasions the parents called supporters, who came to the house or got in touch with Roby by phone. In one case, Roby was violent and two of the supporters took him with them for a long drive in their car. They stayed with him until late at night. At about 4:00 AM, Roby asked to return home to sleep, and one of the supporters proposed that he should sleep at his (the supporter's) house to cool down the friction between him and his parents. Roby agreed and ended by staying with this family for 3 days. During this time, he agreed to plan a budget with the help of the financial advisor. He also agreed to the supporter's suggestion that he should see a psychiatrist, an option he had blatantly refused when it came from his parents. He was referred to a psychiatrist that had worked with us before. The psychiatrist told Roby that he would update his parents about the treatment, but would keep discretion about his intimate life. After a brief discussion on those limits, Roby agreed. The psychiatrist updated the parents and was, in turn, updated by the NVR therapist. In this way, with the help of the parents' support network, Roby was also able to get professional assistance.

When Roby would start blaming Martha, she would politely say that she would not continue the conversation. On those occasions, the two supporters from abroad proved particularly helpful. They would call Roby and talk to him, and tell him that the blaming, besides being unacceptable, was not helping him. However, they believed in him and trusted that he could surmount the crisis. Those conversations were much shorter than were those with the mother. Those supporters also helped "smuggle" parental messages of appreciation and reminders to past positive joint events in which Roby had played a special role. They would say things like: "Your father told me how you fixed the car on your trip abroad when it seemed you were stuck for the night! I didn't know about that!" or "Your mother said she knew that, when in trouble, she can always count on you. She told me how you took your younger brother to school and back for a month when he was threatened by bullies!" Gradually, the parents became able to retell those and other positive stories in pleasant conversations with Roby.

Roby went back to college after the semester break. Martha was sad that their special relationship had cooled, but she also felt that, in the last couple of years, the good aspects had degenerated. Roby now preferred to call Eli instead of Martha. At the final session (out of 13), the therapist and parents discussed how to react if the difficulties reappeared. When Roby was in his third year of college, he had a new crisis with manic symptoms of an aggressive nature. It turned out he was taking Ecstasy. He was taken to the psychiatrist with whom he had built a good relationship. The psychiatrist convinced him to accept a brief hospitalization because he was in great danger of hurting himself and perhaps others as well. After 2 weeks in the hospital, the symptoms diminished and he could return to his parents' home until he was able to return to his studies. The parents came to a few sessions and some supporters were mobilized. The supporters proved vital in getting Roby to persist with the medical treatment. The management of this crisis showed that the parents were less helpless and Roby could now profit from professional attention. Roby's problems were far from being solved, but the conditions for dealing with them were better than they had been in the past.

DISCUSSION

Although the effectiveness of NVR in reducing suicide risk has yet not been researched, NVR is known to positively affect some of the factors that have been shown to increase risk: (a) hostility, detachment, and other forms of poor communication between parents and child have been linked to suicide risk (Daniel & Goldston, 2009; Dube et al., 2001; Fergusson et al., 2000; Johnson et al., 2002; Wagner et al., 2003). NVR reduces hostility,

negative feelings, and power struggles, and increases parental involvement and positive parental acts toward the child (Lavi-Levavi et al., 2013; Weinblatt & Omer, 2008). (b) Lack of parental knowledge (or monitoring) has been implicated in increased risk for adolescents in virtually all fields of risk behavior (Racz & McMahon, 2011), including suicide attempts and ideation (King et al., 2001). NVR greatly increases parental knowledge by means of nonintrusive vigilant care (Farah et al., 2013; Omer, 2011). (c) Affective dysregulation is widely experienced among suicidal adolescents (Yen, Gagnon, & Spirito, 2013), and affective dysregulation in parents and children are shown to be significantly associated (Buckholdt, Parra, & Jobe-Shields, 2013). NVR improves parental self-control and reduces emotional outbursts (Gershy, 2014; Lavi-Levavi et al., 2013; Weinblatt & Omer, 2008). (d) lack of positive connectedness has been associated with increased suicide risk (Center for Disease Control & Prevention, 2008); NVR increases connectedness (Newman et al., 2013; Weinblatt & Omer, 2008).

The NVR model has a number of characteristics that are different from those of most other approaches: (a) it helps parents resist threat and coercion and at the same time support the child, (b) it addresses the issues of escalation and accommodation, (c) it recognizes parent distress as no less important than child distress, (d) it helps parents take positive initiatives without fearing the child's rejection, (e) it dispels secrecy in ways that quickly increase connectedness, and (f) it does not assume that the child cooperates with therapy. This last, perhaps unique, characteristic of NVR has already shown itself to be valuable with other problems such as children with anxiety disorders or adults with entitled dependence who refuse therapy (Lebowitz et al., 2012, 2013). In many cases, the implementation of NVR leads to increased readiness of the child to accept therapy at a later stage (Lebowitz et al., 2013). In case of suicide threats, as shown in the case example above, this feature of NVR can make it invaluable.

In spite of its supportive characteristics, the idea that NVR can be a first-line approach for suicide threats may give rise to doubts. The reaction of most professionals to a child who mentions suicide is the desire to increase the flow of positive affection. For this reason, an approach that is purely based on improving the quality of attachment might have a more immediate appeal in this area. In effect, we think that, in many cases, the adequacy of such an approach is beyond doubt. Diamond et al. (2011, 2010) demonstrated that in cases where suicide ideation is directly linked to the absence of positive affect and to a deep sense of rejection (e.g., adolescents who are profoundly at odds with their parents because of their peculiar sexual tendencies), focusing treatment on improving parental acceptance and the quality of the parent–child bond not only improves the relationship but also reduces depression and suicidality. We believe there is a continuum between those cases, in which suicide ideation arises out of a sense of neglect and rejection, and cases in which suicide threats emerge in the context of demands for inappropriate services or escalating clashes. Ideally, one should be able to match the treatment to the child's place in that continuum; families closer to the neglect-rejection pole would receive an attachment-based intervention, while families closer to the escalation-coercion end would receive an NVR intervention. It is, however, difficult to establish a clear dividing line between cases. Our hypothesis would be that, in cases where the suicide threat has elements of intimidation and the relationship is of a coercive or accommodating nature, the efficacy of NVR should be especially high. It is also important to understand that NVR aims at restoring and stabilizing the parent–child bond. In this respect it is not only not opposed to an attachment-based therapy, but can actually be viewed as attachment-oriented. In effect, NVR has been proposed as a bridge between parental authoritativeness and secure attachment through the provision of a parental anchor (Omer et al., 2013).

A possible concern regarding NVR regards potential contra-indications, especially in cases of severe psychopathology. It should be stressed that in severe conditions, as in any

case involving suicide threat, NVR represents only one aspect of the therapeutic process. The suicidal person and his or her family require professional attention of various kinds (psychiatric, social, individual, and family assistance). The fact that NVR attends to the different facets of the social and professional network facilitates integration between the different agencies.

As regards especially severe forms of psychopathology, NVR has been implemented with hospitalized psychotic adolescents (Goddard, Van Gink, Van der Stegen, Van Driel, & Cohen, 2009), and with young adults with depression and borderline or avoidant personality disorder (Lebowitz et al., 2012). Those cases require more attention and often a longer therapeutic process. Special efforts should then be devoted to coordinating the parents' treatment with other professionals working with the case. Yet, could NVR be dangerous in some cases? We believe that this could sometimes be the case and that a number of preventive care measures should be taken. First, NVR can be misinterpreted and misused to achieve control and challenge the child in a truculent way. With young people who threaten suicide, considerable attention should be devoted to this issue: Parents should take care to communicate with the child in a supportive, rather than a challenging or controlling way. Second, it is crucial to assign one or more members of the helpers a definite role in support of the child. The best candidates for this role are members who have a positive relationship with the child. It is especially important to verify the availability of such supporters during the containment stage. We believe that such a clear offer of support can help strengthen the positive voices in the young person's 'inner parliament'. In the absence of such a candidate, it might be justified to contact the youngsters' friends. Such friends would usually not take part in the supporters' meeting, to prevent conflicts of loyalty, but should be contacted and informed that the threatening youth is in acute crisis and has threatened suicide. Under such conditions, friends usually become willing to help. We emphasize that those care measures are highly coherent with the NVR approach and in all probability would reduce risk. In contrast, risk might increase if parents declare their decision to cut down existing services without verifying that the child is closely accompanied and offered relevant support.

As the cases on which NVR was used with suicide threats were conducted in Israel, the question of generalization to other cultures and countries should be raised. Although developed in Israel, NVR has been used in a variety of countries and studies have been conducted in Germany (Ollefs et al., 2009), the UK (Newman et al., 2013), Holland (Goddard et al., 2009a,b) the US (Lebowitz et al., 2013), and Belgium (Van Holen, 2014). The effects were very similar to those we found with Israeli samples. Systematic research on the application of NVR for cases of suicide threat is still not available. However, to our minds there are good reasons to assume that the parallels that were obtained in other areas will hold for the present problem as well.

We would like to conclude with a few directions for research. We are presently developing a "threat questionnaire" for parents, which includes items in different areas (e.g., threat of running away, of destroying family property, of increasing delinquent activities, and of committing suicide). Our intent is to investigate frequency of threats and parental coping before and after therapy. We are including assessment not only by the parents but also by a collateral (child's teacher or close member of the support system) of the child's risk level, as well as of depression and suicidality. Unfortunately our attempts to measure depression and suicidality directly have failed, as in our samples many of the children refuse to cooperate. In other programs, where the children are already in therapy, NVR could be offered to parents and the effects on child depression and suicidality could be directly measured. Finally, we have developed and validated a "Parental Anchoring Questionnaire" (Carthy et. al., unpublished data) that measures the ability of parents to anchor themselves in their parental roles and support systems, so as to offer the child a more

stable relational frame. We are presently using the questionnaire in our studies of NVR in different diagnostic categories. We hypothesize that parental anchoring will rise as an effect of treatment and that this will be linked to improved child and family functioning and symptoms, including depression and suicidality.

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